Populated Printable COP

Excluding To Be Determined Partners

2007

Rwanda

Country Contacts

Contact Type	First Name	Last Name	Title	Email
DOD In-Country Contact	Ronald	Miller	Defense Attache'	MillerRJ@state.gov
HHS/CDC In-Country Contact	Timothy	Cote'	Country Director	Cotet@CDC-Rwanda.org
Peace Corps In-Country Contact	Praya	Baruch	Program Analyst	PBaruch@peacecorps.gov
USAID In-Country Contact	Kevin	Mullally	Mission Director	kmullally@usaid.gov
U.S. Embassy In-Country Contact	Arietti	Michael	Ambassador	AriettiMR@state.gov

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:

Table 2: Prevention, Care, and Treatment Targets

2.1 Targets for Reporting Period Ending September 30, 2007

	National 2-7-10 (Focus Country Only)	USG Downstream (Direct) Target End FY2007	USG Upstream (Indirect) Target End FY2007	USG Total Target End FY2007
Prevention				
	End of Plan Goal: 157,643			
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting		3,648	6,104	9,752
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		112,146	191,094	303,240
Care				
	End of Plan Goal: 250,000	79,309	39,502	118,811
Total number of individuals provided with HIV-related palliative care (including TB/HIV)		50,000	39,502	89,502
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (a subset of indicator 6.2)		2,420	800	3,220
Number of OVC served by OVC programs		29,309	0	29,309
Number of individuals who received counseling and testing for HIV and received their test results (including TB)		124,864	231,891	356,755
Treatment				
	End of Plan Goal: 50,000	25,000	25,400	50,400
Number of individuals receiving antiretroviral therapy at the end of the reporting period		25,000	25,400	50,400

2.2 Targets for Reporting Period Ending September 30, 2008

	National 2-7-10 (Focus Country Only)	USG Downstream (Direct) Target End FY2008	USG Upstream (Indirect) Target End FY2008	USG Total Target End FY2008
Prevention				
	End of Plan Goal: 157,643			
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting		4,518	5,487	10,005
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		129,161	217,399	346,560
Care				
	End of Plan Goal: 250,000	142,675	39,900	182,575
Total number of individuals provided with HIV-related palliative care (including TB/HIV)		93,100	39,900	133,000
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (a subset of indicator 6.2)		3,500	1,000	4,500
Number of OVC served by OVC programs		49,575	0	49,575
Number of individuals who received counseling and testing for HIV and received their test results (including TB)		175,190	364,810	540,000
Treatment				
	End of Plan Goal: 50,000	36,946	21,379	58,325
Number of individuals receiving antiretroviral therapy at the end of the reporting period		36,946	21,379	58,325

Table 3.1: Funding Mechanisms and Source

Mechanism Name: Health Systems 20/20

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4694
Planned Funding($): $ 100,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: ABT Associates
New Partner: Yes

Mechanism Name: N/A

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 8600
Planned Funding($): $ 400,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Abt Associates
New Partner: No

Mechanism Name: FANTA

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4708
Planned Funding($): $ 0.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Academy for Educational Development
New Partner: No

Mechanism Name: ACDI-VOCA Title II

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4695
Planned Funding($): $ 20,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: ACDI/VOCA
New Partner: Yes

Mechanism Name: Refugees AHA

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4318
Planned Funding($): $ 0.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: African Humanitarian Action
New Partner: No

Mechanism Name: Africare Track 1

Mechanism Type: Central - Headquarters procured, centrally funded
Mechanism ID: 4319
Planned Funding($): $ 760,451.00
Agency: U.S. Agency for International Development
Funding Source: Central (GHAI)
Prime Partner: Africare
New Partner: No

Mechanism Name: AABB

Mechanism Type: Central - Headquarters procured, centrally funded
Mechanism ID: 4728
Planned Funding($): $ 400,000.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: Central (GHAI)
Prime Partner: American Association of Blood Banks
New Partner: Yes

Mechanism Name: AIHA Twinning Ctr

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4320
Planned Funding($): $ 0.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Prime Partner: American International Health Alliance
New Partner: No

Mechanism Name: Refugees - Rwanda

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4321
Planned Funding($): $ 0.00
Agency: Department of State / Population, Refugees, and Migration
Funding Source: GHAI
Prime Partner: American Refugee Committee
New Partner: Yes

Mechanism Name: American Society of Clinical Pathology

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4322
Planned Funding($): $ 0.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Prime Partner: American Society of Clinical Pathology
New Partner: No

Mechanism Name: Land

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4713
Planned Funding($): $ 200,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Associates in Rural Development
New Partner: Yes

Mechanism Name: Leg (formerly TBD)

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 6140
Planned Funding($): $ 400,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Associates in Rural Development
New Partner: Yes

Mechanism Name: AVSI Track 1

Mechanism Type: Central - Headquarters procured, centrally funded
Mechanism ID: 4323
Planned Funding($): $ 358,280.00
Agency: U.S. Agency for International Development
Funding Source: Central (GHAI)
Prime Partner: Associazione Volontari per il Servizio Internazionale
New Partner: No

Mechanism Name: AIDS Relief

Mechanism Type: Central - Headquarters procured, centrally funded
Mechanism ID: 4325
Planned Funding($): $ 621,139.00
Agency: HHS/Health Resources Services Administration
Funding Source: Central (GHAI)
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: HTXS - ARV Services

Sub-Partner: Bushenge Health District
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Kibogora Health District
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Karangara Health Center
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: Yes

Associated Program Areas: HBHC - Basic Health Care and Support
HTXS - ARV Services

Mechanism Name: CRS Track 1

Mechanism Type: Central - Headquarters procured, centrally funded
Mechanism ID: 4324
Planned Funding($): $ 176,592.00
Agency: U.S. Agency for International Development
Funding Source: Central (GHAI)
Prime Partner: Catholic Relief Services
New Partner: No

Mechanism Name: Catholic Relief Services Supplemental

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4326
Planned Funding($): $ 2,504,097.00
Agency: HHS/Health Resources Services Administration
Funding Source: GHAI
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: HTXS - ARV Services

Sub-Partner: Muhura Health Center
Planned Funding: $ 20,608.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Rushaki Health Center
Planned Funding: $ 23,600.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Muyange Health Center
Planned Funding: $ 26,613.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Mwezi Health Center
Planned Funding: $ 15,209.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Kamonyi Health Center
Planned Funding: $ 14,067.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVCT - Counseling and Testing

Sub-Partner: Nyamasheke Health Center
Planned Funding: $ 14,903.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Kibogora Health Center
Planned Funding: $ 21,897.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Gatare Health Center
Planned Funding: $ 15,238.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Ruheru Health Center
Planned Funding: $ 26,457.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Yove Health Center
Planned Funding: $ 14,168.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVCT - Counseling and Testing

Mechanism Name: CRS USAID Supplemental

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 7327
Planned Funding($): $ 150,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Catholic Relief Services
New Partner:

Mechanism Name: TBD--TBD GBV

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 6152
Planned Funding($): $ 150,000.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Prime Partner: Catholic Relief Services
New Partner: No

Mechanism Name: Catholic Relief Services Supplemental GHAI

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 6219
Planned Funding($): $ 138,000.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Prime Partner: Catholic Relief Services
New Partner:

Mechanism Name: CRS Title II

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4706
Planned Funding($): $ 50,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Catholic Relief Services
New Partner: No

Mechanism Name: Columbia/MCAP

Mechanism Type: Central - Headquarters procured, centrally funded
Mechanism ID: 4327
Planned Funding($): $ 4,600,000.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: Central (GHAI)
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: HTXS - ARV Services

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

Mechanism Name: Columbia MCAP Supplement

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4329
Planned Funding($): $ 2,081,143.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Prime Partner: Columbia University Mailman School of Public Health
New Partner: No

Sub-Partner: Karengera Health Center, Rwanda
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Muhima Health District
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner:

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Shyira District Hospital
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Kabaya Health District
Planned Funding:
Funding is TO BE DETERMINED: Yes

New Partner:

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Gisenyi Health District
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Muhororo Health District
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Kibuye Health District
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Mugonero Health District
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Kirinda Health District
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

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

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Murunda Health District
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Mechanism Name: Columbia UTAP

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4328
Planned Funding($): $ 3,600,000.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Prime Partner: Columbia University Mailman School of Public Health
New Partner: No

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

Associated Program Areas: HLAB - Laboratory Infrastructure

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

Associated Program Areas: HVTB - Palliative Care: TB/HIV

Sub-Partner: University of Butare
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HTXS - ARV Services
HLAB - Laboratory Infrastructure

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

Associated Program Areas: HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HTXS - ARV Services

Mechanism Name: CHAMP

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4330
Planned Funding($): $ 12,409,083.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Community Habitat Finance International
New Partner: No

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

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HKID - OVC
HVCT - Counseling and Testing
OHPS - Other/Policy Analysis and Sys Strengthening

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

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HKID - OVC
HVCT - Counseling and Testing
OHPS - Other/Policy Analysis and Sys Strengthening

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

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HKID - OVC
HVCT - Counseling and Testing
OHPS - Other/Policy Analysis and Sys Strengthening

Sub-Partner:	Society of Women Against AIDS, Rwanda
Planned Funding:	
Funding is TO BE DETERMINED:	Yes
New Partner:	No
Associated Program Areas:	MTCT - PMTCT HVAB - Abstinence/Be Faithful HVOP - Condoms and Other Prevention HBHC - Basic Health Care and Support HKID - OVC HVCT - Counseling and Testing OHPS - Other/Policy Analysis and Sys Strengthening
Sub-Partner:	Pamasor
Planned Funding:	
Funding is TO BE DETERMINED:	Yes
New Partner:	No
Associated Program Areas:	MTCT - PMTCT HVAB - Abstinence/Be Faithful HVOP - Condoms and Other Prevention HBHC - Basic Health Care and Support HKID - OVC HVCT - Counseling and Testing OHPS - Other/Policy Analysis and Sys Strengthening
Sub-Partner:	Rwanda's Women Network
Planned Funding:	
Funding is TO BE DETERMINED:	Yes
New Partner:	No
Associated Program Areas:	MTCT - PMTCT HVAB - Abstinence/Be Faithful HVOP - Condoms and Other Prevention HBHC - Basic Health Care and Support HKID - OVC HVCT - Counseling and Testing OHPS - Other/Policy Analysis and Sys Strengthening
Sub-Partner:	Icyuzuzo Womens Group
Planned Funding:	
Funding is TO BE DETERMINED:	Yes
New Partner:	No
Associated Program Areas:	MTCT - PMTCT HVAB - Abstinence/Be Faithful HVOP - Condoms and Other Prevention HBHC - Basic Health Care and Support HKID - OVC HVCT - Counseling and Testing OHPS - Other/Policy Analysis and Sys Strengthening
Sub-Partner:	Urunana
Planned Funding:	
Funding is TO BE DETERMINED:	Yes
New Partner:	No
Associated Program Areas:	MTCT - PMTCT HVAB - Abstinence/Be Faithful HVOP - Condoms and Other Prevention HBHC - Basic Health Care and Support HKID - OVC HVCT - Counseling and Testing OHPS - Other/Policy Analysis and Sys Strengthening
Sub-Partner:	Johns Hopkins University Center for Communication Programs

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

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HKID - OVC
HVCT - Counseling and Testing
OHPS - Other/Policy Analysis and Sys Strengthening

Sub-Partner: Catholic Relief Services
Planned Funding:
Funding is TO BE DETERMINED: Yes
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HKID - OVC
HVCT - Counseling and Testing
OHPS - Other/Policy Analysis and Sys Strengthening

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

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HKID - OVC
HVCT - Counseling and Testing
OHPS - Other/Policy Analysis and Sys Strengthening

Mechanism Name: HIV Support to RDF

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4331
Planned Funding($): $ 1,453,858.01
Agency: Department of Defense
Funding Source: GHAI
Prime Partner: Drew University
New Partner: No

Mechanism Name: Call to Action/EGPAF

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4332
Planned Funding($): $ 699,999.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
New Partner: No

Sub-Partner: Butamwa Health Center, Rwanda
Planned Funding: $ 0.00

Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVCT - Counseling and Testing

Sub-Partner: Gikomero Health Center
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Kabuga Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Masaka Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVCT - Counseling and Testing

Sub-Partner: Muhima Dispensary
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVCT - Counseling and Testing

Sub-Partner: Rwankuba Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT

Sub-Partner: Nzige Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Nyagasambu Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Kabusunzu Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVCT - Counseling and Testing

Sub-Partner: Jali Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No

New Partner: No

Associated Program Areas: MTCT - PMTCT
HVCT - Counseling and Testing

Sub-Partner: Rubungo Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Program for Appropriate Technology in Health
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT

Mechanism Name: EGPAF New Bilateral

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 7089
Planned Funding($): $ 3,687,001.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
New Partner: No

Sub-Partner: Kabarore Health Center
Planned Funding: $ 34,853.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing

Sub-Partner: Kamabuye Health Center
Planned Funding: $ 59,213.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Butamwa Health Center, Rwanda
Planned Funding: $ 35,888.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Kiziguro District Hospital
Planned Funding: $ 57,458.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Cor Unum Health Center
Planned Funding: $ 46,524.00

Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Masaka Health Center, Rwanda
Planned Funding: $ 50,324.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Muhura Health Center
Planned Funding: $ 25,329.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Gakenke Health Center
Planned Funding: $ 34,479.00
Funding is TO BE DETERMINED: No
New Partner: Yes

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Muyumbu Health Center
Planned Funding: $ 63,947.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing

Sub-Partner: Gahini Health Center
Planned Funding: $ 137,062.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing

Sub-Partner: Gitiku Health Center
Planned Funding: $ 44,775.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing

Sub-Partner: Humure Health Center
Planned Funding: $ 32,445.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing

Sub-Partner: Mwogo Health Center
Planned Funding: $ 64,555.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing

Sub-Partner: Kabarondo Health Center
Planned Funding: $ 20,459.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing

Sub-Partner: Nyagasambu Health Center, Rwanda
Planned Funding: $ 40,426.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Nyamata Hospital, Rwanda
Planned Funding: $ 78,319.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Nzangwa Health Center
Planned Funding: $ 59,691.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Nzige Health Center, Rwanda
Planned Funding: $ 43,056.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Remera Health District
Planned Funding: $ 36,532.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Rubona Health Center
Planned Funding: $ 48,914.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Rugarama Health Center
Planned Funding: $ 37,299.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Rukara Health Center
Planned Funding: $ 37,159.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing

Sub-Partner: Ruhunda Health Center
Planned Funding: $ 49,364.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing

Sub-Partner: Rukoma Sake Health Center
Planned Funding: $ 37,215.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Rukumberi Health Center
Planned Funding: $ 67,285.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Ruramira Health Center
Planned Funding: $ 20,010.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing

Sub-Partner: Gatsibo District
Planned Funding: $ 20,309.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Gituza Health Center
Planned Funding: $ 66,731.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Kibungo Prison
Planned Funding: $ 6,811.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Kibungo Hospital, Rwanda

Planned Funding: $ 80,795.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Muhima Hospital
Planned Funding: $ 64,987.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT

Sub-Partner: Ngarama Health Center
Planned Funding: $ 28,800.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Ngoma District
Planned Funding: $ 20,901.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Nyagahanga Health Center
Planned Funding: $ 39,877.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention
HBHC - Basic Health Care and Support
HVTB - Palliative Care: TB/HIV
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Rwamagana Hospital
Planned Funding: $ 35,062.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Central Hospital Kigali
Planned Funding: $ 31,077.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT

Sub-Partner: Kayonza District
Planned Funding: $ 22,519.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Sub-Partner: Rwamanyoni Health Center

Planned Funding: $ 36,747.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HTXS - ARV Services

Mechanism Name: Data Analysis and Use

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 5410
Planned Funding($): $ 0.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Prime Partner: Family Health International
New Partner: No

Mechanism Name: FHI Bridge

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4729
Planned Funding($): $ 0.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Family Health International
New Partner: No

Sub-Partner: Muyanza Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HBHC - Basic Health Care and Support
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Byumba Hospital, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HBHC - Basic Health Care and Support
HTXS - ARV Services

Sub-Partner: Nyabikenke Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HBHC - Basic Health Care and Support
HTXS - ARV Services

Sub-Partner: Mukungu Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HBHC - Basic Health Care and Support
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Kigeme Hospital, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HBHC - Basic Health Care and Support
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Kirambi Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HBHC - Basic Health Care and Support
HTXS - ARV Services

Sub-Partner: Ruramba Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HBHC - Basic Health Care and Support
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Kivumu Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HBHC - Basic Health Care and Support
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Mugina Health Center
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HBHC - Basic Health Care and Support
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Nyarusange Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HBHC - Basic Health Care and Support
HTXS - ARV Services

Sub-Partner: Ruhango Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HBHC - Basic Health Care and Support
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Kabgayi Hospital, Rwanda
Planned Funding: $ 0.00

Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HBHC - Basic Health Care and Support
HTXS - ARV Services

Sub-Partner: Gitwe Hospital, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HBHC - Basic Health Care and Support
HTXS - ARV Services

Sub-Partner: Remera-Rukoma Hospital, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HBHC - Basic Health Care and Support
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Masaka Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HBHC - Basic Health Care and Support
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Nyamata Hospital, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HBHC - Basic Health Care and Support
HTXS - ARV Services

Sub-Partner: Ruli Hospital, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HVCT - Counseling and Testing

Sub-Partner: Biryogo Health Center
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HBHC - Basic Health Care and Support
HVCT - Counseling and Testing

Sub-Partner: Bungwe Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HBHC - Basic Health Care and Support
HVCT - Counseling and Testing

Sub-Partner: Rugege Health Center

Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HBHC - Basic Health Care and Support
HVCT - Counseling and Testing

Sub-Partner: Kayove Health Center
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HBHC - Basic Health Care and Support
HVCT - Counseling and Testing

Sub-Partner: Kigufi Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HBHC - Basic Health Care and Support
HVCT - Counseling and Testing
HTXS - ARV Services

Sub-Partner: Murara Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HBHC - Basic Health Care and Support
HVCT - Counseling and Testing

Sub-Partner: Gitarama Health Center, Rwanda
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: MTCT - PMTCT
HBHC - Basic Health Care and Support

Mechanism Name: FHI New Bilateral

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 7088
Planned Funding($): $ 6,989,319.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Family Health International
New Partner:

Mechanism Name: Transport Corridor Initiative

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4333
Planned Funding($): $ 963,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Family Health International
New Partner: No

Mechanism Name: Biodiversity

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4696
Planned Funding($): $ 150,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: International Resources Group
New Partner:

Mechanism Name: Capacity

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4334
Planned Funding($): $ 1,325,001.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: IntraHealth International, Inc
New Partner: No

Mechanism Name: IntraHealth New Bilateral

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 7090
Planned Funding($): $ 4,049,999.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: IntraHealth International, Inc
New Partner: No

Mechanism Name: Twubakane

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4335
Planned Funding($): $ 950,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: IntraHealth International, Inc
New Partner: No

Mechanism Name: Safe Injection

Mechanism Type: Central - Headquarters procured, centrally funded
Mechanism ID: 4336
Planned Funding($): $ 0.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: Central (GHAI)
Prime Partner: John Snow, Inc.
New Partner: No

Mechanism Name: Deliver follow-on

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4707
Planned Funding($): $ 100,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: John Snow, Inc.
New Partner:

Mechanism Name: N/A

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 8601
Planned Funding($): $ 500,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Land O'Lakes
New Partner: Yes

Mechanism Name: Measure DHS

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4337
Planned Funding($): $ 550,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Macro International
New Partner: No

Mechanism Name: RPM+

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4338
Planned Funding($): $ 2,360,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Management Sciences for Health
New Partner: No

Mechanism Name: HIV/AIDS Performance Based Financing

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4339
Planned Funding($): $ 4,531,200.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Management Sciences for Health
New Partner: No
Early Funding Request: Yes
Early Funding Request Amount: $ 1,300,000.00
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 ($900,000) is 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.

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

Associated Program Areas: MTCT - PMTCT
OHPS - Other/Policy Analysis and Sys Strengthening

Mechanism Name: MoH CoAg

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 5108
Planned Funding($): $ 250,000.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Prime Partner: Ministry of Health, Rwanda
New Partner: No

Mechanism Name: Strengthening Blood Transfusion Services

Mechanism Type: Central - Headquarters procured, centrally funded
Mechanism ID: 4340
Planned Funding($): $ 2,700,000.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: Central (GHAI)
Prime Partner: National Program for Blood Transfusion, Rwanda
New Partner: No

Mechanism Name: National Reference Laboratory

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4341
Planned Funding($): $ 500,000.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Prime Partner: National Reference Laboratory
New Partner: No

Mechanism Name: BASICS

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4342
Planned Funding($): $ 320,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Partnership for Child HealthCare Inc.
New Partner: No

Mechanism Name: SCMS

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4741
Planned Funding($): $ 20,892,880.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Partnership for Supply Chain Management
New Partner: No
Early Funding Request: Yes
Early Funding Request Amount: $ 4,000,000.00
Early Funding Request Narrative: PFSCM is the primary EP mechanism for ARV and other commodity procurement. in order to ensure that funding is available in time for upcoming procurements and that there will be no gap in funding, it will be important to have some funds on hand as early as possible in the year.

Early Funding Associated Activities:

Program Area:HTXD - ARV Drugs
Planned Funds: $13,750,000.00
Activity Narrative: This activity relates to HBHC (8716), HVTB (8664), HVCT (8167), HLAB (8189), HTXS (7161, 7174, 7213,

Mechanism Name: PSI Healthy Schools

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4343
Planned Funding($): $ 750,000.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Prime Partner: Population Services International
New Partner: No

Sub-Partner: Ministry of Education, Rwanda
Planned Funding: $ 45,000.00
Funding is TO BE DETERMINED: No

New Partner: Yes

Associated Program Areas: HVAB - Abstinence/Be Faithful
HVOP - Condoms and Other Prevention

Mechanism Name: PSI Bilateral

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4345
Planned Funding($): $ 0.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Population Services International
New Partner: No

Mechanism Name: PSI-DOD

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4344
Planned Funding($): $ 570,000.00
Agency: Department of Defense
Funding Source: GHAI
Prime Partner: Population Services International
New Partner: No

Mechanism Name: Blood Safety Technical Assistance

Mechanism Type: Central - Headquarters procured, centrally funded
Mechanism ID: 4346
Planned Funding($): $ 0.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: Central (GHAI)
Prime Partner: Sanquin Diagnostic Services
New Partner: No

Mechanism Name: COPRS

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4715
Planned Funding($): $ 0.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Social and Scientific Systems
New Partner: Yes

Mechanism Name: Health Policy Initiative

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4347
Planned Funding($): $ 0.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: The Futures Group International
New Partner: No

Mechanism Name: TRAC Cooperative Agreement

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4351
Planned Funding($): $ 1,570,000.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Prime Partner: Treatment and Research AIDS Center
New Partner: No

Mechanism Name: UTAP

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4352
Planned Funding($): $ 950,000.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Prime Partner: Tulane University
New Partner: No

Mechanism Name: Tulane bilateral

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4353
Planned Funding($): $ 862,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: Tulane University
New Partner: No

Mechanism Name: Refugees UNHCR

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4740
Planned Funding($): $ 307,420.00
Agency: Department of State / Population, Refugees, and Migration
Funding Source: GHAI
Prime Partner: United Nations High Commissioner for Refugees
New Partner: Yes

Mechanism Name: Measure Eval

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4354
Planned Funding($): $ 0.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: University of North Carolina
New Partner: No

Sub-Partner: John Snow, Inc.
Planned Funding: $ 650,000.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HVSI - Strategic Information

Mechanism Name: Central Contraceptive Procurement

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4355
Planned Funding($): $ 450,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: US Agency for International Development
New Partner: No

Mechanism Name: USAID Rwanda Mission

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4356
Planned Funding($): $ 4,275,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: US Agency for International Development
New Partner: No

Mechanism Name: CDC Country Office GAP/TA

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4357
Planned Funding($): $ 1,135,000.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GAP
Prime Partner: US Centers for Disease Control and Prevention
New Partner: No

Mechanism Name: CDC Country Office GAP/TA

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4358
Planned Funding($): $ 3,226,000.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Prime Partner: US Centers for Disease Control and Prevention
New Partner: No

Mechanism Name: DOD Rwanda Office

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4359
Planned Funding($): $ 155,000.00
Agency: Department of Defense
Funding Source: GHAI
Prime Partner: US Department of Defense
New Partner: No

Mechanism Name: NHRC

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4742
Planned Funding($): $ 60,000.00
Agency: Department of Defense
Funding Source: GHAI
Prime Partner: US Department of Defense Naval Health Research Center
New Partner: No

Mechanism Name: Embassy Rwanda

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4360
Planned Funding($): $ 50,000.00
Agency: Department of State / African Affairs
Funding Source: GHAI
Prime Partner: US Department of State
New Partner: No

Mechanism Name: Peace Corps

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4897
Planned Funding($): $ 200,000.00
Agency: Peace Corps
Funding Source: GHAI
Prime Partner: US Peace Corps
New Partner: Yes

Mechanism Name: HIV/AIDS Reporting System

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4348
Planned Funding($): $ 850,000.00
Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Prime Partner: Voxiva, Inc.
New Partner: Yes

Mechanism Name: WR Track 1.0

Mechanism Type: Central - Headquarters procured, centrally funded
Mechanism ID: 4361
Planned Funding($): $ 429,408.00
Agency: U.S. Agency for International Development
Funding Source: Central (GHAI)
Prime Partner: World Relief Corporation
New Partner: No

Mechanism Name: WR Supplement

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 4362
Planned Funding($): $ 250,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: World Relief Corporation
New Partner: No

Mechanism Name: WR bilateral

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4363
Planned Funding($): $ 0.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: World Relief Corporation
New Partner: No

Sub-Partner: CARE International
Planned Funding: $ 0.00
Funding is TO BE DETERMINED: No
New Partner: No

Associated Program Areas: HBHC - Basic Health Care and Support

Mechanism Name: WV Title II

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 4718
Planned Funding($): $ 50,000.00
Agency: U.S. Agency for International Development
Funding Source: GHAI
Prime Partner: World Vision International
New Partner: No

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: $ 6,111,574.01

Program Area Context:

According to the 2005 RDHS-III, Rwandan women of reproductive age have a 3.6% HIV prevalence rate. HIV prevalence is higher in urban areas than in rural areas (8.6% vs. 2.6%). The GOR has aggressively expanded PMTCT services throughout the country to ensure availability to the general population, primarily using GFATM and EP resources. As of June 2006, there were 223 sites offering PMTCT services in Rwanda. By the end of FY 2006 and FY 2007 respectively, the GOR plans to have 300 and 350 PMTCT sites. The GOR objective is to have PMTCT services in all 400 health facilities by the end of FY 2008.

PMTCT services are offered as part of the ANC package, with rapid tests conducted with same day results. HIV testing acceptance in PMTCT settings is high in Rwanda, at 94%. Between June 2005 and June 2006, 230,965 women were tested. Among those tested, 4.4% were identified as HIV-positive. During the same time period, PMTCT sites reported 173,045 births. Sixty-two percent of infants born to HIV-positive mothers were administered NVP. Nationally, 69% of HIV-positive pregnant women identified in PMTCT sites received NVP prophylaxis. At EP-supported PMTCT sites, 75-80% of HIV-positive women completed the NVP prophylaxis regimen.

In FY 2006, the PMTCT program is introducing a more effective ARV regimen for pregnant women and their children, including HAART for eligible pregnant women and AZT plus single dose NVP for women who are not eligible for HAART. HIV-exposed infants will receive one dose of NVP in the first 72 hours plus AZT for the first month of life. A CD4 count is now obligatory for any identified HIV-positive pregnant woman, with clients referred to ARV services for HAART, as needed. PMTCT national guidelines recommend exclusive breastfeeding with early weaning at six months. Follow-up of HIV-exposed children occurs when children present for vaccination. To identify HIV-exposed children, mothers are advised to bring their antenatal card (where the mother’s test result is noted) to the first vaccination visit of the newborn, typically at six weeks. In order to provide optimal care and treatment for infants, early infant HIV diagnosis is a priority for the GOR. Since being introduced in late 2005 by EP at selected PMTCT sites, early infant testing using DBS PCR at six weeks has been used to test 207 infants, resulting in early identification and referral for treatment of 27 HIV-positive children. Children nine months and older continue to be tested with rapid tests, and of the 2,359 tested between June 2005 and June 2006, 12% were identified as HIV-positive.

By the end of FY 2006, the EP will directly support 116 PMTCT sites. In addition to direct site support, the USG is providing technical and financial support to TRAC for the standardization and utilization of PMTCT guidelines, training curricula, reporting tools, and training of trainers and supervisors.

The Rwanda PMTCT program still faces many challenges, including low rates of ANC attendance during the first trimester and the low rates of deliveries at health facility. This remains a problem especially in the context of the new PMTCT ARV regimen, which starts from 28 weeks of gestation and continues at delivery and post-partum. According to the 2005 RDHS-III, national coverage of ANC was 94% for one visit, with six months as the median gestational age at first visit. Only 43% of women attended two or more ANC visits, whereas the national ANC strategy calls for four ANC visits. The same survey showed that 70% of births take place at home. Other challenges include poor linkages between PMTCT services and ARV and MCH services, and difficulty adhering to exclusive breastfeeding and early weaning, as some mothers cannot afford the weaning food.

In FY 2007, the USG will continue to support TRAC for national PMTCT policies, guidelines review and training of trainers in PMTCT. The USG will also continue assisting TRAC in the regular functioning of the PMTCT TWG. The EP will support DHTs to strengthen their capacity to coordinate an effective network of PMTCT and other HIV/AIDS medical services. This network will focus on maximizing access to PMTCT and other HIV/AIDS services and improving quality of care at the most decentralized level.

The EP will maintain its support for 116 existing sites, and launch 34 new sites. Each partner will support a comprehensive PMTCT package at site level, including CT, counseling and support for infant feeding, CD4 count and clinical staging for any woman identified as HIV-positive, combination ARV regimens for non-eligible women and HAART for eligible pregnant women, delivery following safer practices, infant and mother follow-up, CTX for OI prevention and infant HIV testing, early HIV infant diagnosis when possible, and community-based services in support of PMTCT. In addition, partners will promote linkages and referral of PMTCT with ART (including provision of referral for HAART as needed) and integration with other MCH, malaria interventions (including PMI, nutrition, and OVC interventions).

As the PMTCT program expands, EP and MOH will improve systematic tracking and follow-up of HIV-positive mothers and exposed children by collaborating closely with community workers and associations of PLWHA, and by adopting successful models from other countries, such as "Mother to Mother-to-be" from South Africa. Case managers at every PMTCT site will coordinate facility and community linkages. In addition, these case managers will continue to provide quality HIV treatment to HIV-positive children by referring pediatric patients from PMTCT sites and nutrition centers to ARV services, and by ensuring that staff from all services follow up on referrals. The EP will continue to improve male involvement in PMTCT activities through social mobilization and by providing CT service during weekends. The EP will also support efforts to identify and refer women who may be victims of violence to appropriate care and support.

In line with the EP Five-Year HIV/AIDS Strategy in Rwanda and sustainability goals, EP partners will ensure that all patients receive the same standard of PMTCT service. The EP will also promote sustainability of services through a combination of input TA and output performance-based financing.

The PMTCT program will continue to reinforce existing program components such as CTX prophylaxis for all HIV-exposed infants, and follow-up of mother-infant pairs. In order to identify HIV-exposed infants earlier and more easily, the EP will support the MOH through the EPI unit to integrate the HIV exposure status element into the national immunization card, and in the expansion of early HIV infant diagnosis.

EP will continue to assist TRAC to strengthen the infant feeding component within PMTCT programs. Initial activities will include supporting models for improving postnatal follow-up and care that include counseling on infant feeding and the procurement of local fortified weaning foods. In addition, EP interventions will wrap around Title II and the World Food Program to meet the other nutritional needs of food insecure households.

Finally, the EP will continue to support monitoring of the PMTCT program by assisting TRAC to improve the M&E system to ensure adherence to the new PMTCT regimen. TRAC will also be supported to revise tools and document best practices implemented by different partners.

Program Area Target:

Number of service outlets providing the minimum package of PMTCT services according to national and international standards	150
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	4,518
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	129,161
Number of health workers trained in the provision of PMTCT services according to national and international standards	965

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: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 7145
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007] 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.

Continued Associated Activity Information

Activity ID:	4871
USG Agency:	U.S. Agency for International Development
Prime Partner:	African Humanitarian Action
Mechanism:	Refugees AHA
Funding Source:	GHAI
Planned Funds:	$ 15,000.00

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	10 - 50
Infrastructure	10 - 50
Linkages with Other Sectors and Initiatives	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 and international standards	1	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	900	☐
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	30	☐
Number of health workers trained in the provision of PMTCT services according to national and international standards	25	☐

Target Populations:

Refugees/internally displaced persons
Pregnant women
Volunteers
HIV positive pregnant women
Laboratory workers
Nurses
HIV positive infants (0-4 years)

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 (prior to 2007)

Table 3.3.01: Activities by Funding Mechanism

Mechanism: Refugees - Rwanda
Prime Partner: American Refugee Committee
USG Agency: Department of State / Population, Refugees, and Migration
Funding Source: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 7150
Planned Funds: $ 0.00

Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007] 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.

Continued Associated Activity Information

Activity ID: 4748
USG Agency: Department of State / Population, Refugees, and Migration
Prime Partner: American Refugee Committee
Mechanism: Refugees - Rwanda
Funding Source: GHAI
Planned Funds: $ 20,000.00

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
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 and international standards	2	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	1,600	☐
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	40	☐
Number of health workers trained in the provision of PMTCT services according to national and international standards	50	☐

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 (prior to 2007)

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:	GHAI
Program Area:	Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code:	MTCT
Program Area Code:	01
Activity ID:	7179
Planned Funds:	$ 626,843.00

Activity Narrative: PMTCT services uptake in Rwanda is high as indicated by ANC attendance and HIV counseling and testing. However mother and infant follow-up is weak due to high rates of home delivery and infants lost to follow-up. With these new funds MCAP will use its network of PLWA associations (in which most women and/or their husbands are registered) to increase hospital delivery for positive pregnant women thus ensuring completion of the new PMTCT regimen. In addition, MCAP will reinforce its outreach team and the MoH health animators with training, and transportation in order to track PMTCT defaulters and give them home visits if needed. MCAP will support PMTCT services providers in HIV care and treatment with emphasis on pediatric care. In addition, MCAP will ensure that all newborns to HIV positive mothers are put on Cotrimoxazole preventive therapy until confirmation of their HIV-negative status.

MCAP will sustain the PMTCT follow-up system through support to the sites for formal meetings and referrals to ensure that mothers and exposed children are followed up regularly in PMTCT ward but also from vaccination, TB and nutrition wards and to care and treatment ward.

This activity relates to activities in HTXS (7174, 7176), HVCT (7178, 7170, 8185), HBHC (7165,7177), HVOP (8133), MTCT (7181, 7208, 7202, 7219, 7244), HVOP (8133), HBHC (7165, 7177), HTXD (8170, 7214), HVSI (7237), HKID (8150), HHVA (8186), HVTB (7162, 7169), and HLAB (7172).

In FY 2006, Columbia is providing financial and technical assistance for PMTCT services in 14 health facilities in the Western province of the country and in Kigali. The PMTCT package includes CT, infant feeding counseling, CD4 count and clinical staging for HIV-positive woman, combination ARV regimens non-eligible women and HAART for eligible women, and delivery following safer practices, infant and mother follow-up, CTX for OI prevention and infant HIV testing.

In FY 2007, Columbia will provide an expanded package of services for 17,328 pregnant women, including an estimated 728 HIV-positive women at 10 existing CT/PMTCT/ART sites, 4 existing CT/PMTCT sites, and 6 new CT/PMTCT/ART sites with an emphasis on quality services and continuum of care through operational partnerships, and sustainability of services through PBF. Eighty percent of these HIV-positive women (582) are expected to complete the course of ARV prophylaxis.

Columbia will offer a standard package of PMTCT services that includes CT with informed consent, male partner and family-centered testing, IPTp in collaboration with PMI, ARV prophylaxis using combination ARV regimens and HAART for eligible women, IF counseling and support, referral for FP and MCH services, and close follow-up of HIV-exposed infants for effective referral to appropriate services, and early infant diagnosis, where possible. In addition, Columbia will ensure access to a comprehensive network of services for PMTCT clients and their families, link PMTCT services with other HIV and MCH interventions, and assure an effective continuum of care by increasing patient involvement and community participation in PMTCT services.

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. In collaboration with DHTs, Columbia will conduct performance improvement and QA of PMTCT services through regular supervision of sites, coaching, and strengthening capacity of sites in M&E. DHTs will build their QA and M&E skills, including in data collection, data use, and reporting.

Linking with MCH services, Columbia will work with IntraHealth to incorporate safe motherhood, FP, and GBV screening into PMTCT activities. Columbia will strengthen follow-up and tracking systems to ensure testing of family members, routine provision of CTX PT and infant diagnosis, ongoing infant feeding counseling and support in collaboration with UNICEF, Title II partners and World Food Program, CD4 monitoring and clinical staging, management of OIs, including TB and other HIV-related illnesses, psychosocial support services at clinic and community levels, identify and refer women who may be victims of gender-based violence to appropriate care in collaboration with Twubakane, and access to clinical and community prevention, care, and treatment services for family members.

Columbia will assure linkage to treatment for eligible women and infant follow-up by using peer support groups, community mobilization, community volunteers, home visits, referral slips, community-based registers, patient cards and other monitoring tools to facilitate transfer of information between facilities and communities. To ensure these linkages, case managers will train and supervise community volunteers and organize monthly health center meetings with staff from all services to follow-up on referrals and other patient-related matters. In collaboration with CHAMP and case managers, 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. In addition these case managers will ensure referrals of pediatric patients from PMTCT sites and nutrition centers to ARV services.

Through the PFSCM, Columbia will provide ARV drugs, CD4 tests, RPR test kits, PCR, rapid HIV test kits, and hemoglobin testing materials to all supported sites. Columbia will also collaborate with RPM+ to improve the capacity of providers in drug management, coordinated site-level storage, inventory, tracking and forecasting. In addition, Columbia will collaborate with CHAMP, GFATM and PMI to refer 728 PLWHA and their families for malaria prevention services including bednet provision. In collaboration with CRS, Columbia will provide weaning food for exposed infants in need. In addition Columbia will leverage food aid from Title II and the World Food Program to meet the other nutritional needs of these food insecure households.

Columbia will provide a package of support to six DHTs to strengthen their capacity to coordinate an effective network of PMTCT and other HIV/AIDS medical services. This network focuses on maximizing access to PMTCT and other HIV/AIDS services and improving quality of care at the most decentralized level. Support to DHTs will focus on strengthening the linkages, referral systems, transport, communications and financing systems necessary to support an effective PMTCT and other HIV/AIDS care network. Columbia will provide a basic package of financial and technical support to DHTs, including staff positions, transportation, communication, training of providers using the trainers trained by TRAC, and other support to carry out their key responsibilities.

PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, Columbia will shift some of its support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of PMTCT and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national quality supervision tool.

Continued Associated Activity Information

Activity ID:	4832
USG Agency:	HHS/Centers for Disease Control & Prevention
Prime Partner:	Columbia University Mailman School of Public Health
Mechanism:	Columbia MCAP Supplement
Funding Source:	GHAI
Planned Funds:	$ 250,000.00

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	51 - 100
Food/Nutrition	10 - 50
Health Care Financing	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	10 - 50

Targets

Target	Target Value	Not Applicable
number of service outlets providing the minimum package of PMTCT services according to national or internal standards that are supported with performance-based financing		☑
Number of service outlets providing the minimum package of PMTCT services according to national and international standards	20	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	17,328	☐
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	782	☐
Number of health workers trained in the provision of PMTCT services according to national and international standards	200	☐

Target Populations:

Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
Traditional birth attendants
HIV/AIDS-affected families
Infants
Pregnant women
Prisoners
Volunteers
Men (including men of reproductive age)
HIV positive pregnant women
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Stigma and discrimination

Food

Increasing women's access to income and productive resources

Reducing violence and coercion

Coverage Areas

Karongi

Rutsiro

Nyabihu

Rubavu

Gasabo

Nyarugenge

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: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 7181
Planned Funds: $ 150,000.00
Activity Narrative: This activity relates to activities in HVAB (7183), HVOP (7184), HVCT (7182), HBHC (7187), HKID (7186), OHPS (7189), and MTCT (7179, 8185, 8698).

The Community HIV/AIDS Mobilization Program (CHAMP), through financial support and technical and institutional capacity building for Rwandan partner organizations, is working to ensure Rwandan communities have equitable access to high quality, sustainable continuum of HIV & AIDS care services. CHAMP supports the provision of community services in all EP-supported districts, especially around EP-supported health facilities.

In FY 2006, CHAMP is training trainers from various community and faith-based organizations to promote PMTCT services by including messages on early ANC attendance, facility deliveries, infant feeding practices, early infant diagnosis and male involvement through home visits and group talks. CHAMP trains volunteers to promote and support exclusive breastfeeding for HIV-positive lactating mothers and to support mothers during the cessation period and provide information about appropriate weaning foods and nutrition counseling.

In FY 2007, CHAMP will continue to provide training for community volunteers to promote PMTCT as part of their training for care to OVC and PLWHA. CHAMP will work with EP-supported clinical partners to strengthen the referral system to get pregnant women to PMTCT services and assist the clinic-based case managers who will provide follow-up to ensure proper treatment adherence. CHAMP will also link women in PMTCT and their families to other key community services, including PLWHA associations, income generating activities, community gardens, malaria prevention and treatment, child survival and health programs, and food assistance. CHAMP will not have any direct targets in this area, but will contribute to increasing the number of people receiving PMTCT services by EP clinical partners.

These activities support the key legislative issues of increasing gender equity in HIV/AIDS programs and decreasing gender and discrimination by assisting pregnant women to access PMTCT services as a routine part of ANC. 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.

Continued Associated Activity Information

Activity ID: 2805
USG Agency: U.S. Agency for International Development
Prime Partner: Community Habitat Finance International
Mechanism: CHAMP
Funding Source: GHAI
Planned Funds: $ 112,790.00

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Food/Nutrition	10 - 50
Information, Education and Communication	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 and international standards		☑
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		☑
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting		☑
Number of health workers trained in the provision of PMTCT services according to national and international standards		☑

Target Populations:

Community-based organizations
Faith-based organizations
People living with HIV/AIDS
HIV positive pregnant women
Caregivers (of OVC and PLWHAs)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Bugesera

Gatsibo

Nyagatare

Rwamagana

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

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:	GHAI
Program Area:	Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code:	MTCT
Program Area Code:	01
Activity ID:	7194
Planned Funds:	$ 125,366.00

Activity Narrative: This extension will continue the activities of a current implementer to prevent treatment interruption. During the extension, implementer will make transition to follow-on awardee expected to be determined in late May.
[CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007]
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.

Continued Associated Activity Information

Activity ID: 2755
USG Agency: U.S. Agency for International Development
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
Mechanism: Call to Action/EGPAF
Funding Source: GHAI

Planned Funds: $ 384,000.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	10 - 50
Infrastructure	10 - 50
Linkages with Other Sectors and Initiatives	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 service outlets providing the minimum package of PMTCT services according to national and international standards	23	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	20,150	☐
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	1,610	☐
Number of health workers trained in the provision of PMTCT services according to national and international standards	250	☐

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) (prior to 2007)

Kigali-Ville (prior to 2007)

Byumba (prior to 2007)

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:	GHAI
Program Area:	Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code:	MTCT
Program Area Code:	01
Activity ID:	7202
Planned Funds:	$ 36,498.00

Activity Narrative: Reprogramming 8/07: This extension will continue the activities of a current implementer to prevent treatment interruption. During the extension, implementer will make transition to follow-on awardee expected to be determined in late May.

Reprogramming: This extension will continue the activities of a current implementer to prevent treatment interruption. During the extension, implementer will make transition to follow-on awardee expected to be determined in late May.
plus-up: **This activity has funds added through both plus-up funding and reprogramming.** In developing PMTCT programs in Rwanda over the past several years, great emphasis has been placed on quality service availability and scale-up of clients, tracking women after they leave the ANC services and pediatric diagnosis and follow-up. At the same time, concurrent funding from the US Government for broad-based promotion of family planning using USAID Child survival and health funding has seen significant scale up in acceptance of modern FP methods on a nation wide scale. Plus-up funding will be used to bridge the gap between these two successful programs and ensure that quality FP counseling and services already supported by the USG are made available as part of the routine PMTCT programming. Counseling will be made available to women and men as a part of integrated antenatal care services and will follow-up with availability of all modern methods including options for long term and permanent methods of contraception after birth.
Significant commitment from the GOR on family planning as well as leveraging of resources from GFATM and UNFPA will ensure that these services are integrated nationwide as a part of a quality package of PMTCT/perinatal services. Note - no FP commodities will be purchased with these funds. This activity will be promoted nationwide.

This activity relates to MTCT (7179, 7181, 7219, 8185, 8697, 8698).

Rwanda has one of the highest maternal mortality ratios in Africa due to poor socio-economic factors and inadequate access and uptake of services. While PMTCT uptake is relatively high, most women only go for one ANC visit late in their pregnancy, deliver at home, and do not return for regular follow-up care. Women in MCH services should receive a full package of care that meets the entire health needs of the family to include targeted HIV/AIDS education and prevention messages, CT, nutrition counseling, infant feeding support, and promotion of early care-seeking behaviors. Similarly, women in PMTCT services should receive regular care such as family planning, IPTp for malaria, syphilis testing and treatment, iron supplementation, safe birth and neonatal care support. In order to improve service uptake, follow-up, and health outcomes, every provider-client contact needs to be maximized through an effective integration of services.

CAPACITY will work closely with USG implementing partners and GOR to integrate PMTCT and other MCH services such as family planning, safe motherhood, well-child visits, and malaria in pregnancy. This integration of services will facilitate improved identification, care and referral of women and HIV-exposed infants. To this end, this activity will support development of national policies, establishment of operational guidelines and adaptation of practical tools such as integrated registers, simple algorithms, and job aids. This activity will capitalize on synergies with other programs such as the PMI, Repositioning Family Planning, and Safe Motherhood, to leverage their financial and technical capabilities. Moreover, CAPACITY's involvement in health provider pre-service and in-service training allows for rapid updates of curricula as needed.

CAPACITY will provide support to PNLP through malaria in pregnancy, MCH and Integration Task Force teams, and TRAC through a long-term advisor position to ensure integration of PMTCT/MCH activities, the functioning of a national PMTCT/MCH integration group, the strengthening of M&E for national PMTCT/MCH activities and training of service providers in integrated PMTCT and MCH. The technical advisor will transfer skills and competencies to existing PMTCT and MCH Task Force staff within the MOH and TRAC to sustain PMTCT/MCH integration. A USAID clinical implementing partner will support two model centers to evaluate the efficiency and effectiveness of new PMTCT/MCH integration protocols and to provide feedback to the national PMTCT and MCH programs.

These activities support the GOR strategic goal of integrating HIV/AIDS services into the overall health system as well as the Rwanda EP goals of supporting sustainable activities

and increasing the quality of facility-based PMTCT services.

Continued Associated Activity Information

Activity ID: 2774
USG Agency: U.S. Agency for International Development
Prime Partner: IntraHealth International, Inc
Mechanism: Capacity
Funding Source: GHAI
Planned Funds: $ 467,200.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Linkages with Other Sectors and Initiatives	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance, Quality Improvement 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 internal standards that are supported with performance-based financing		☑
Number of service outlets providing the minimum package of PMTCT services according to national and international standards		☑
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		☑
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting		☑
Number of health workers trained in the provision of PMTCT services according to national and international standards		☑

Target Populations:

Faith-based organizations
Family planning clients
Doctors
Nurses
Pharmacists
Traditional birth attendants
HIV/AIDS-affected families
Infants
Non-governmental organizations/private voluntary organizations
Pregnant women
Volunteers
Women (including women of reproductive age)
HIV positive pregnant women
Other MOH staff (excluding NACP staff and health care workers described below)
Laboratory workers
Implementing organizations (not listed above)
HIV positive infants (0-4 years)

Key Legislative Issues

Stigma and discrimination

Other

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Coverage Areas:

National

Table 3.3.01: Activities by Funding Mechanism

Mechanism:	Twubakane
Prime Partner:	IntraHealth International, Inc
USG Agency:	U.S. Agency for International Development
Funding Source:	GHAI
Program Area:	Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code:	MTCT
Program Area Code:	01
Activity ID:	7208
Planned Funds:	$ 150,000.00

Activity Narrative: This activity relates to OHPS (8181) and will be a follow-on activity to an existing FY 2006 activity.

Although exact estimates of the prevalence of GBV associated with women's participation in HIV services are not available, 2005 Rwanda DHS-III data reveals that nearly one-third (31%) of women in Rwanda have suffered from physical violence since the age of 15. In 47% of these cases, the perpetrator of these acts of violence was the husband or partner. Furthermore, 10% of women said that they had suffered from acts of violence while they were pregnant. The health and social consequences of GBV against women are severe but often not addressed by health providers, even though they have a unique opportunity to make an impact on this problem.

Currently, Twubakane is implementing a GBV/PMTCT Readiness Assessment in three districts in Rwanda. The assessment will take place in six USG-funded PMTCT sites in order to (1) assess current provider knowledge, attitudes/perceptions and practices of screening and counseling clients for GBV, (2) assess the facility readiness of PMTCT sites to provide GBV services, and (3) identify and assess existing GBV community and social services in the catchment area. The objective of this activity is to improve the quality of PMTCT services to prevent and mitigate GBV that may arise from women's disclosure of their HIV status. Twubakane created an Assessment Steering Committee including GOR and relevant stakeholders to guide the assessment process which will run through mid-2007.

With FY 2007 funding, the results of the current assessment will be used to develop and implement a multi-level and multi-sectoral GBV/PMTCT integrated strategy. The strategy will take a three-pronged approach: (1) to strengthen the policy/legal environment in Rwanda to address GBV; (2) to improve health service and delivery systems; and (3) to mobilize health providers and communities to respond to the needs of clients who live with GBV and HIV. In the area of policy and advocacy, Twubakane will hold a 3-day GBV and HIV/PMTCT service stakeholder retreat to disseminate the results of the assessment and discuss strategies and activities to improve services and reduce GBV. In collaboration with USG partners and other bilateral agencies such as the BTC, Twubakane will develop workplace policies and clinic protocols for the identification and management of GBV at PMTCT sites. This will include designing a GBV monitoring and record-keeping system. Twubakane will pilot these procedures and tools in the six PMTCT assessment sites. They will also adapt, translate and implement IntraHealth's one-day GBV workshop sensitization module for HIV and PMTCT service providers and supervisors in these sites. In addition, this activity will support south-to-south capacity building with a study tour to the Nairobi Women's Hospital's Gender Recovery Center and the Kwazulu Natal Forensic Nursing Program to evaluate potential models for the operationalization of the MOH's standards for the management of sexual violence. In addition, IntraHealth will build linkages between microfinance programs and GBV survivor services in collaboration with CHAMP. Finally, this activity will support RALGA and Profemme in their efforts to impact the efficacy of local governments in addressing GBV and engaging local leaders to become anti-GBV advocates.

The overall goal of this activity is to educate service providers on how to identify women experiencing GBV at selected PMTCT sites, assess whether these women are at increased risk for HIV transmission, and provide appropriate care and referrals to social services. By training service providers to identify women at increased risk for HIV transmission, this activity also seeks to build the capacity of physicians and nurses to recognize the links between GBV and HIV transmission and to understand the necessity of integrating medical and social services to effectively address this cross-cutting issue. This activity addresses the key legislative issue of gender, particularly reducing violence, and reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan.

Continued Associated Activity Information

Activity ID: 6453
USG Agency: U.S. Agency for International Development
Prime Partner: IntraHealth International, Inc
Mechanism: Twubakane

Funding Source: GHAI
Planned Funds: $ 125,000.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Policy and Guidelines	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 internal standards that are supported with performance-based financing		☑
Number of service outlets providing the minimum package of PMTCT services according to national and international standards		☑
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		☑
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting		☑
Number of health workers trained in the provision of PMTCT services according to national and international standards		☑

Target Populations:

Non-governmental organizations/private voluntary organizations

HIV positive pregnant women

Public health care workers

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Reducing violence and coercion

Stigma and discrimination

Coverage Areas:

National

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: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 7219
Planned Funds: $ 746,240.00

Activity Narrative: This activity relates to MTCT (7179, 7181, 8185, 8698), HBHC (7220), HVTB (7221), HVCT (7217), HTXS (7222), HVSI (8743).

Performance-based financing is an innovative approach to financing of health services that enhances quality of services and leads to greater efficiency and sustainability. Financial incentives provided by performance-based funding motivate health facilities to improve performance through investments in training, equipment, personnel and payment systems that better link individual pay to individual performance. PBF financing is directly applied to PMTCT and other HIV indicators at the facility level. As a result of successful pilots implemented by CordAID, GTZ and BTC, the MOH has endorsed national scale-up of performance-based financing for all health services. The USG, in partnership with the World Bank, BTC and other donors, is supporting national implementation of performance-based financing of health services.

In FY 2006, MSH/PBF supported the GOR in collaboration with key donors to develop a national strategy, policy, and implementation model of performance-based financing that applies to all health assistance. The initial strategy for EP-supported PBF activities was to transfer USG site support from a traditional inputs–based model to a purely output purchases model as sites achieved a certain level of technical competence. However, the implementation of COP06 activities brought a change in the USG team's thinking about this approach. Few, if any USG supported sites were found to be ready for complete graduation to an exclusively PBF model. While PBF clearly increases performance, technical assistance and basic input support is still needed, especially in the current context of rapid decentralization and accelerated national roll-out of the PBF model by the GOR. Therefore, an adjusted strategy has been developed that provides a combination of both input and output financing to all EP-supported sites. The combination of financing modalities will properly motivate health facilities for higher performance while providing necessary resources and tools to meet the established targets.

In FY 2007, MSH/PBF will continue to provide support to the MOH Performance Based Financing department and the national PBF TWG. In addition, MSH/PBF will provide TA to DHTs in all PEPFAR districts and to USG implementing partners to effectively shift some of their input financing to output-based financing for TB and other indicators in accordance with national policy. MSH/PBF will also provide output financing to health facilities in 6 districts (where other clinical partners will only provide input financing) through direct performance sub-contracts with health centers and district hospitals for PMTCT and other indicators. Output financing involves the purchase of a certain quantity of indicators with a performance incentive for the production of more than agreed upon quantities of services. Full or partially reduced payment of TB and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool.

At the health center level, MSH/PBF will use a 'fixed price plus award fee' contract model to purchase a quantity of PMTCT and other HIV indicators with a performance incentive. Examples of PMTCT indicators include number of pregnant women tested for HIV, number of couples and partners tested for HIV, mother and child pair treated according to national protocol, children born to HIV-positive mothers tested for HIV, number of HIV-positive women who are using FP. Performance on these indicators will be measured during monthly control activities jointly conducted by the MSH/PBF district coordinator and the district's Family Health Unit and quality of services will be evaluated through the existing national supervisory and quality assurance mechanisms. The quantity and quality scores will be merged during the quarterly District PBF Steering Committee meetings and the final payments will be approved.

At the district hospital level, MSH/PBF will have sub-contracts with slightly different purpose and scope from that of health centers. In addition to the focus on increasing better quality service outputs, there is an emphasis on quality assurance, self-evaluation, and review by peers similar to an accreditation scheme. There will be payment for indicators from the National District Hospital PBF Scheme which reinforces the supervisory role hospitals play in district health networks.

At the district level, MSH/PBF will support the national model by 1) placing a district coordinator within the Family Health Unit to work with national family health steering

committee during data collection/entry and control of indicators, 2) facilitating the quantity control function by providing TA and paying associated costs, and 3) support secretarial functions for the Family Health Unit at the district level. Support to the district is critical for the proper functioning of the national PBF model since monthly HIV/AIDS invoice approved by the health center PBF management committee (COGE) and MSH are presented to the district steering committee for merging with quality index and final approval before payments are made.

PBF of PMTCT and other HIV services is a critical step to achieving the goal of sustainable, well-managed, high quality, and cost-effective PMTCT service delivery in a comprehensive HIV/AIDS treatment network. This financing modality supports the Rwanda EP five-year strategy for increasing institutional capacity for a district-managed network model of HIV clinical treatment and care services.

Continued Associated Activity Information

Activity ID:	2814
USG Agency:	U.S. Agency for International Development
Prime Partner:	Management Sciences for Health
Mechanism:	HIV/AIDS Performance Based Financing
Funding Source:	GHAI
Planned Funds:	$ 600,000.00

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, Quality Improvement 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 internal standards that are supported with performance-based financing	135	☐
Number of service outlets providing the minimum package of PMTCT services according to national and international standards	0	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	0	☐
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	0	☐
Number of health workers trained in the provision of PMTCT services according to national and international standards	0	☐

Target Populations:

Faith-based organizations
Family planning clients
Doctors
Nurses
Pharmacists
Traditional birth attendants
Infants
Non-governmental organizations/private voluntary organizations
Pregnant women
Volunteers
HIV positive pregnant women
Other MOH staff (excluding NACP staff and health care workers described below)
Laboratory workers
Implementing organizations (not listed above)
HIV positive infants (0-4 years)

Key Legislative Issues

Gender

Coverage Areas

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Karongi

Rutsiro

Ngororero

Nyabihu

Nyamasheke

Rubavu

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 7244
Planned Funds: $ 300,000.00
Activity Narrative: This activity relates to activities in HVCT (7242), HTXS (7246), HBHC (7245), MTCT (7179, 7181, 7202, 7208, 7219, 8122, 8184, 8185).

In FY 2006 TRAC is conducting TOT sessions for PMTCT service provision and supervision for 90 district-level supervisors and trainers from all 30 districts. These training sessions cover all aspects of the expanded national PMTCT protocol, including ARV prophylaxis, PCR testing for HIV-exposed infants, CTX for all HIV-exposed infants, routine CD4 testing and clinical staging for all HIV-positive pregnant women, counseling on infant feeding and nutrition for HIV-positive pregnant women and HIV exposed infants.

In FY 2007 TRAC will continue to conduct refresher training of trainers and supervisors in the expanded PMTCT protocol. To ensure quality of PMTCT services and consistent implementation of the new protocol, TRAC will conduct quarterly supervision of all districts.

With TA from CDC, TRAC will reinforce the M&E system for the PMTCT program, in particularly the M&E of the new PMTCT regimen, through the improvement of M&E tools, and documentation of best practices implemented by different partners.

In order to establish a system to trace HIV-positive mother/infant pairs, in collaboration with the national PMTCT TWG, TRAC will revise PMTCT norms and tools as needed (e.g. follow-up tools, client forms, monitoring tools for QA related to infant feeding counseling, etc) and disseminate them to all health facilities providing PMTCT services. The budget for this activity includes payment of two PMTCT technical advisors within TRAC's PMTCT/VCT unit.

This activity directly supports the Rwanda EP five-year strategy by scaling up PMTCT and strengthening the capacity of local institution.

Continued Associated Activity Information

Activity ID: 2743
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Treatment and Research AIDS Center
Mechanism: TRAC Cooperative Agreement
Funding Source: GHAI
Planned Funds: $ 60,000.00

Emphasis Areas	% Of Effort
Policy and Guidelines	51 - 100
Quality Assurance, Quality Improvement 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 the minimum package of PMTCT services according to national and international standards		☑
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		☑
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting		☑
Number of health workers trained in the provision of PMTCT services according to national and international standards	90	☐

Indirect Targets

Tracs is the agency responsible for developing policies, norms and guidelines for clinical HIV/AIDS services. This activity direct support TRAC for PMTCT targeted evaluation which will inform of the revision of protocol and tools which will be used by 350 health facilities offering PMTCT where 276360 pregnant women will be tested

Target Populations:

Doctors

Nurses

Laboratory workers

Other Health Care Worker

Coverage Areas:

National

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: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 8116
Planned Funds: $ 0.00

Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007]
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).

Continued Associated Activity Information

Activity ID: 4764
USG Agency: U.S. Agency for International Development
Prime Partner: Family Health International
Mechanism: FHI Bridge

Funding Source: GHAI
Planned Funds: $ 796,800.00

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
Training	10 - 50

Targets

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

Coverage Areas

Byumba (prior to 2007)

Gikongoro (prior to 2007)

Gisenyi (prior to 2007)

Gitarama (prior to 2007)

Kibuye (prior to 2007)

Kigali (Rurale) (prior to 2007)

Kigali-Ville (prior to 2007)

Table 3.3.01: Activities by Funding Mechanism

Mechanism:	HIV Support to RDF
Prime Partner:	Drew University
USG Agency:	Department of Defense
Funding Source:	GHAI
Program Area:	Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code:	MTCT
Program Area Code:	01
Activity ID:	8122
Planned Funds:	$ 64,246.00

Activity Narrative: This activity relates to activities in HTXS (7190), HVCT (8165), HBHC (7191), HVOP (8135), MTCT (7181, 7208, 7202, 7219, 7244), HVOP (8133), HTXD (8170, 7214) ; HVSI (7237), HKID (8150), HLAB (7192), HVAB (7230), HBTB (8146).

In the RDF health network there are three military hospitals and five brigade clinics throughout the country. Drew University began working in two military hospitals and three brigade clinics in FY 2005 with EP support. The support modalities include TA and training on ARV and palliative care, M&E, and laboratory infrastructure. Drew collaborates with CHAMP for services in military communities such as OVC support, and receives drug procurement from PFSCM. In line with national policies, the hospitals incorporate performance-based financing as incentives for facilities.

In FY 2007, Drew University will work with the RDF and TRAC to increase access to PMTCT services in RDF settings. PMTCT services will be integrated into existing infrastructure in military HIV/AIDS service delivery sites. Drew University will provide financial and technical assistance for PMTCT services in three military hospital sites. Drew will offer a standard package of PMTCT services to 2,599 pregnant women which includes CT with informed consent, male partner and family-centered testing, IPTp in collaboration with PMI, ARV prophylaxis using combination ARV regimens and HAART for eligible women, identify and refer women who may be victims of gender-based violence to appropriate care in collaboration with Twubakane, IF counseling and support, referral for FP and MCH services, and close follow-up of HIV-exposed infants for effective referral to appropriate services, and early infant diagnosis, where possible. In addition, Drew will ensure access to a comprehensive network of services for PMTCT clients and their families, link PMTCT services with other HIV and MCH interventions, and assure an effective continuum of care by increasing patient involvement and community participation in PMTCT services.

Through the DMS and a combination of input TA and output performance based financing, Drew University will ensure access to a comprehensive network of services for PMTCT clients and their families, link PMTCT services with other HIV and MCH interventions, and assure an effective continuum of care by increasing patient involvement and community participation in PMTCT services.

Drew University will train RDF providers and second technical staff at three military hospitals of Kanombe, Kaduha and Ngarama with new and refresher on-the-job training in the expanded national PMTCT protocol, including use of site-level algorithms and checklists, as well as for laboratory monitoring. In collaboration with DMS, Drew University will conduct performance improvement and QA of PMTCT services through regular supervision of sites, coaching, and strengthening capacity of sites in M&E of PMTCT. Drew University will support DMS build their QA and M&E skills, including in data collection, data use, and reporting.

In collaboration with CHAMP, GFATM, PMI and case managers, providers will refer PMTCT clients and their families to HBC, OVC support, IGA, and facility- and community-based MCH services promoting key preventive interventions such as bednets, immunizations, hygiene/safe drinking water and nutritional support. These community-based services will assist in the monitoring and tracking of pregnant and postpartum HIV-positive women and their infants, as well as promote MCH and PMTCT health seeking behaviors which will intensify case finding and improve adherence to the new regimen. In addition these case managers will ensure referrals of pediatric patients from PMTCT sites and nutrition centers to ARV services.

PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, Drew will shift some of its support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of PMTCT and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national quality supervision tool.

Through the PFSCM, Drew will provide ARV drugs, CD4 tests, RPR test kits, PCR, rapid HIV test kits, and hemoglobin testing materials to all supported sites. Drew will also

collaborate with RPM+ to improve the capacity of providers in drug management, coordinated site-level storage, inventory, tracking and forecasting. In addition, Drew will collaborate with CHAMP, GFATM and PMI to refer 728 PLWHA and their families for malaria prevention services including bednet provision. In collaboration with CRS, Drew will provide weaning food for exposed infants in need. In addition Drew will leverage food aid from Title II and the World Food Program to meet the other nutritional needs of these food insecure households.

This activity supports the EP five-year strategy for national scale-up and sustainability and the Rwandan Government decentralization plan.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	51 - 100
Food/Nutrition	10 - 50
Health Care Financing	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing the minimum package of PMTCT services according to national and international standards	3	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	2,599	☐
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	87	☐
Number of health workers trained in the provision of PMTCT services according to national and international standards	30	☐

Target Populations:

Community-based organizations
Doctors
Nurses
HIV/AIDS-affected families
Infants
Military personnel
Pregnant women
Volunteers
Men (including men of reproductive age)
HIV positive pregnant women
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)

Key Legislative Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS programs

Increasing women's access to income and productive resources

Wrap Arounds

Other

Coverage Areas

Nyamagabe

Gatsibo

Kicukiro

Table 3.3.01: 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: GHAI

Program Area: Prevention of Mother-to-Child Transmission (PMTCT)

Budget Code: MTCT

Program Area Code: 01

Activity ID: 8184

Planned Funds: $ 83,000.00

Activity Narrative: This activity relates to MTCT activity 7244.

In FY 2007, CDC will support the position of PMTCT Officer (health specialist) to oversee planning, implementation, and M&E of all USG activities in the area of PMTCT, as well as provide technical input to the MOH through technical working groups. CDC will continue to support the MOH and TRAC to integrate PMTCT services and PMI into the MCH system. In addition, CDC will continue to assist TRAC in implementing the scale-up plan for early HIV infant HIV diagnosis by reinforcing the M&E of this program and by assisting TRAC in the revision of tools for infant follow-up as needed.

CDC will support TRAC in reinforcing the M&E system to ensure adherence to the new PMTCT regimen through TA from CDC HQ for aspects of program monitoring such as revision of M&E tools and documentation of best practices implemented by different implementing partners.

These activities fully support PMTCT in line with Rwanda EP five-year strategy for prevention.

Emphasis Areas	% Of Effort
Policy and Guidelines	51 - 100
Quality Assurance, Quality Improvement and Supportive Supervision	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 and international standards		☑
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		☑
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting		☑
Number of health workers trained in the provision of PMTCT services according to national and international standards		☑

Target Populations:

Doctors

Nurses

Laboratory workers

Other Health Care Worker

Coverage Areas:

National

Table 3.3.01: Activities by Funding Mechanism

Mechanism:	Catholic Relief Services Supplemental
Prime Partner:	Catholic Relief Services
USG Agency:	HHS/Health Resources Services Administration
Funding Source:	GHAI
Program Area:	Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code:	MTCT
Program Area Code:	01
Activity ID:	8185
Planned Funds:	$ 688,338.00

Activity Narrative: This activity is related to activities in HTXS (7158, 7161), HVCT (8164), HVOP (8132), MTCT (7179, 7181, 7208, 7202, 7219, 7244, 8122, 8696, 8698), HVOP (8132), HBHC (7163, 7160), HTXS (7213), HTXD (8170, 7161, 7158), HVSI (7237), HKID (8150), HVTB (7162), HKID (8150).

In FY 2007 CRS will provide an expanded package of services for 11,263 pregnant women, including an estimated 473 HIV-positive women at 2 new CT/PMTCT sites, and 11 new CT/PMTCT/ART sites with an emphasis on quality services and continuum of care through operational partnerships, and sustainability of services through PBF. Eighty percent of these HIV-positive women (378) are expected to complete the course of ARV prophylaxis.

CRS will offer a standard package of PMTCT services that includes CT with informed consent, male partner and family-centered testing, IPTp in collaboration with PMI, ARV prophylaxis using combination ARV regimens and HAART for eligible women, IF counseling and support, referral for MCH services, and close follow-up of HIV-exposed infants for effective referral to appropriate services, and early infant diagnosis, where possible. In addition, CRS will ensure access to a comprehensive network of services for PMTCT clients and their families, link PMTCT services with other HIV and MCH interventions, and assure an effective continuum of care by increasing patient involvement and community participation in PMTCT services.

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. In collaboration with DHTs, CRS will conduct performance improvement and QA of PMTCT services through regular supervision of sites, coaching, and strengthening capacity of sites in M&E. DHTs will build their QA and M&E skills, including in data collection, data use, and reporting.

Linking with MCH services, CRS will work with IntraHealth to incorporate safe motherhood and GBV screening into PMTCT activities. CRS will strengthen follow-up and tracking systems to ensure testing of family members, routine provision of CTX PT and infant diagnosis, ongoing infant feeding counseling and support in collaboration with UNICEF, Title II partners and World Food Program, CD4 monitoring and clinical staging, management of OIs, including TB and other HIV-related illnesses, psychosocial support services at clinic and community levels, identify and refer women who may be victims of gender-based violence to appropriate care in collaboration with Twubakane, and access to clinical and community prevention, care, and treatment services for family members.

CRS will assure linkage to treatment for eligible women and infant follow-up by using peer support groups, community mobilization, community volunteers, home visits, referral slips, community-based registers, patient cards and other monitoring tools to facilitate transfer of information between facilities and communities. To ensure these linkages, case managers will train and supervise community volunteers and organize monthly health center meetings with staff from all services to follow-up on referrals and other patient-related matters. In collaboration with CHAMP and case managers, 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. In addition these case managers will ensure referrals of pediatric patients from PMTCT sites and nutrition centers to ARV services.

Through the PFSCM, CRS will provide ARV drugs, CD4 tests, RPR test kits, PCR, rapid HIV test kits, and hemoglobin testing materials to all supported sites. CRS will also collaborate with RPM+ to improve the capacity of providers in drug management, coordinated site-level storage, inventory, tracking and forecasting. In addition, CRS will collaborate with CHAMP, GFATM and PMI to refer 473 PLWHA and their families for malaria prevention services including bednet provision. CRS will provide weaning food for exposed infants in need at all EP-supported PMTCT sites. In addition CRS will leverage food aid from Title II and the World Food Program to meet the other nutritional needs of these food insecure households.

CRS will provide a package of support to two DHTs to strengthen their capacity to coordinate an effective network of PMTCT and other HIV/AIDS medical services. This network focuses on maximizing access to PMTCT and other HIV/AIDS services and improving quality of care at the most decentralized level. Support to DHTs will focus on strengthening the linkages, referral systems, transport, communications and financing systems necessary to support an effective PMTCT and other HIV/AIDS care network. CRS will provide a basic package of financial and technical support to DHTs, including staff positions, transportation, communication, training of providers using the trainers trained by TRAC, and other support to carry out their key responsibilities.

PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, CRS will shift some of its support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of PMTCT and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national quality supervision tool.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	51 - 100
Food/Nutrition	10 - 50
Health Care Financing	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
number of service outlets providing the minimum package of PMTCT services according to national or internal standards that are supported with performance-based financing		☑
Number of service outlets providing the minimum package of PMTCT services according to national and international standards	13	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	11,263	☐
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	378	☐
Number of health workers trained in the provision of PMTCT services according to national and international standards	65	☐

Target Populations:

Community-based organizations
Faith-based organizations
Doctors
Nurses
HIV/AIDS-affected families
Infants
Pregnant women
Volunteers
Men (including men of reproductive age)
HIV positive pregnant women
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Stigma and discrimination

Food

Increasing women's access to income and productive resources

Wrap Arounds

Other

Reducing violence and coercion

Coverage Areas

Burera

Gicumbi

Nyamasheke

Gatsibo

Table 3.3.01: Activities by Funding Mechanism

Mechanism: Refugees UNHCR
Prime Partner: United Nations High Commissioner for Refugees
USG Agency: Department of State / Population, Refugees, and Migration
Funding Source: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 8696
Planned Funds: $ 35,000.00

Activity Narrative: This activity relates to MTCT (7208, 7179, 7244, 8697, 8698), HVAB (8700), HVOP (8711, 7251, 8134), HBHC (8718, 8144, 7177), HVTB (8670), HKID (8148, 8150, 8152), HVCT (8732), HTXD (8170), HTXS (7176, 8172, 8737), HLAB (8189). Funds for this activity will address the key legislative areas of gender, wrap around and stigma and discrimination.

Rwanda is host to almost 50,000 refugees in camps around the country. Refugee populations are considered to be at high risk of infectious disease, in particular HIV, as well as GBV and other forms of violence, and economic and psychological distress. While much is currently unknown about HIV prevalence rates in the camp populations in Rwanda, recent service statistics of newly implemented VCT and PMTCT programs in two camps record a prevalence rate around 5% among those tested, with at least 200 individuals currently known to be living with HIV. Since 2005, the EP has supported UNHCR implementing partners AHA and ARC to provide HIV prevention and care services in Kiziba, Gihembe and Nyabiheke refugee camps with linkages and referrals for treatment.

In FY 2007, USG will consolidate its support by funding UNHCR directly to expand the package of services for the prevention, care, and treatment of PLWHA. Funds will also be leveraged from the World Bank-funded GLIA and OPEC to complement EP-supported services. UNHCR will subcontract to AHA and ARC to continue providing a standard package of PMTCT services at 3 refugee camps - Kiziba, Gihembe and Nyabiheke - to reach 1,800 women with PMTCT and CT services and 40 HIV-positive women with the full short-course prophylaxis. AHA will also support a small camp of 2,000 refugees with PMTCT promotion and linkages to the nearby health center.

UNHCR partners will offer a standard package of PMTCT services that includes CT with informed consent, male partner and family-centered testing, IPTp in collaboration with PMI, ARV prophylaxis using combination ARV regimens and HAART for eligible women, IF counseling and support, referral for FP and MCH services, and close follow-up of HIV-exposed infants for effective referral to appropriate services, and early infant diagnosis, where possible. In addition, UNHCR partners will ensure access to a comprehensive network of services for PMTCT clients and their families, link PMTCT services with other HIV and MCH interventions, and assure an effective continuum of care by increasing patient involvement and community participation in PMTCT services.

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. In collaboration with DHTs, UNHCR partners will conduct performance improvement and QA of PMTCT services through regular supervision of sites, coaching, and strengthening capacity of sites in M&E. DHTs will build their QA and M&E skills, including in data collection, data use, and reporting.

UNHCR partners will work in close collaboration with the district hospital and USG clinical partners in their respective districts to strengthen the network system of services between the district hospital and the refugee health centers for referrals for services not available at the camps, including CD4 and PCR, diagnosis and treatment of complicated OIs and management of side effects, management of severe malnutrition, and for referrals for pediatric HIV infection as necessary. As Nyabiheke is the smallest and newest camp, the camps will refer HIV-positive pregnant women for referral for initial prescription of the PMTCT regimen.

UNHCR partners will strengthen the referral system between camp-based services, including ART, OVC, IGA and facility and community-based MCH services promoting and distributing key preventive interventions such as bednets, immunizations, hygiene/safe drinking water and nutritional support within the camps, through the use of peer support groups, community mobilization, community volunteers, home visits, referral slips, community-based registers, patient cards and other monitoring tools to facilitate transfer of information between facilities and communities. To enhance community participation and ownership, UNHCR partners will take advantage of the 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, MCH and PMTCT health seeking behaviors, and to assist in the follow-up and tracking of PMTCT mothers and family members.

AHA, which supports a small camp of 2000 refugees in close proximity to Kigeme District Hospital, will also support PMTCT promotion and health seeking behaviors at the camp through creation of Anti-SIDA clubs, training of refugee leaders and refugee women's groups, and training of TBAs. AHA will work with Kigeme DH to ensure access to PMTCT services for pregnant women.

SCMS will procure all commodities for the revised PMTCT protocol, including ARVs, laboratory commodities, CTX and micronutrients. UNHCR refugee partners will work with SCMS and the district pharmacies to ensure adequate supply and appropriate storage facilities for these commodities at the camps.

UNHCR will provide technical support and monitoring of IP activities and data collection, and ensure appropriate reporting to USG/Rwanda through the hiring of a technical and program manager.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Food/Nutrition	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Quality Assurance, Quality Improvement 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 and international standards	3	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	1,800	☐
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	40	☐
Number of health workers trained in the provision of PMTCT services according to national and international standards	25	☐

Target Populations:

Community leaders
Community-based organizations
Nurses
Traditional birth attendants
Refugees/internally displaced persons
Pregnant women
Volunteers
Men (including men of reproductive age)
HIV positive pregnant women
Caregivers (of OVC and PLWHAs)
Widows/widowers
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

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

Stigma and discrimination

Wrap Arounds

Food

Microfinance/Microcredit

Coverage Areas

Byumba (prior to 2007)

Kibuye (prior to 2007)

Umutara (Mutara) (prior to 2007)

Gicumbi

Gatsibo

Karongi

Table 3.3.01: Activities by Funding Mechanism

Mechanism: BASICS
Prime Partner: Partnership for Child HealthCare Inc.
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 8697
Planned Funds: $ 200,000.00

Activity Narrative: This activity relates to MTCT (7179, 7181, 7244, 8122, 8123, 8185, 8696, 8698); HBHC (7245, 8141, 8714), HKID (7186).

The 2005 RDHS-III results indicate 45% of children under five are stunted due to chronic malnutrition. According to the Rwanda National Nutrition Plan 2005-2010, chronic malnutrition in under-fives is significantly associated with poor infant feeding practices. Although the 2005 RDHS-III indicates high rates of exclusive breastfeeding for infants less than six months, a UNICEF study indicates only 17.4% exclusive breastfeeding for infants of the same age. Both studies demonstrate insufficient introduction of complementary food for infants between 6 and 24 months.

Since 2005, UNICEF in collaboration with TRAC has led the adaptation of the WHO/UNICEF IYCF guidelines and development of training materials and tools in Rwanda for the strengthening of IYCF counseling and support in the context of PMTCT. During FY 2006, EP will collaborate with UNICEF to support training at PMTCT sites in IYCF. However, UNICEF does not have the in-country capacity to ensure ongoing support, monitoring, and refresher training of sites in the country. FY 2007 EP funds will support an IYCF advisor to provide TA to the MOH and TRAC for ongoing monitoring of IYCF. This advisor will be placed at the MOH with the MCH Task Force and will collaborate closely with UNICEF and TRAC. TA will include rapid assessment of current provider knowledge and skills in IYCF, use of and adherence to AFASS guidelines and criteria during IF counseling for pregnant HIV-positive women, and pre- and post-partum IYCF counseling and support. The advisor will also work with UNICEF, MCH Task Force and TRAC to adapt monitoring tools, checklists and job aids for providers, conduct with TRAC and MOH an integrated TOT for IYCF and training of district supervisors in follow-up supervision of providers in IYCF counseling, adherence to AFASS protocols, lactation management, particularly among symptomatic HIV-positive mothers, and support to HIV-positive mothers in adhering to their infant feeding choice. The IYCF Advisor will collaborate closely with clinical partners, including coordination meetings to discuss issues and challenges around IYCF, provide guidelines, job aids, AFASS checklists, and other tools to clinical partners to distribute to sites, and conduct periodic TA visits in collaboration with clinical partners and districts.

With the expansion of early infant diagnosis, there could be an increase in pregnant mothers who choose early replacement feeding. Follow-up monitoring and support will be required for these mothers and their infants to ensure appropriate use and preparation of weaning foods, and monitor health status and growth of replacement-fed infants. To inform the program on locally available foods for replacement and complementary feeding, the IYCF Advisor in collaboration with UNICEF will carry out an assessment using a model field tested in several southern African countries to assess availability and types of locally produced foods, how foods are prepared, acceptability, and costs of these foods. Mothers who choose replacement feeding are also more at risk of becoming pregnant than when exclusively breastfeeding. Counseling and/or referrals for FP and nutrition counseling services will need to be integrated into the IYCF post-natal and follow-up counseling for HIV-positive mothers. The IYCF Advisor will work with the FANTA advisor at TRAC, UNICEF and the MOH MCH Task Force to ensure linkages are made to FP and other MCH services and that messages for FP, nutrition and child survival are incorporated into IYCF training modules.

The IYCF Advisor in collaboration with TRAC/PMTCT, and UNICEF, will also provide TA to CHAMP for the integration of a training module for community workers in IYCF in the context of PMTCT. This will be integrated into the PMTCT curriculum being developed during FY2006 by CHAMP. The IYCF advisor will also support TRAC/PMTCT to revise patient and community-based IEC materials for pregnant and post-partum women, their partners and family members on IF choices, and types and preparation of replacement and complementary foods. The IYCF Advisor will also advocate for integration of IYCF activities into OVC programming through participation in the OVC Technical Working Group.

To ensure ongoing support and sustainability for IYCF in the context of PMTCT, the IYCF and Nutrition advisor will work with TRAC and the MOH to include or revise IYCF indicators in the standardized PMTCT and SIS reporting forms, and advocate to the GOR PBF to include a provider performance indicator on appropriate IYCF counseling. The IYCF

Advisor will also continue to advocate and promote the importance of EBF for all mothers and work with the GOR to ensure IYCF receives adequate attention in its goal of strengthening overall MCH outcomes.

This activity addresses the key legislative areas of gender and stigma and discrimination.

Emphasis Areas	**% Of Effort**
Linkages with Other Sectors and Initiatives	10 - 50
Needs Assessment	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance, Quality Improvement 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 internal standards that are supported with performance-based financing		☑
Number of service outlets providing the minimum package of PMTCT services according to national and international standards		☑
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results		☑
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting		☑
Number of health workers trained in the provision of PMTCT services according to national and international standards		☑

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas:

National

Table 3.3.01: Activities by Funding Mechanism

Mechanism: HIV Support to RDF
Prime Partner: Drew University
USG Agency: Department of Defense
Funding Source: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 11042
Planned Funds: $ 0.01
Activity Narrative: test

Table 3.3.01: Activities by Funding Mechanism

Mechanism: Catholic Relief Services Supplemental GHAI
Prime Partner: Catholic Relief Services
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 11153
Planned Funds: $ 138,000.00
Activity Narrative: In collaboration with MOH, [the partner(s)] will update the tools for community mobilization for PMTCT, provide training to community volunteers to promote PMTCT, and will work with EP-supported clinical partners to strengthen the referral system to get pregnant women to PMTCT services. The community volunteers will work closely with the case managers, PLWHA associations, TBA's, and local authorities. These community-based services will assist in the monitoring and tracking of pregnant and postpartum HIV-positive women and their infants to ensure proper treatment adherence. Linking women in PMTCT and their families to other key community services will extend the reach of PMTCT services. These other services will include PLWHA associations, income generating activities, community gardens, malaria prevention and treatment, child survival and health programs, and food assistance.

Table 3.3.01: Activities by Funding Mechanism

Mechanism: FHI New Bilateral
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 15208
Planned Funds: $ 551,734.00

Activity Narrative: This activity relates to activities in MTCT (7181, 7208, 8185, 7219, 7244, 8697, 7179, 8170), HVAB (8129), HVOP (8137), HBHC (8144), HVTB (8147), HVCT (8168), HXTD (8170), HTXS (8172), HLAB (7224, 8189). In FY 2006, USAID partners are providing financial and technical assistance for PMTCT services in 96 health facilities throughout Rwanda. The PMTCT package includes CT, infant feeding counseling, CD4 count and clinical staging for HIV-positive woman, combination ARV regimens non-eligible women and HAART for eligible women, and delivery following safer practices, infant and mother follow-up, CTX for OI prevention and infant HIV testing. In FY 2007 USAID awarded three new cooperative agreements - one of the three to Family Health International - that will provide clinical services in existing sites and expand services according to the joint USG-GOR expansion plans within PEPFAR districts. FHI will provide an expanded package at 24 existing VCT/PMTCT/ART sites, 36 existing VCT/PMTCT sites, and 9 new VCT/PMTCT sites with an emphasis on quality services and continuum of care through operational partnerships, and sustainability of services through PBF.

FHI will offer a standard package of PMTCT services that includes CT with informed consent, male partner and family-centered testing, IPTp in collaboration with PMI, ARV prophylaxis using combination ARV regimens and HAART for eligible women, IF counseling and support, referral for FP and MCH services, and close follow-up of HIV-exposed infants for effective referral to appropriate services, and early infant diagnosis, where possible. In addition, FHI will ensure access to a comprehensive network of services for PMTCT clients and their families, link PMTCT services with other HIV and MCH interventions, and assure an effective continuum of care by increasing patient involvement and community participation in PMTCT services. 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. In collaboration with DHTs, FHI will conduct performance improvement and QA of PMTCT services through regular supervision of sites, coaching, and strengthening capacity of sites in M&E.

DHTs will build their QA and M&E skills, including in data collection, data use, and reporting. Linking with MCH services, FHI will work with IntraHealth to incorporate safe motherhood, FP, and GBV screening into PMTCT activities. Plus-up funding will be used to bridge the gap between the PMTCT and FP programs and ensure that quality FP counseling and services already supported by the USG are made available as part of the routine PMTCT and HIV programming. Counseling will be made available to women and men as a part of integrated antenatal care services and will follow-up with availability of all modern methods including options for long term and permanent methods of contraception after birth with commodities procured with CSH POP funds. FHI will strengthen follow-up and tracking systems to ensure testing of family members, routine provision of CTX PT and infant diagnosis, ongoing infant feeding counseling and support in collaboration with UNICEF, Title II partners and World Food Program, CD4 monitoring and clinical staging, management of OIs, including TB and other HIV-related illnesses, psychosocial support services at clinic and community levels, identify and refer women who may be victims of gender-based violence to appropriate care in collaboration with Twubakane, and access to clinical and community prevention, care, and treatment services for family members. FHI will assure linkage to treatment for eligible women and infant follow-up by using peer support groups, community mobilization, community volunteers, home visits, referral slips, community-based registers, patient cards and other monitoring tools to facilitate transfer of information between facilities and communities. To ensure these linkages, case managers will train and supervise community volunteers and organize monthly health center meetings with staff from all services to follow-up on referrals and other patient-related matters. In collaboration with CHAMP and case managers, 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. In addition these case managers will ensure referrals of pediatric patients from PMTCT sites and nutrition centers to ARV services. Through the PFSCM, FHI will provide ARV drugs, CD4 tests, RPR test kits, PCR, rapid HIV test kits, and hemoglobin testing materials to all supported sites. FHI will also collaborate with RPM+ to improve the capacity of providers in drug management, coordinated site-level storage, inventory,

tracking and forecasting. In addition, FHI will collaborate with CHAMP, GFATM and PMI to refer PLWHA and their families for malaria prevention services including bednet provision. In collaboration with CRS, FHI will provide weaning food for exposed infants in need. In addition FHI will leverage food aid from Title II and the World Food Program to meet the other nutritional needs of these food insecure households.

PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, FHI will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of PMTCT and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national quality supervision tool. FHI will provide a package of support to 5 DHTs to strengthen their capacity to coordinate an effective network of PMTCT and other HIV/AIDS medical services. This network focuses on maximizing access to PMTCT and other HIV/AIDS services and improving quality of care at the most decentralized level. Support to DHTs will focus on strengthening the linkages, referral systems, transport, communications and financing systems necessary to support an effective PMTCT and other HIV/AIDS care network. FHI will provide a basic package of financial and technical support to DHTs, including staff positions, transportation, communication, training of providers using the trainers trained by TRAC, and other support to carry out their key responsibilities. This activity supports the EP five-year strategy for national scale-up and sustainability and the Rwandan Government decentralization plan.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	51 - 100
Food/Nutrition	10 - 50
Health Care Financing	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	10 - 50

Targets

Target	Target Value	Not Applicable
number of service outlets providing the minimum package of PMTCT services according to national or internal standards that are supported with performance-based financing	45	☐
Number of service outlets providing the minimum package of PMTCT services according to national and international standards	45	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	34,315	☐
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	1,340	☐
Number of health workers trained in the provision of PMTCT services according to national and international standards	223	☐

Target Populations:

HIV/AIDS-affected families
Volunteers
Men (including men of reproductive age)
Women (including women of reproductive age)
HIV positive pregnant women
Doctors
Laboratory workers
Nurses
Pharmacists
Traditional birth attendants
HIV positive infants (0-4 years)

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

Stigma and discrimination

Wrap Arounds

Food

Other

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Karongi

Table 3.3.01: Activities by Funding Mechanism

Mechanism: EGPAF New Bilateral
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 15215
Planned Funds: $ 427,453.00

Activity Narrative: This activity relates to activities in MTCT (7181, 7208, 8185, 7219, 7244, 8697, 7179, 8170), HVAB (8129), HVOP (8137), HBHC (8144), HVTB (8147), HVCT (8168), HXTD (8170), HTXS (8172), HLAB (7224, 8189). In FY 2006, USAID partners are providing financial and technical assistance for PMTCT services in 96 health facilities throughout Rwanda. The PMTCT package includes CT, infant feeding counseling, CD4 count and clinical staging for HIV-positive woman, combination ARV regimens non-eligible women and HAART for eligible women, and delivery following safer practices, infant and mother follow-up, CTX for OI prevention and infant HIV testing. IIn FY 2007 USAID awarded three new cooperative agreements - one of the three to EGPAF - that will provide clinical services in existing sites and expand services according to the joint USG-GOR expansion plans within PEPFAR districts.

EGPAF will provide an expanded package at 18 existing VCT/PMTCT/ART sites, 24 existing VCT/PMTCT sites, and 7 new VCT/PMTCT sites with an emphasis on quality services and continuum of care through operational partnerships, and sustainability of services through PBF. EGPAF will offer a standard package of PMTCT services that includes CT with informed consent, male partner and family-centered testing, IPTp in collaboration with PMI, ARV prophylaxis using combination ARV regimens and HAART for eligible women, IF counseling and support, referral for FP and MCH services, and close follow-up of HIV-exposed infants for effective referral to appropriate services, and early infant diagnosis, where possible. In addition, EGPAF will ensure access to a comprehensive network of services for PMTCT clients and their families, link PMTCT services with other HIV and MCH interventions, and assure an effective continuum of care by increasing patient involvement and community participation in PMTCT services. 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. 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. 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 screening into PMTCT activities. Plus-up funding will be used to bridge the gap between the PMTCT and FP programs and ensure that quality FP counseling and services already supported by the USG are made available as part of the routine PMTCT and HIV programming. Counseling will be made available to women and men as a part of integrated antenatal care services and will follow-up with availability of all modern methods including options for long term and permanent methods of contraception after birth with commodities procured with CSH POP funds. EGPAF will strengthen follow-up and tracking systems to ensure testing of family members, routine provision of CTX PT and infant diagnosis, ongoing infant feeding counseling and support in collaboration with UNICEF, Title II partners and World Food Program, CD4 monitoring and clinical staging, management of OIs, including TB and other HIV-related illnesses, psychosocial support services at clinic and community levels, identify and refer women who may be victims of gender-based violence to appropriate care in collaboration with Twubakane, and access to clinical and community prevention, care, and treatment services for family members. EGPAF will assure linkage to treatment for eligible women and infant follow-up by using peer support groups, community mobilization, community volunteers, home visits, referral slips, community-based registers, patient cards and other monitoring tools to facilitate transfer of information between facilities and communities. To ensure these linkages, case managers will train and supervise community volunteers and organize monthly health center meetings with staff from all services to follow-up on referrals and other patient-related matters. In collaboration with CHAMP and case managers, 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. In addition these case managers will ensure referrals of pediatric patients from PMTCT sites and nutrition centers to ARV services. Through the PFSCM, EGPAF will provide ARV drugs, CD4 tests, RPR test kits, PCR, rapid HIV test kits, and hemoglobin testing materials to all supported sites. EGPAF will also collaborate with RPM+ to improve the capacity of providers in drug management, coordinated site-level storage, inventory, tracking and forecasting. In addition, EGPAF will collaborate with CHAMP, GFATM and PMI to refer PLWHA and their families for malaria

prevention services including bednet provision. In collaboration with CRS, EGPAF will provide weaning food for exposed infants in need. In addition EGPAF will leverage food aid from Title II and the World Food Program to meet the other nutritional needs of these food insecure households. PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, EGPAF will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of PMTCT and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national quality supervision tool. EGPAF will provide a package of support to 5 DHTs to strengthen their capacity to coordinate an effective network of PMTCT and other HIV/AIDS medical services. This network focuses on maximizing access to PMTCT and other HIV/AIDS services and improving quality of care at the most decentralized level. Support to DHTs will focus on strengthening the linkages, referral systems, transport, communications and financing systems necessary to support an effective PMTCT and other HIV/AIDS care network.

EGPAF will provide a basic package of financial and technical support to DHTs, including staff positions, transportation, communication, training of providers using the trainers trained by TRAC, and other support to carry out their key responsibilities. This activity supports the EP five-year strategy for national scale-up and sustainability and the Rwandan Government decentralization plan.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	51 - 100
Food/Nutrition	10 - 50
Health Care Financing	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
number of service outlets providing the minimum package of PMTCT services according to national or internal standards that are supported with performance-based financing		☑
Number of service outlets providing the minimum package of PMTCT services according to national and international standards	31	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	35,935	☐
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	1,112	☐
Number of health workers trained in the provision of PMTCT services according to national and international standards	116	☐

Target Populations:

Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
Traditional birth attendants
HIV/AIDS-affected families
Volunteers
Men (including men of reproductive age)
HIV positive pregnant women
Laboratory workers
HIV positive infants (0-4 years)

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

Stigma and discrimination

Wrap Arounds

Food

Other

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Umutara (Mutara) (prior to 2007)

Karongi

Table 3.3.01: Activities by Funding Mechanism

Mechanism: IntraHealth New Bilateral
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 15219
Planned Funds: $ 530,856.00

Activity Narrative: This activity relates to activities in MTCT (7181, 7208, 8185, 7219, 7244, 8697, 7179, 8170), HVAB (8129), HVOP (8137), HBHC (8144), HVTB (8147), HVCT (8168), HXTD (8170), HTXS (8172), HLAB (7224, 8189). In FY 2006, USAID partners are providing financial and technical assistance for PMTCT services in 96 health facilities throughout Rwanda. The PMTCT package includes CT, infant feeding counseling, CD4 count and clinical staging for HIV-positive woman, combination ARV regimens non-eligible women and HAART for eligible women, and delivery following safer practices, infant and mother follow-up, CTX for OI prevention and infant HIV testing. In FY 2007 USAID awarded three new cooperative agreements - one of the three to IntraHealth - that will provide clinical services in existing sites and expand services according to the joint USG-GOR expansion plans within PEPFAR districts. IntraHealth will provide an expanded package at 15 existing VCT/PMTCT/ART sites, 13 existing VCT/PMTCT sites, and 7 new VCT/PMTCT sites with an emphasis on quality services and continuum of care through operational partnerships, and sustainability of services through PBF.

IntraHealth will offer a standard package of PMTCT services that includes CT with informed consent, male partner and family-centered testing, IPTp in collaboration with PMI, ARV prophylaxis using combination ARV regimens and HAART for eligible women, IF counseling and support, referral for FP and MCH services, and close follow-up of HIV-exposed infants for effective referral to appropriate services, and early infant diagnosis, where possible. In addition, IntraHealth will ensure access to a comprehensive network of services for PMTCT clients and their families, link PMTCT services with other HIV and MCH interventions, and assure an effective continuum of care by increasing patient involvement and community participation in PMTCT services. 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. In collaboration with DHTs, IntraHealth will conduct performance improvement and QA of PMTCT services through regular supervision of sites, coaching, and strengthening capacity of sites in M&E. DHTs will build their QA and M&E skills, including in data collection, data use, and reporting. Linking with MCH services, IntraHealth will work with IntraHealth/Twubakane to incorporate safe motherhood, FP, and GBV screening into PMTCT activities. Plus-up funding will be used to bridge the gap between the PMTCT and FP programs and ensure that quality FP counseling and services already supported by the USG are made available as part of the routine PMTCT and HIV programming. Counseling will be made available to women and men as a part of integrated antenatal care services and will follow-up with availability of all modern methods including options for long term and permanent methods of contraception after birth with commodities procured with CSH POP funds. IntraHealth will strengthen follow-up and tracking systems to ensure testing of family members, routine provision of CTX PT and infant diagnosis, ongoing infant feeding counseling and support in collaboration with UNICEF, Title II partners and World Food Program, CD4 monitoring and clinical staging, management of OIs, including TB and other HIV-related illnesses, psychosocial support services at clinic and community levels,identify and refer women who may be victims of gender-based violence to appropriate care in collaboration with Twubakane, and access to clinical and community prevention, care, and treatment services for family members. IntraHealth will assure linkage to treatment for eligible women and infant follow-up by using peer support groups, community mobilization, community volunteers, home visits, referral slips, community-based registers, patient cards and other monitoring tools to facilitate transfer of information between facilities and communities. To ensure these linkages, case managers will train and supervise community volunteers and organize monthly health center meetings with staff from all services to follow-up on referrals and other patient-related matters. In collaboration with CHAMP and case managers, 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. In addition these case managers will ensure referrals of pediatric patients from PMTCT sites and nutrition centers to ARV services. Through the PFSCM, IntraHealth will provide ARV drugs, CD4 tests, RPR test kits, PCR, rapid HIV test kits, and hemoglobin testing materials to all supported sites. IntraHealth will also collaborate with RPM+ to improve the capacity of providers in drug management, coordinated site-level storage, inventory, tracking and forecasting. In addition, IntraHealth

will collaborate with CHAMP, GFATM and PMI to refer PLWHA and their families for malaria prevention services including bednet provision. In collaboration with CRS, IntraHealth will provide weaning food for exposed infants in need. In addition IntraHealth will leverage food aid from Title II and the World Food Program to meet the other nutritional needs of these food insecure households. PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, IntraHealth will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of PMTCT and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national quality supervision tool. IntraHealth will provide a package of support to 4 DHTs to strengthen their capacity to coordinate an effective network of PMTCT and other HIV/AIDS medical services. This network focuses on maximizing access to PMTCT and other HIV/AIDS services and improving quality of care at the most decentralized level. Support to DHTs will focus on strengthening the linkages, referral systems, transport, communications and financing systems necessary to support an effective PMTCT and other HIV/AIDS care network. IntraHealth will provide a basic package of financial and technical support to DHTs, including staff positions, transportation, communication, training of providers using the trainers trained by TRAC, and other support to carry out their key responsibilities.

This activity supports the EP five-year strategy for national scale-up and sustainability and the Rwandan Government decentralization plan

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	51 - 100
Food/Nutrition	10 - 50
Health Care Financing	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	10 - 50

Targets

Target	Target Value	Not Applicable
number of service outlets providing the minimum package of PMTCT services according to national or internal standards that are supported with performance-based financing		☑
Number of service outlets providing the minimum package of PMTCT services according to national and international standards	35	☐
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	25,920	☐
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	778	☐
Number of health workers trained in the provision of PMTCT services according to national and international standards	216	☐

Target Populations:

Community-based organizations
Faith-based organizations
Volunteers
Men (including men of reproductive age)
HIV positive pregnant women
Doctors
Laboratory workers
Nurses
Pharmacists
Traditional birth attendants
HIV positive infants (0-4 years)

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

Food

Other

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Karongi

Table 3.3.01: Activities by Funding Mechanism

Mechanism: National Reference Laboratory
Prime Partner: National Reference Laboratory
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 18992
Planned Funds: $ 100,000.00
Activity Narrative: This activity will renovate laboratory work areas at the Central University Hospital in Butare, allowing it to become only the second reference laboratory in Rwanda capable of performing PCR testing for early infant HIV diagnosis. This proposed activity addresses an oversight in COP 2007 planning: PCR equipment and reagents were funded in COP 2007 to equip this laboratory; however funds were not allocated for the renovations needed. This activity helps expand integrated PMTCT, early infant diagnosis and pediatric care and treatment services into the south and southwest parts of Rwanda.

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: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 19246
Planned Funds: $ 450,000.00
Activity Narrative: n/a

Table 3.3.01: Activities by Funding Mechanism

Mechanism: Twubakane
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 19247
Planned Funds: $ 450,000.00
Activity Narrative: n/a

Table 3.3.01: Activities by Funding Mechanism

Mechanism: EGPAF New Bilateral
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Prevention of Mother-to-Child Transmission (PMTCT)
Budget Code: MTCT
Program Area Code: 01
Activity ID: 19253
Planned Funds: $ 247,000.00
Activity Narrative: n/a

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: $ 5,628,547.00

Program Area Context:

According to the 2006 UNAIDS estimates, Rwanda's adult HIV prevalence is 3.1%. Seroprevalence rates among women (3.6%) are higher than men (2.3%) and are higher in urban areas (7.3%) than rural areas (2.2%). Prevalence rises progressively with age with women having higher prevalence rates than men up until 35-39 years after which the trend is reversed (2005 RDHS-III).

The age of sexual debut in Rwanda is relatively late for both women and men (20.3 and 20.8, respectively), and the prevalence rates among the youngest age group (15-19) reflect this data with 0.6% prevalence among girls and 0.4% prevalence among boys. However, the prevalence rate increases dramatically to 2.5% for women in the 20-24 age group, while the prevalence among men 20-24 remains almost the same at 0.5%. This difference suggests that women aged 20-24 are engaging in trans-generational sex with older men who also have higher prevalence rates. According to the 2005 RDHS-III, the HIV prevalence rate among women who reported having their first sexual experience with a partner 10 or more years older is 10.4%.

Knowledge of HIV/AIDS is almost universal in Rwanda. Knowledge of methods to reduce the risk of getting the AIDS virus varies by sex: 80% of women and 90% of men know that the risk of contracting HIV/AIDS can be reduced by using condoms; 86.8% of women and 87% of men know it can be reduced by limiting sexual intercourse to one un-infected partner; and 81.8% of women and 88.1% of men know about abstinence as a prevention method. Knowledge of HIV and HIV prevention is similar for youth aged 15-24. When asked about sexual behaviors in the past 12 months, 15% of young women and 48% of young men (15-24) had had higher-risk sexual intercourse. Among this cohort, 26% of women and 40% of men had used a condom at last reported higher-risk sexual intercourse.

In Rwanda, 33.8% of women reported having ever experienced physical or sexual violence by their husband. Among women who reported that their husband "gets drunk often", 71.6% experienced physical or sexual violence. The EP will integrate HIV prevention strategies with the effects of alcohol and violence to improve programming in FY 2007.

Although Rwanda has a comparatively low prevalence in relation to neighboring countries, the epidemic is considered generalized. The EP prevention strategy will target the general population with a special emphasis on MARPs – youth, especially young girls; HIV-positive individuals and their families; prisoners; military; refugees; older men engaging in transactional or intergenerational sex; and the sexual networks of CSWs and truck drivers. The EP AB programs will take an integrated approach, which would target individual behavior and societal norms, as well as linking AB with C/OP, particularly for programs targeting MARPs. This strategy supports the GOR newly revised 2006 national prevention strategy.

Since the beginning of the EP, AB programs have reached more than 500,000 individuals and trained over 11,500 individuals to provide AB prevention messages. The interventions ranged from mass media radio dramas to interpersonal peer education. In FY 2007, the EP IPs will provide AB messages to military, youth, OVC, PLWHA, refugees, families and caretakers. Prevention messages will be integrated into all EP-supported activities, including counseling and testing, clinical care and treatment, PMTCT services, ART services, and community-based activities for OVC and PLWHA. Moreover, the EP will support FBOs to raise AB awareness and foster dialogue among pastors, youth, young couples and parents; and will build the capacity of CBOs and FBOs to incorporate AB messages into their activities.

In FY 2007, the EP will issue an integrated prevention RFA for a new partner to implement a BCC and social marketing campaign. The campaign will target young boys and girls with messages focusing on increased awareness about gender issues and HIV; improved communication between young boys and girls; and empowerment of young girls. It will focus on life skills building to strengthen young people's negotiation, communication, decision-making, and leadership skills, self-affirmation, and ability to resist

peer pressure. Strengthening long-term life skills at an early age will enable young people to make healthier, safer and informed choices about their sexuality and reproductive health, thus preventing new HIV infections. The campaign will increase demand for abstinence and fidelity behaviors among youth by increasing their personal risk perception; addressing gender barriers; and building life skills to enable them to say no to sex, negotiate delayed sexual debut, or stay faithful to one partner if already sexually active and in a stable partnership.

The campaign will also address issues of transactional and cross-generational sex by targeting young women, older men, parents, and political and religious leaders. Based on best practices from the region, the campaign will use advocacy and mass-media strategies to address societal norms and increase awareness about the dangers of these practices among religious, political and business leaders at national and local levels. Advocacy efforts will stimulate a national debate, change the societal view of these practices, and create a sense of responsibility among parents and leaders to take a public stance against and halt the practice of transactional and cross-generational sex. Simultaneously, a mid-level and interpersonal communications campaign will target young girls to increase their personal risk perception related to transactional relationships with older men; strengthen their life skills and empower them to say no to risky sex; and provide them with economic alternatives to trading their bodies for material and financial gains, such as small income generating activities and vocational trainings.

Other channels for prevention education include school-based AB training and life skills classes for young people; OVC programs which train mentors and caregivers in delivery of AB prevention messages; military interventions; and, post-test club support programs emphasizing prevention for positives. The EP assistance will increase its efforts to target mobile MARPs with integrated health messaging, including AB, through the regional ROADS Project. The EP will expand health promotion, integrating AB with C/OP, with workplace programs and community discussions among women's groups, youth, former prisoners, and health care providers.

With the increase in AB resources, the EP estimates that over 828,000 individuals will be reached with face-to-face messages and 6,883 individuals will be trained to promote abstinence and fidelity in FY 2007.

All EP prevention activities will continue to support the GOR National Plan for HIV Prevention (2005-2009). AB activities support the EP Five-Year HIV/AIDS Strategy in Rwanda 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 (a subset of total reached with AB)	218,313
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	828,232
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	6,883

Table 3.3.02: Activities by Funding Mechanism

Mechanism: Refugees - Rwanda
Prime Partner: American Refugee Committee
USG Agency: Department of State / Population, Refugees, and Migration
Funding Source: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 7151
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY 2006 -- NO NEW FUNDING IN FY 2007]

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.

Continued Associated Activity Information

Activity ID: 4864
USG Agency: Department of State / Population, Refugees, and Migration
Prime Partner: American Refugee Committee
Mechanism: Refugees - Rwanda
Funding Source: GHAI
Planned Funds: $ 45,000.00

Emphasis Areas

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 (a subset of total reached with AB)	4,500	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	11,000	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	50	☐

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 (prior to 2007)

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: Central (GHAI)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 7157
Planned Funds: $ 176,592.00
Activity Narrative: This activity relates to activities in HKID (8150, 7186).

CRS, in collaboration with its partner Caritas-Rwanda, implements the "Avoiding Risk, Affirming Life" project which focuses on HIV prevention through abstinence, secondary abstinence and fidelity in marriage. CRS successfully integrates this AB prevention program into its other Track 1.0 programs for OVC and ART. These HIV prevention activities are also linked to other existing CRS programs for the promotion of good governance through their Justice and Peace Program and for nutritional support through Title II food assistance and agro-business enterprise. CRS works closely with the GOR, the Catholic Church, USG-supported groups, and established community based groups, such as Parent-Teacher Associations, to implement the below activities.

The "Avoiding Risk, Affirming Life" project began implementing activities in Rwanda in September 2005 with a Knowledge, Attitudes and Practices (KAP) study. CRS then conducted a series of 18 focus groups in January 2006 to gather information about HIV knowledge, stigma, and first sexual encounter. Using the results of this research, CRS developed radio messages for specific target groups – in-school and out-of-school youth and married couples. In order to coordinate and integrate activities at the parish level, CRS created parish commissions which help mobilize the community and monitor activities. Parish commission members, teachers, students, priests and members of the Catholic Action Movement participated in three-day trainings on the Choose Life curriculum, developed by World Relief. In addition to the Choose Life AB curriculum, CRS developed and distributed peer education and premarital counseling materials in all 22 participating parishes. The 230 trained peer educators, teachers and priests have reached over 32,000 youth and young adults since the project began with messages promoting abstinence outside of marriage and faithfulness in marriage. Other FY 2006 activities included a two-day workshop with 90 OVC participating in HIV prevention sessions and a one-day training on child rights and sexual exploitation for 19 church leaders. In June 2006, CRS and Caritas-Rwanda conducted a workshop for 15 newspaper and radio journalists and organized song competitions in the 22 parishes to raise awareness about HIV/AIDS, VCT and the fight against stigma and discrimination.

With FY 2007 funding, CRS plans to continue working closely with Caritas-Rwanda to expand activities into 2 new dioceses and 11 new parishes. CRS will train more than 800 new teachers, religious leaders, and peer educators in HIV/AIDS prevention focusing on abstinence and fidelity. Those trained will then reach more than 83,000 individuals with AB messages. These targets represent a significant increase over FY 2006 targets. In addition to providing AB messages through peer education, Radio Maria, the Catholic newspaper and youth clubs, the project will also strengthen referrals to health facilities for VCT and other HIV/AIDS services. This program addresses the key legislative issues of stigma reduction, male norms, and reducing violence. These activities support Rwanda's National Prevention Plan and Rwanda's EP five-year strategy of using religious networks and church-based mass media campaigns to address HIV/AIDS.

Continued Associated Activity Information

Activity ID: 5233
USG Agency: U.S. Agency for International Development
Prime Partner: Catholic Relief Services
Mechanism: CRS Track 1
Funding Source: N/A

Planned Funds: $ 0.00

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
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 (a subset of total reached with AB)	42,813	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	83,197	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	884	☐

Target Populations:

Adults
Community-based organizations
Faith-based organizations
Orphans and vulnerable children
Teachers
Volunteers
Children and youth (non-OVC)
Out-of-school youth
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

Gisagara

Huye

Nyanza

Nyaruguru

Rutsiro

Ngororero

Nyabihu

Rubavu

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: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 7183
Planned Funds: $ 720,000.00
Activity Narrative: This activity relates to MTCT (7181), HVOP (7184), HVCT (7182), HBHC (7187), HKID(7186), OHPS (7189), and HVAB (8130, 7199).

CHF/CHAMP, through financial support and technical and institutional capacity building for Rwandan partner organizations, is working to ensure Rwandan communities have equitable access to high quality, sustainable continuum of HIV & AIDS care services. CHAMP supports the provision of community services in all EP-supported districts, especially around the EP-supported health facilities.

The CHAMP program will mobilize and support community-based HIV prevention efforts, including prevention for positives, that focus on abstinence and/or fidelity. CHAMP will provide technical and financial assistance to Rwandan CBOs and FBOs who will incorporate prevention messages into their programs for community and religious leaders, youth, families affected by HIV/AIDS, and OVC including child-headed households.

In FY 2006 CHAMP-supported partners are reaching over 9,000 individuals with abstinence and/or faithfulness messages and training over 300 community volunteers to provide these messages.

In FY 2007 many of the general prevention activities will be transferred to the new prevention RFA being issued by USAID. However, CHAMP will continue to provide technical and financial support to Rwandan partner organizations to include appropriate and targeted prevention messages in their programs for OVC and PLWHA. Messages will be delivered through face-to-face interactions and will use a family-centered approach, addressing the entire household. These messages will include the linkages between alcohol use, violence and HIV; stigma reduction; abstinence; fidelity; partner reduction; the vulnerability of young women; and, the importance of knowing you and your family HIV status. This program will reinforce the norms of Rwandan society which have led to a relatively late age of sexual debut (20.3 among women 25-49 and 20.8 among men 25-59). This is especially important as traditional family and community structures are affected by HIV and AIDS. In addition, the programs will support activities which will enable individuals to practice abstinence and/or faithfulness, such as life skills and income generating activities, and will address the societal norms surrounding cross-generational and transactional sex.

CHAMP will continue to use and distribute IEC materials developed in FY 2006 and will ensure their partners have access to best practices developed by other EP implementing partners. The messages and tools used by this activity will increase the effectiveness of CBOs and faith-based networks and their volunteers to change high-risk behaviors and norms and to effectively promote abstinence before marriage and fidelity in marriage.

These efforts address key legislative issues related to gender, specifically increasing gender equity in HIV/AIDS programs, addressing male norms and behaviors, and violence and coercion, and support the Rwanda EP five-year strategy to support youth peer education and parent/child counseling through church networks and support mass media and church-based campaigns addressing HIV risk.

Continued Associated Activity Information

Activity ID: 2807
USG Agency: U.S. Agency for International Development
Prime Partner: Community Habitat Finance International

Mechanism: CHAMP
Funding Source: GHAI
Planned Funds: $ 1,780,000.00

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

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (a subset of total reached with AB)	20,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	105,000	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	3,000	☐

Target Populations:

Community leaders
Community-based organizations
Faith-based organizations
HIV/AIDS-affected families
Orphans and vulnerable children
People living with HIV/AIDS
Volunteers
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

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Bugesera

Gatsibo

Nyagatare

Rwamagana

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 7199
Planned Funds: $ 488,000.00

Activity Narrative: This activity relates to HVOP (7199), HVCT (7201), HKID (8727), HBHC (8142) and OHPS (8744).

The overall goal of the ROADS Project is to stem HIV transmission and mitigate the consequences of HIV/AIDS on vulnerable populations along major East African transport corridors. This multisectoral project will target high-risk mobile populations--drivers and their assistants, CSWs, members of the uniformed services and stop-over site communities--with regionally coordinated SafeTStop messages. It will also link these target populations with new or improved HIV/AIDS services and care tailored to meet their needs. Innovative elements of the SafeTStop model include essential HIV-related programming on alcohol, gender-based violence, food security and economic empowerment. The ROADS Project works in Kenya, Uganda, Djibouti, Southern Sudan, Rwanda, Burundi and the DRC.

Over the last year, the ROADS Project focused on three sites in Rwanda: Kigali-ville, Gatuna on the Uganda border and Cyangugu on the DRC border. FHI launched the SafeTStop campaign in November 2005 with participation from the three major transport associations in Rwanda (Truck drivers, Mini-bus drivers and Motorcycle Taximen) as well as from the Association of Truckers' Wives, the CNLS and the Ministry of Labor. ROADS has trained 132 peer educators from the associations who in turn reached more than 3,400 individuals with ABC messages, information on STIs, and VCT referral. In FY 2006, ROADS completed an assessment on alcohol and HIV as part of a three-country study requested by the ECSA Ministers. ROADS will finalize rapid assessments in all three SafeTStop sites to identify programming needs. ROADS will continue to train peer educators to convey HIV prevention messages including the risks associated with cross-generational sex and prevention for positives. The peer educators will be out-of-school youth, truck drivers, commercial sex workers, and other community members. ROADS will work in partnership with PSI and health facilities to provide mobile VCT services.

With FY 2007 funding, ROADS will continue the above HIV prevention activities, training an additional 400 peer educators and reaching an estimated 40,000 people with HIV/AIDS prevention information and referral to services. The target of 1,000 individuals reached with A messages represents OVC under the age of 14. This group of youth will receive age-appropriate messages encouraging them to protect their health by abstaining from sex outside of marriage. The other target groups will receive comprehensive prevention messages. Of the 400 peer educators, 100 will be trained exclusively in AB prevention for youth while 300 will focus on integrated prevention education. The project will continue to link and make referrals to existing OVC and PLWHA services in the communities through their prevention activities. In FY 2007, ROADS partners will begin providing care and support services to vulnerable HIV-affected families in the three communities. The 1,000 OVC, all PLWHA, as well as their families will receive HIV/AIDS prevention education and a comprehensive menu of services.

Using information from the FY 2006 alcohol assessment, ROADS will initiate a focused campaign with bars/lodging owners, restaurants and local leaders to reduce alcohol abuse and domestic violence among truck drivers and men in the three communities. ROADS will also explore different alcohol-treatment options for patients on or about to initiate ART. ROADS will work with TRAC to integrate alcohol and gender-based violence programming into CT, care and treatment programs. The project will train about 20 volunteers (teachers, community leaders, religious leaders, health workers) to provide truck drivers, low-income women and out-of-school youth with life skills and alternative activities in the evening.

To enhance access to HIV care and support, the ROADS Project developed the LifeWorks Partnership, which creates jobs for marginalized, vulnerable people in East and Central Africa, including PLWHA, older orphans and low-income women. Through this partnership, ROADS attempts to secure the long-term economic health of individuals, families and communities as a key HIV care and prevention strategy. To implement this program, ROADS has enlisted the private sector to: 1) identify small business opportunities for women and older orphans, including design and production of home and fashion accessories; 2) provide source financing through development banks; and 3) give pro bono business expertise to help these new businesses grow. A key feature of LifeWorks is

that nascent businesses not only provide jobs for the most vulnerable people in a community, but that the companies themselves fight AIDS through their own corporate responsibility platforms. This partnership will be partially supported by HVAB funding. ROADS will provide TA in M&E and in community mobilization and advocacy to an estimated 25 different local associations, women's groups and CBOs.

This activity addresses the key legislative issues of gender, violence, stigma reduction, and wraps around Microfinance/Microcredit. This activity also reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan by focusing prevention efforts on high-risk, mobile populations.

Continued Associated Activity Information

Activity ID: 4776
USG Agency: U.S. Agency for International Development
Prime Partner: Family Health International
Mechanism: Transport Corridor Initiative
Funding Source: GHAI
Planned Funds: $ 100,800.00

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
Workplace Programs	10 - 50

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (a subset of total reached with AB)	1,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	40,000	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	100	☐

Target Populations:

Business community/private sector
Commercial sex workers
Community-based organizations
Faith-based organizations
Discordant couples
Street youth
Truck drivers
Non-governmental organizations/private voluntary organizations
Orphans and vulnerable children
Volunteers
Out-of-school youth
Partners/clients of CSW

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

Gicumbi

Rusizi

Gasabo

Kicukiro

Table 3.3.02: Activities by Funding Mechanism

Mechanism: PSI Healthy Schools
Prime Partner: Population Services International
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 7226
Planned Funds: $ 550,000.00

Activity Narrative: Reprogramming 8/07: This activity will provide support to the Rwandan Ministry of Education. While the MINEDUC is heavily involved in PSI's school-based HIV/AIDS prevention activities, human resources at the Ministry are scarce. There is currently one person, the Coordinator of HIV/AIDS programs, who is responsible for planning, coordination, and monitoring of all HIV/AIDS activities in the education sector. The Ministry would greatly benefit from two additional positions in the HIV/AIDS department. These two locally-hired FTE positions will be hired by PSI and seconded to the MINEDUC under this activity.

This activity relates to HVOP (7232) and HVAB (7265).

The overall goal of PSI's Healthy Schools Initiative is to reduce HIV/AIDS incidence among youth aged 15-24 by promoting abstinence and safer sexual behaviors, changing social norms among men and women, as well as improving communication among secondary school youth. According to the 2005 RDHS-III, the median age for sexual debut among Rwandans is 20.3 years for women and 20.8 years for men. Given this relatively late age of sexual debut, both abstinence and be faithful messages are appropriate interventions for youth in secondary schools.

During FY 2006, PSI collaborated with the MINEDUC to strengthen the HIV/AIDS competencies of teachers and anti-AIDS clubs by identifying thirty target schools and assessing their needs for training and support materials. PSI also created a BCC peer education Life Skills module and trained members of anti-AIDS clubs as peer educators. One component of the Life Skills curriculum is a module on gender, which focuses on techniques to strengthen girls' empowerment. The Healthy Schools Initiative also included abstinence BCC campaigns targeting youth, which utilized interpersonal communication sessions and mobile video shows to promote abstinence messages. PSI also developed a parent-child curriculum aimed at improving communication about HIV/AIDS and sexuality which is being used to train community-based facilitators to work with parents and religious leaders.

In FY 2006, PSI's focused, high-intensity prevention interventions reached 12,000 students with AB messages. This accounts for approximately 4% of Rwandan secondary school youth. National scale-up of this program is not feasible due to a high program cost per student. This activity has thus been altered slightly for FY 2007 so that a greater percentage of Rwandan youth (30-50%) will be reached with prevention messages.

In FY 2007, PSI will target a larger portion of Rwandan school youth with prevention messages using midlevel media in at least 200 secondary schools. This effort will complement the newly GOR approved HIV/AIDS curriculum for secondary schools. Mobile video shows will present abstinence and be faithful messages that focus on improved communication between boys and girls to strengthen negotiation skills, increased ability to resist peer pressure, the risks of cross-generational and transactional sex, and better understanding of gender equality. Two teams will be deployed to present the mobile shows in all 30 districts of the country. The program will maximize coverage of these prevention activities and reach at least 144,000 youth during FY 2007.

As a second component of this program, PSI will continue production of the ABAJENE! youth call-in radio shows to reinforce the prevention messages communicated during mobile presentations. The ABAJENE! youth magazine will also be produced quarterly and disseminated to 75,000 youth in secondary schools. Assuming that each magazine will be read by at least four youth, the program intends to reach at least 300,000 students.

The Healthy Schools Initiative addresses the key legislative issues of gender, particularly male norms, and stigma reduction. This activity also reflects the ideas presented in the EP Five-Year HIV/AIDS Strategy in Rwanda, and the GOR National Prevention Plan by expanding abstinence programs at secondary schools.

Continued Associated Activity Information

Activity ID: 2795
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Population Services International

Mechanism: HIV/AIDS School Based Program-Procurement
Funding Source: GHAI
Planned Funds: $ 350,000.00

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
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 (a subset of total reached with AB)	48,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	144,000	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	45	☐

Target Populations:

Secondary school students

Key Legislative Issues

Addressing male norms and behaviors

Stigma and discrimination

Gender

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: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 7230
Planned Funds: $ 60,000.00
Activity Narrative: This activity relates to HVOP (7229) and HVCT (7231).

PSI and the DMS work together to promote HIV prevention among members of the RDF. Soldiers' living situation, mobility and age make them vulnerable to HIV. While many soldiers practice sexual abstinence and fidelity, the distance from their families and spouses can make it difficult to maintain stable relationships. A KAP survey conducted by PSI in 2004 (in Gitarama, Butare and Kigali-rural brigades) indicated that out of 1,171 soldiers, 60% were single, and 90% were aged between 20 and 34.

In FY 2006, this program reached over 10,000 members of the RDF with primary prevention messages. Soldiers are encouraged to abstain and be faithful while they are away from their spouses and partners. Prevention of alcohol abuse and the links between alcohol use, risky behaviors and violence are addressed in the peer education trainings and through IEC materials. AB messages are delivered as part of PSI's overall military program. According to a KAP survey conducted in 2004, 4.3% of 1,171 soldiers had abstained from sex during their lifetime. Consequently, it is important to promote AB as a stand-alone campaign with the goal of reducing the number of sexual partners per soldier to zero or one.

In FY 2007, these activities will reach 15,000 members of the RDF with prevention messages. PSI, in collaboration with the DMS, will implement an AB campaign and continue to provide trainings and TA to anti-AIDS-clubs and peer educators. The peer educators and TOT will be trained in ABC prevention messages that address the links between HIV, alcohol use and violence. PSI will train 142 peer educators to promote ABC messages, stressing AB or C to different sub-groups within the RDF based on KAP research and segmentation of the target population. The peer educators will encourage married members of the RDF who live far away from their families to practice abstinence while on duty at the same time being faithful to their spouses. An interpersonal and mass media communication strategy will be employed in order to reach both primary and secondary (spouses and partners of soldiers) target audiences. Peer educators will emphasize the benefits of abstinence in terms of professional future and moral and cultural values. By FY 2008, the EP will reach all military personnel with prevention messages.

These activities addresses the key legislative issues of gender, especially male norms, and stigma reduction. The activity supports the Rwanda EP five-year strategy by collaborating with the GOR to implement prevention activities for the military.

Continued Associated Activity Information

Activity ID: 4004
USG Agency: Department of Defense
Prime Partner: Population Services International
Mechanism: PSI-DOD
Funding Source: GHAI
Planned Funds: $ 35,000.00

Emphasis Areas

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 (a subset of total reached with AB)	0	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	15,000	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	142	☐

Target Populations:

Military personnel

Key Legislative Issues

Addressing male norms and behaviors

Reducing violence and coercion

Coverage Areas:

National

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: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 7233
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY 2006 -- NO NEW FUNDING IN FY 2007]

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 FY 2005 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 FY 2006, PSI plans to reach 20,000 high-risk individuals with ABC messages; these targets appear under Other Prevention, Activity #4877.

Continued Associated Activity Information

Activity ID: 4878
USG Agency: U.S. Agency for International Development
Prime Partner: Population Services International
Mechanism: PSI Bilateral
Funding Source: GHAI
Planned Funds: $ 38,400.00

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 (a subset of total reached with AB)		☑
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful		☑
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful		☑

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: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 7253
Planned Funds: $ 20,000.00
Activity Narrative: USAID/Rwanda has been providing local and international technical assistance to GOR agencies and limited direct grants to local NGOs since FY 2004.

In FY 2007, the EP will expand this to further build local capacity. USAID anticipates continuing financial and technical support to Rwanda NGOs in sponsoring or attending conferences, workshops and technical meetings on HIV treatment. USAID will also support direct TA to other GOR agencies as needed, in particular CNLS and MIGEPROF.

Continued Associated Activity Information

Activity ID: 4967
USG Agency: U.S. Agency for International Development
Prime Partner: US Agency for International Development
Mechanism: USAID Rwanda Mission
Funding Source: GHAI
Planned Funds: $ 225,000.00

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 (a subset of total reached with AB)		☑
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful		☑
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful		☑

Coverage Areas:

National

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: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 7265
Planned Funds: $ 0.00
Activity Narrative: Reprogramming 8/07: This activity has been reprogrammed to a partner.

This activity relates to HVAB (7226) and HVOP (7232).

During FY 2006, PSI collaborated with the MINEDUC to strengthen the HIV/AIDS competencies of teachers and anti-AIDS clubs through BCC and Life Skills training of peer educators. The Healthy Schools Initiative also targeted youth with abstinence BCC campaigns, which utilized interpersonal communication sessions and mobile video shows to promote safer sexual behavior messages. PSI developed a parent-child curriculum aimed at improving communication about HIV/AIDS and sexuality which will be used to train community-based facilitators to work with parents and religious leaders.

In FY 2007, PSI will target a larger portion of Rwandan school youth with prevention messages using midlevel media in at least 200 secondary schools. Mobile video shows will present A and B messages that focus on improved communication between boys and girls to strengthen negotiation skills, increased ability to resist peer pressure, the risks of cross-generational and transactional sex, and better understanding of gender equality. PSI will also continue production of the ABAJENE! youth call-in radio shows and the ABAJENE! youth magazine to reinforce the prevention messages communicated during mobile presentations.

The first component of this activity involves providing two to three short-term TA visits from CDC headquarters prevention specialists to support PSI's interventions with adolescents in order to ensure effective programs and assist with M&E components.

The second component will provide support to the Rwandan MINEDUC. While the MINEDUC is heavily involved in PSI's school-based HIV/AIDS prevention activities, human resources at the Ministry are scarce. There is currently one person, the Coordinator of HIV/AIDS programs, who is responsible for planning, coordination, and monitoring of all HIV/AIDS activities in the education sector. The Ministry would greatly benefit from two additional positions in the HIV/AIDS department. These two locally-hired FTE positions will be supported by CDC and seconded to the MINEDUC under this activity. The Planning and Evaluation Officer will help plan, coordinate, and evaluate all HIV/AIDS activities in the education sector, including the Healthy Schools Initiative. The Community Mobilization Officer will actively collaborate with partners as well as ensure implementation of community-based HIV/AIDS activities in the education sector.

Assistance to the Healthy Schools Initiative and MINEDUC reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan by supporting abstinence and faithfulness programs that target secondary school youth and by building the capacity of coordinating entities and strengthening collaboration with government partners.

Continued Associated Activity Information

Activity ID: 2849
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: US Centers for Disease Control and Prevention
Mechanism: CDC Country Office GAP/TA
Funding Source: GHAI
Planned Funds: $ 0.00

Emphasis Areas

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

Targets

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

Target Populations:

USG in-country staff

Implementing organizations (not listed above)

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: Central (GHAI)
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 7270
Planned Funds: $ 429,408.00
Activity Narrative: This Track 1.0 activity is linked to supplemental HVAB funding (#7272) for World Relief.

World Relief's "Mobilizing Youth for Life" project aims to 1) engage youth in interactive learning to establish standards of sexual protection, 2) equip influential adults to guide youth in making wise life choices, and 3) obtain commitments to abstinence before marriage and fidelity in marriage from youth aged 10-24 years old. Since the project's inception in March 2004, World Relief has reached over 400,000 youth through a combination of activities in over 2380 churches, 520 schools, 684 clubs and other community settings. Over the past three years, the project expanded its activities into all 30 districts making it a national HIV prevention and stigma reduction program.

With FY 2006 funding, World Relief continues to expand existing skills-based education activities and introduce interventions that address sexual coercion and cross generational and transactional sex, especially among adolescent girls. The program developed the "Choose Life" (Hitamo Kubaho) curriculum for three different age groups: 8-10, 11-15 and 16-18 year olds. The project also developed and aired radio spots reinforcing abstinence and fidelity. As a partner under CHAMP, World Relief also receives EP funding to provide ABC messages for a family-centered approach, reaching adults as well as youth with age-appropriate HIV prevention materials. World Relief encouraged collaboration of church partners through district level Interfaith Committees, whose members are elected from different church denominations. These committees coordinate HIV/AIDS initiatives in their districts and give leadership and support to volunteers that have been trained by World Relief. The volunteers attribute their commitment to this program in large part due to the support they receive from their church groups and the encouragement of the Interfaith Committees. In FY 2006, World Relief invested resources in developing the capacity of local partners, such as the Association of Committed Teachers (ACT) Rwanda and Rwanda University Bible Group (Campus pour Christ). World Relief trained 284 teachers from ACT in several districts in Kigali, North, East and West provinces. Campus Pour Christ now includes 217 university youth trainers trained by World Relief. These youth plan, implement, and report on HIV prevention activities in six universities. Other FY 2006 activities included a poetry competition on the theme of HIV/AIDS that provided successful participants with school fees for next year.

In FY 2007, World Relief will focus Track 1 funding in the 20 CHAMP districts to ensure integration and coverage in these EP focus areas. The supplemental AB funding from USAID/Rwanda will support activities in 10 additional districts in the country. This youth focused HIV prevention program will continue supporting the youth who have already made a commitment to abstinence, while encouraging other youth aged 10-24 to personally pledge abstinence as a means of protection from the HIV virus and other STIs. With $360,000 in Track 1 funding, World Relief will train 800 youth leaders, peer educators and teachers with the Choose Life curriculum to reach an estimated 20,000 new youth with abstinence-only messages and 60,000 new youth with AB messages. World Relief plans to address the issues of alcohol abuse and GBV as a facilitating factor in HIV transmission by adding a supplement to the Choose Life Manual. This program addresses the key legislative issues of stigma reduction, male norms, and reducing violence. These efforts to delay youth's sexual debut, promote abstinence and increase mutual faithfulness and partner reduction reflect 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.

Continued Associated Activity Information

Activity ID: 2790
USG Agency: U.S. Agency for International Development
Prime Partner: World Relief Corporation
Mechanism: WR Track 1.0
Funding Source: N/A
Planned Funds: $ 0.00

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 (a subset of total reached with AB)	20,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	60,000	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	800	☐

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Coverage Areas

Burera

Gakenke

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Bugesera

Gatsibo

Nyagatare

Rwamagana

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 7272
Planned Funds: $ 250,000.00
Activity Narrative: This activity relates to HVAB (7183, 7270).

World Relief's "Mobilizing Youth for Life" project aims to: 1) engage youth in interactive learning to establish standards of sexual protection, 2) equip influential adults to guide youth in making wise life choices, and 3) obtain commitments to abstinence before marriage and fidelity in marriage from youth aged 10-24 years old. World Relief encourages collaboration of church partners through district level Interfaith Committees whose members are elected from different church denominations. These committees coordinate HIV/AIDS initiatives in their districts and give leadership and support to volunteers that have been trained by World Relief. The volunteers attribute their commitment to this program in large part due to the support they receive from their church groups and the encouragement of the Interfaith Committees.

Since the project's inception in March 2004, World Relief has reached more than 400,000 youth through a combination of activities in 2,380 churches, 520 schools, 684 clubs and other community settings. Since FY 2004, the project expanded its activities into all 30 districts making it a national HIV prevention and stigma reduction program.

In FY 2006, World Relief continues to provide skills-based education activities and introduce interventions that address sexual coercion and cross-generational and transactional sex, especially among adolescent girls. The program developed the "Choose Life" (Hitamo Kubaho) curriculum for three different age groups: 8-10, 11-15 and 16-18 year olds. The project also developed and aired radio spots reinforcing abstinence and fidelity. As a partner under CHF/CHAMP, World Relief receives additional EP funding to provide ABC messages using a family-centered approach, reaching adults and youth with age-appropriate HIV prevention materials. World Relief invested resources in developing the capacity of local partners, such as the Association of Committed Teachers (ACT) Rwanda, and Rwanda University Bible Group (Campus pour Christ). World Relief trained 284 teachers from ACT and 217 Campus pour Christ youth trainers in 6 universities. Other FY 2006 activities included a poetry competition on the theme of HIV/AIDS that provided successful participants with school fees for next year.

In FY 2007, World Relief will focus Track 1.0 funding in the 20 CHAMP districts to ensure integration and coverage in these EP focus areas. This supplemental AB funding will support activities in 10 additional districts in the country. The program will continue to support youth who have already made a commitment to abstinence, while encouraging other youth aged 10-24 to personally pledge abstinence as a means of protection from HIV infection and other STIs. With this supplemental funding, World Relief will train 320 youth leaders, peer educators and teachers using the "Choose Life" curriculum to reach an estimated 12,000 new youth with abstinence-only messages and 32,000 new youth with AB messages. World Relief plans to address the issues of alcohol abuse and GBV as a facilitating factor in HIV transmission by adding a supplement to the "Choose Life" Manual.

This program addresses the key legislative issues of gender - particularly male norms and reducing violence - and stigma reduction. These efforts to delay youth's sexual debut, promote abstinence and increase mutual faithfulness and partner reduction reflect 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.

Continued Associated Activity Information

Activity ID: 2820
USG Agency: U.S. Agency for International Development
Prime Partner: World Relief Corporation
Mechanism: WR Supplement
Funding Source: GHAI
Planned Funds: $ 480,000.00

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 (a subset of total reached with AB)	12,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	32,000	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	320	☐

Target Populations:

Community leaders
Community-based organizations
Faith-based organizations
HIV/AIDS-affected families
Orphans and vulnerable children
Volunteers
Children and youth (non-OVC)
Caregivers (of OVC and PLWHAs)
Out-of-school youth
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

Burera

Musanze

Gisagara

Huye

Nyanza

Kayonza

Kirehe

Ngoma

Rusizi

Nyamasheke

Table 3.3.02: Activities by Funding Mechanism

Mechanism:	Biodiversity
Prime Partner:	International Resources Group
USG Agency:	U.S. Agency for International Development
Funding Source:	GHAI
Program Area:	Abstinence and Be Faithful Programs
Budget Code:	HVAB
Program Area Code:	02
Activity ID:	8124
Planned Funds:	$ 100,000.00

Activity Narrative: This activity relates to HVOP (7184, 8131), HVAB (7183), HBHC (7187), and HKID (7186).

The Biodiversity project is a USAID four-year, $3.8 million project which will focus on the Nyungwe Forest National Park and its surrounding buffer areas in southwestern Rwanda. The project's primary objective is to encourage sustainable rural economic growth through the development of a tourism sector that is compatible with existing and potential community development activities. The project will focus 20% of its resources on community based health activities to raise awareness of the interlinking issues of population, health and the environment. The Biodiversity Project will work in five districts with some of the highest population densities in the country (250-500/km2), reaching approximately 300,000 people. More than 90% of the people living in this catchment area are farmers. The people living around Nyungwe Park are highly marginalized with low education levels, large families, poor housing, frequent food insecurity, and limited access to basic health care and infrastructure. The populations living within 10 kms of the Nyungwe Forest National Park are considered high risk because they will experience an influx of migration from private enterprises and increased tourists around the park. These populations have little access to information about HIV and will likely see an increase in income through the economic benefits of ecotourism, as well as increases in outside populations drawn to the Nyungwe area for work and livelihood.

With $200,000 in Family Planning and Infectious Disease funding and a total of $150,000 in EP funding (HVAB - $100,000 and HVOP - $50,000), the project will provide information about family planning, malaria prevention, and HIV/AIDS prevention to the populations around Nyungwe Park. Communities will be encouraged to seek antenatal services, VCT, and facility-based deliveries. They will also receive HIV prevention messages that focus on abstinence, fidelity, partner reduction, alcohol use, and GBV through IEC print materials, mobile video screenings, interpersonal communications, and community drama. The need to shift social norms, particularly male behaviors, will be emphasized through community events. An estimated 20,000 individuals will receive direct AB messages, which will reinforce the services and information provided at the health facilities in these communities. The Biodiversity project will work to strengthen referrals to HIV/AIDS services and the linkages between the health facility and the community.

Biodiversity will use existing IEC materials and messages approved by the CNLS BCC Steering Committee. The project will coordinate closely with CHAMP and the Child Survival Grants Project consortium - Concern, IRC and World Relief - who works in part of the five Biodiversity districts. This activity supports the integration of HIV/AIDS and health through community-based services. This activity reflects the EP Five Year Strategy of involving the private sector and targeting vulnerable 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

Targets

Target	Target Value	Not Applicable
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (a subset of total reached with AB)	4,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	20,000	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	300	☐

Target Populations:

Adults
Business community/private sector
Community leaders
Community-based organizations
Faith-based organizations
HIV/AIDS-affected families
Non-governmental organizations/private voluntary organizations
Volunteers

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

Stigma and discrimination

Coverage Areas

Nyamagabe

Nyaruguru

Nyamasheke

Table 3.3.02: Activities by Funding Mechanism

Mechanism: HIV Support to RDF
Prime Partner: Drew University
USG Agency: Department of Defense
Funding Source: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 8125
Planned Funds: $ 91,780.00
Activity Narrative: This activity relates to HTXS (7190), HBHC (7191), HVOP (8135), HVTB (8146), HKID (7186) and HVCT (8165).

The RDF supports three military hospitals and five brigade clinics throughout the country. In FY 2005, Drew University began working in two military hospitals and three brigade clinics with EP support. This support included TA and training on ARV treatment, palliative care, M&E, and lab infrastructure. This support has been expanded to cover the entire clinical package - ARV services, TB/HIV, PMTCT, Palliative Care and Prevention for Positives. In collaboration with CHAMP, Drew will link to community services surrounding the military facilities, especially for OVC. Drew will receive drug procurement from PFSCM. In line with national policies, the military hospitals will use performance-based financing as incentives for facilities.

Because the EP will initiate a standard prevention for positive package for beneficiaries starting in FY 2007, Drew University will include these interventions as it scales up in the military facilities.

In FY 2007, Drew University will work with the RDF to improve HIV care for military personnel, their partners and families, and community members who live in the surrounding areas. Drew University will provide TA to RDF to design a prevention campaign targeting PLWHA individuals receiving HIV care and treatment at RDF sites. The overall goal of this activity is to reduce the risk of further HIV transmission among discordant couples. New preventions will be prevented through BCC with a focus on AB messages. As part of the prevention for positives initiative, soldiers are encouraged to abstain and be faithful while they are away from their spouses and partners. Ten thousand individuals will be reached with AB messages. Prevention of alcohol abuse and the link between alcohol use, sexual risk behaviors and gender-based violence are a focus of the peer education trainings and IEC materials promoting AB.

In collaboration with the DMS, Drew University will implement an AB campaign and continue trainings and TA to anti-AIDS-clubs and peer educators. One hundred peer educators will be trained to provide ABC prevention messages that address the links between HIV, alcohol and gender-based-violence and will stress AB or C depending on the different sub-groups. Peer educators will encourage married members of the RDF to practice abstinence while on duty and stay faithful to their spouses.

These activities addresses the key legislative issues of gender, especially on male norms and reducing violence. The activity also reflects the Rwanda National Plan for HIV infection prevention and the Rwanda EP five-year strategy for averting 157,000 new infections by 2010.

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 (a subset of total reached with AB)	2,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	10,000	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	100	☐

Target Populations:

Community leaders
Community-based organizations
Doctors
Nurses
Pharmacists
Discordant couples
HIV/AIDS-affected families
Military personnel
People living with HIV/AIDS
Volunteers
Men (including men of reproductive age)
Women (including women of reproductive age)
Caregivers (of OVC and PLWHAs)
Other Health Care Worker

Key Legislative Issues

Addressing male norms and behaviors

Reducing violence and coercion

Coverage Areas

Gicumbi

Nyamagabe

Kicukiro

Table 3.3.02: 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: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 8186
Planned Funds: $ 113,422.00
Activity Narrative: This activity relates to HVAB (7157), HVOP (8133) and HBHC (7177, 7187).

In FY 2006, Columbia University began providing prevention for positives services as part of the clinical care package to 22,000 PLWHA enrolled at 35 clinical sites. Social workers and nurses conducted prevention education on a regular basis at those sites. In addition, they also trained peer educators, PLWHA and community volunteers to conduct extensive prevention outreach in the community and at PLWHA associations.

Since this inception of the EP, all USG clinical partners were expected to provide an integrated health message to all clients. In an effort to both harmonize and improve the quality of clinical services across USG partners, the EP will initiate a standard prevention for positive package for beneficiaries starting in FY 2007.

In FY 2007, Columbia University will provide prevention messages, focusing on abstinence and reduction of sexual partners to 51,000 beneficiaries at 35 existing sites and seven new sites as well as their surrounding communities. During each clinical exam, consultation, and pharmacy visit, doctors, nurses and social workers who will function as case managers will provide prevention education to patients using the nationally approved curriculum and IEC materials for youth and pre-marital couples. Different messages will be used to match patients' profiles, circumstances and prevention needs.

Using CRS's "Avoiding Risk, Affirming Life" curriculum and materials, Columbia will train 268 nurses social workers, community volunteers, youth and PLWHA to conduct AB education in the community and with members of nearby PLWHA associations and their families.

As many risky behaviors can often be linked to other contextual factors such as unemployment, poverty, trauma, and psychosocial needs, Columbia will work with CHF/CHAMP and other USG partners to strengthen referrals for patients to access IGA, vocational training, trauma counseling, legal support, mental health care and support for at-risk clients, particularly HIV-positive ones.

The integrated AB messages within the clinical package aims to provide a complete package of services to every client and is part of the USG's strategy to strengthen prevention for positives and to reduce transmission of HIV.

This activity addresses the key legislative issues of gender and stigma and discrimination. This activity reflects the Rwandan national plan for HIV infection prevention and EP goal of averting 157,000 new infections by 2010.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
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 (a subset of total reached with AB)	10,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	51,000	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	268	☐

Target Populations:

Commercial sex workers
Community leaders
Faith-based organizations
Doctors
Nurses
Discordant couples
Street youth
People living with HIV/AIDS
Pregnant women
Prisoners
Volunteers
Girls
Boys
Primary school students
Secondary school students
University students
Men (including men of reproductive age)
Women (including women of reproductive age)
HIV positive pregnant women
Religious leaders
Other Health Care Worker

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

Table 3.3.02: Activities by Funding Mechanism

Mechanism: Catholic Relief Services Supplemental
Prime Partner: Catholic Relief Services
USG Agency: HHS/Health Resources Services Administration
Funding Source: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 8187
Planned Funds: $ 55,335.00
Activity Narrative: This activity relates to HBHC (7163) and HVAB (7157).

In FY 2006, CRS, in collaboration with Caritas-Rwanda, implemented the "Avoiding Risk, Affirming Life" project which focused on HIV prevention through abstinence, secondary abstinence and fidelity in marriage. CRS developed and distributed peer education and premarital counseling materials in all 22 participating parishes. Since the project began, 230 trained peer educators, teachers and priests have reached more than 32,000 youth and young adults with messages promoting abstinence and faithfulness in marriage. Other FY 2006 activities included a two-day workshop with 90 OVC participating in HIV prevention sessions and a one-day training on child rights and sexual exploitation for 19 church leaders. In June 2006, CRS and Caritas-Rwanda conducted a workshop for 15 newspaper and radio journalists and organized song competitions in the 22 parishes to raise awareness about HIV/AIDS, VCT and the fight against stigma and discrimination.

Since this inception of the EP, all USG clinical partners were expected to provide an integrated health message to all clients. In an effort to both harmonize and improve the quality of clinical services across USG partners, the EP will initiate standard AB prevention for positive interventions for beneficiaries starting in FY 2007.

In FY 2007 through these supplemental funds, CRS will provide prevention messages, focusing on abstinence and reduction of sexual partners to 16,535 beneficiaries in eight existing clinical sites, three additional sites, and their surrounding communities. During visits to clinics and pharmacies, the staff, including nurses and social workers who are hired as HIV case managers, will provide prevention education to patients using the curriculum and IEC materials for youth and pre-marital couples. The AB messages will be tailored to patients based on their age, marital status, HIV status, and identified risk behaviors. Using the "Avoiding Risk, Affirming Life" curriculum and materials, CRS will train 104 nurses, social workers ,community volunteers, youth and PLWHA peer educators to conduct health education for members of nearby associations of PLWHA, their families and communities.

As many risky behaviors can often be linked to other contextual factors such as unemployment, poverty, trauma, and psychosocial needs, CRS will work with CHAMP and other partners to strengthen referrals and mechanisms for patients to access IGA, vocational training, trauma counseling, legal support, mental health care and support for HIV-positive clients.

The integration of AB messages within the clinical package aims to provide a comprehensive services to every client and is part of the USG's strategy to strengthen prevention for positives and continue to reduce transmission of HIV.

This activity addresses the key legislative issue of gender and stigma and discrimination. This activity reflects the Rwandan national plan for HIV infection prevention and EP goal of averting 157,000 new infections by 2010.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
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 (a subset of total reached with AB)	2,000	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	16,535	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	104	☐

Target Populations:

Commercial sex workers
Community leaders
Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
Traditional birth attendants
Discordant couples
Street youth
HIV/AIDS-affected families
People living with HIV/AIDS
Pregnant women
Volunteers
Girls
Boys
Primary school students
Secondary school students
University students
Men (including men of reproductive age)
Women (including women of reproductive age)
HIV positive pregnant women
Caregivers (of OVC and PLWHAs)
Religious leaders
Public health care workers
Other Health Care Worker

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Burera

Gicumbi

Gatsibo

Nyamasheke

Table 3.3.02: Activities by Funding Mechanism

Mechanism:	Refugees UNHCR
Prime Partner:	United Nations High Commissioner for Refugees
USG Agency:	Department of State / Population, Refugees, and Migration
Funding Source:	GHAI
Program Area:	Abstinence and Be Faithful Programs
Budget Code:	HVAB
Program Area Code:	02
Activity ID:	8700
Planned Funds:	$ 52,000.00

Activity Narrative: This activity relates to MTCT (8696), HVOP (8711), HBHC (8718), HVTB (8670), HKID (8148, 8150, 8152), HVCT (8732), and HTXS (8737).

Rwanda is host to nearly 50,000 refugees in four camps around the country. Refugee populations are considered at higher risk for diseases, particularly HIV, as well as other forms of violence, economic and psychological distress. While much is currently unknown about prevalence rates in the camp populations in Rwanda, recent service statistics of newly implemented VCT and PMTCT programs in two camps show a prevalence of 5% among CT clients. Since 2005, the EP has provided refugees with HIV/AIDS prevention and care services with linkages and referrals to local health facilities for treatment.

Because the EP will initiate a standard prevention for positive package for beneficiaries starting in FY 2007, UNHCR as a new clinical partner will include these interventions from the beginning of its implementation.

In FY 2007, UNHCR will expand AB activities to three camps, and initiate community-based AB activities in a fourth camp. At the clinic level, UNHCR will expand their services to include AB messages during post-test counseling of all clients and follow-up with HIV-positive patients and their family members. Different messages will be used to match patients' profiles, circumstances and prevention needs. The providers will adapt and integrate a screening tool to be used during initial and follow-up CT sessions. This tool will be used by providers to monitor HIV-positive patients, particularly for asymptomatic HIV-positive and patients on ART. Checklists and job aids will be used to facilitate the counseling messages. Partners will adapt program-level indicators into existing forms and tools for each of their sites.

UNHCR will also promote AB messages at the community level to in- and out-of-school refugee youth, men, and vulnerable women of reproductive age. UNHCR will train or, as necessary, provide refresher training to peer educators using AB materials adapted for the refugee context. UNHCR will support interpersonal prevention activities that aim to increase youth access to prevention services, such as anti-AIDS clubs, life-skills training, school-based HIV prevention education, and community discussions. Messages delivered will not only focus on abstinence and fidelity, but will also include topics on the relationship between alcohol use, violence, HIV, and stigma reduction. Young girls in the refugee community, particularly female OVC, are vulnerable to predatory sexual behaviors of older men, as well as child sexual abuse, domestic violence, and sexual harassment at school. Prevention efforts under this activity will focus on changing social acceptance of cross-generational and transactional sex. UNHCR will strengthen the GBV strategies and role-plays developed by FHI/REDSO. Key influential community members such as traditional and religious leaders and refugee camp leaders will also reinforce the messages of abstinence, delayed sexual debut, being faithful, reduction of GBV and responsible consumption of alcohol.

As many risky behaviors can often be linked to other contextual factors such as unemployment, poverty, trauma, and psychosocial needs, UNHCR will strengthen referrals and mechanisms in coordination with GLIA and other partners to provide refugee clients and their family members access to IGA, OVC programs, food support through wrap around Title II and WFP, vocational training, trauma counseling, legal support, and mental health care and support for at-risk clients.

CSWs are an important target group due to their risk exposure, difficulties to negotiate condom use, psychosocial needs, and the lack of alternative means for generating income. Cost-shared with C/OP funds, UNHCR will help establish support groups for CSWs to create opportunities for exchange and peer support, linkages to IGA and microfinance activities, vocational training, promotion of healthy RH behaviors, and psychosocial support and counseling.

This activity addresses the key legislative issues of gender, stigma and discrimination, and food and microfinance wrap around through HIV/AIDS BCC messages, and linking to other sectors for strengthening income-generation opportunities and access to food support for vulnerable refugee women, girls and their families. This activity reflects the priorities of the five year EP strategy and the GOR national prevention plan.

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
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (a subset of total reached with AB)	2,500	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	9,800	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	120	☐

Target Populations:

Commercial sex workers
Community leaders
Community-based organizations
Family planning clients
Refugees/internally displaced persons
Orphans and vulnerable children
People living with HIV/AIDS
Secondary school students
Men (including men of reproductive age)
Women (including women of reproductive age)
HIV positive pregnant women
Widows/widowers
Out-of-school youth
Religious leaders
Nurses

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Reducing violence and coercion

Increasing women's access to income and productive resources

Stigma and discrimination

Food

Microfinance/Microcredit

Coverage Areas

Byumba (prior to 2007)

Kibuye (prior to 2007)

Umutara (Mutara) (prior to 2007)

Gicumbi

Gatsibo

Karongi

Table 3.3.02: Activities by Funding Mechanism

Mechanism: DOD Rwanda Office
Prime Partner: US Department of Defense
USG Agency: Department of Defense
Funding Source: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 9098
Planned Funds: $ 55,000.00
Activity Narrative: This activity relates to HVAB (7230), HVOP (7229), and HVCT (7231).

The EP has supported the RDF since FY 2005 with activities aimed at promoting abstinence and fidelity among soldiers and their partners; increasing access and use of VCT services by providing mobile VCT services in battalions; addressing stigma associated with condom use; and promoting correct and consistent condom use among soldiers. To improve the quality of these services and assess their impact, more information is needed on the soldiers' behavior and their HIV knowledge.

To provide this support, the Director of the DOD HIV/AIDS Prevention Program will conduct an assessment by making multiple visits to Rwanda to meet with program staff, GOR officials, and beneficiaries.

The objective of this support is to assess the military population and the relationship between their sexual behavior, gender norms, and HIV knowledge and practice. The activity will focus on the level of alcohol consumption, condom use and gender based behaviors in the military. Primary data show that excessive alcohol consumption by a husband/partner appears to be a determining factor in the frequency of GBV within military families. Research has also shown that alcohol abuse not only increases the risk of violence, but also often results in sexual abuse and unprotected sex.

This activity addresses the key legislative issues of gender, particularly male norms and reducing violence. This activity supports the Rwanda EP five-year strategy by preventing transmission of HIV to high-risk groups and addressing gender relations in the context of HIV/AIDS.

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

Targets

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

Target Populations:

Military personnel

Key Legislative Issues

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Coverage Areas:

National

Table 3.3.02: Activities by Funding Mechanism

Mechanism: FHI New Bilateral
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 15212
Planned Funds: $ 645,335.00
Activity Narrative: This activity relates to MTCT (8698), HVAB (8130), HVOP (8138, 8137), HBHC (8144), HVTB (8147), HVCT (8168), and HTXS (8172). In FY 2006, all USAID clinical partners are providing a standard package of services including PMTCT, CT, OI, other palliative care, and ART. In order to improve prevention for positives programming, FHI is providing TA to TRAC to assess sexual and risk behaviors among PLWHA and their networks. FHI will use this information to revise clinical and community IEC materials to fill gaps in existing prevention for positives and adapt a training module for prevention messaging in clinical settings.

The revised curriculum will be integrated into the national care and treatment training to be used by all clinical partners in FY 2007. Since this inception of the EP, all USG clinical partners were expected to provide an integrated health message to all clients. In an effort to both harmonize and improve the quality of clinical services across USG partners, the EP will initiate a standard prevention for positive package for beneficiaries starting in FY 2007. In FY 2007, USAID awarded three cooperative agreements - one of the three to FHI - that will expand quality clinical services, including prevention messages. FHI will expand its clinical services to include AB messages during post-test counseling and follow-up sessions with HIV-positive patients and their family members. Appropriate AB messages will be integrated into the clinical services and home based care. Health care providers, case managers and community volunteers will use client contacts to deliver key AB messages tailored to individual groups.

Different messages will be used to match patients' profiles and circumstances and prevention needs. As many high-risk behaviors can often be linked to other contextual factors such as unemployment, poverty, trauma, and psychosocial needs, clinical partners will work with CHAMP and other partners to strengthen referrals and mechanisms for patients to access IGA, vocational training, trauma counseling, legal support, and psychological and mental health care and support for at-risk clients, particularly HIV-positive patients. FHI will adapt and integrate a screening tool for clients to be used during CT sessions, follow-up counseling, and patient monitoring, particularly of asymptomatic patients and patients on ART. Checklists and job aids will be used to facilitate and standardize the counseling messages providers deliver to patients. FHI will also adapt program-level indicators into existing reporting forms and tools for monitoring. The clinical package aims to provide integrated services, including AB messaging, to every client and is part of the EP strategy to strengthen prevention for positives and continue to reduce transmission of HIV. This activity addresses the key legislative issue of stigma reduction. This activity reflects the Rwandan national plan for HIV infection prevention and EP goal of averting 157,000 new infections by 2008.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
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 (a subset of total reached with AB)	5,400	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	18,600	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	110	☐

Target Populations:

Commercial sex workers
Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
Traditional birth attendants
Most at risk populations
Discordant couples
HIV/AIDS-affected families
People living with HIV/AIDS
Prisoners
Volunteers
Men (including men of reproductive age)
Women (including women of reproductive age)
HIV positive pregnant women
Caregivers (of OVC and PLWHAs)
Out-of-school youth
Public health care workers
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Table 3.3.02: Activities by Funding Mechanism

Mechanism: EGPAF New Bilateral
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 15220
Planned Funds: $ 289,742.00
Activity Narrative: This activity relates to MTCT (8698), HVAB (8130), HVOP (8138, 8137), HBHC (8144), HVTB (8147), HVCT (8168), and HTXS (8172). In FY 2006, all USAID clinical partners are providing a standard package of services including PMTCT, CT, OI, other palliative care, and ART. In order to improve prevention for positives programming, FHI is providing TA to TRAC to assess sexual and risk behaviors among PLWHA and their networks. FHI will use this information to revise clinical and community IEC materials to fill gaps in existing prevention for positives and adapt a training module for prevention messaging in clinical settings. The revised curriculum will be integrated into the national care and treatment training to be used by all clinical partners, including EGPAF, in FY 2007. Since this inception of the EP, all USG clinical partners were expected to provide an integrated health message to all clients. In an effort to both harmonize and improve the quality of clinical services across USG partners, the EP will initiate a standard prevention for positive package for beneficiaries starting in FY 2007.

In FY 2007, USAID awarded three cooperative agreements - one of the three to EGPAF - that will expand quality clinical services, including prevention messages. EGPAF will expand its clinical services to include AB messages during post-test counseling and follow-up sessions with HIV-positive patients and their family members. Appropriate AB messages will be integrated into the clinical services and home based care. Health care providers, case managers and community volunteers will use client contacts to deliver key AB messages tailored to individual groups. Different messages will be used to match patients' profiles and circumstances and prevention needs. As many high-risk behaviors can often be linked to other contextual factors such as unemployment, poverty, trauma, and psychosocial needs, clinical partners will work with CHAMP and other partners to strengthen referrals and mechanisms for patients to access IGA, vocational training, trauma counseling, legal support, and psychological and mental health care and support for at-risk clients, particularly HIV-positive patients.

EGPAF will adapt and integrate a screening tool for clients to be used during CT sessions, follow-up counseling, and patient monitoring, particularly of asymptomatic patients and patients on ART. Checklists and job aids will be used to facilitate and standardize the counseling messages providers deliver to patients. EGPAF will also adapt program-level indicators into existing reporting forms and tools for monitoring. The clinical package aims to provide integrated services, including AB messaging, to every client and is part of the EP strategy to strengthen prevention for positives and continue to reduce transmission of HIV. This activity addresses the key legislative issue of stigma reduction. This activity reflects the Rwandan national plan for HIV infection prevention and EP goal of averting 157,000 new infections by 2008.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
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 (a subset of total reached with AB)	5,760	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	18,000	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	120	☐

Target Populations:

Commercial sex workers
Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
Traditional birth attendants
Most at risk populations
Discordant couples
HIV/AIDS-affected families
People living with HIV/AIDS
Prisoners
Volunteers
Men (including men of reproductive age)
Women (including women of reproductive age)
HIV positive pregnant women
Caregivers (of OVC and PLWHAs)
Out-of-school youth
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Table 3.3.02: Activities by Funding Mechanism

Mechanism: IntraHealth New Bilateral
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Abstinence and Be Faithful Programs
Budget Code: HVAB
Program Area Code: 02
Activity ID: 15221
Planned Funds: $ 381,933.00
Activity Narrative: This activity relates to MTCT (8698), HVAB (8130), HVOP (8138, 8137), HBHC (8144), HVTB (8147), HVCT (8168), and HTXS (8172). In FY 2006, all USAID clinical partners are providing a standard package of services including PMTCT, CT, OI, other palliative care, and ART. In order to improve prevention for positives programming, FHI is providing TA to TRAC to assess sexual and risk behaviors among PLWHA and their networks. FHI will use this information to revise clinical and community IEC materials to fill gaps in existing prevention for positives and adapt a training module for prevention messaging in clinical settings. The revised curriculum will be integrated into the national care and treatment training to be used by all clinical partners, including IntraHealth, in FY 2007. Since this inception of the EP, all USG clinical partners were expected to provide an integrated health message to all clients. In an effort to both harmonize and improve the quality of clinical services across USG partners, the EP will initiate a standard prevention for positive package for beneficiaries starting in FY 2007.

In FY 2007, USAID awarded three cooperative agreements - one of the three to IntraHealth - that will expand quality clinical services, including prevention messages. IntraHealth will expand its clinical services to include AB messages during post-test counseling and follow-up sessions with HIV-positive patients and their family members. Appropriate AB messages will be integrated into the clinical services and home based care. Health care providers, case managers and community volunteers will use client contacts to deliver key AB messages tailored to individual groups. Different messages will be used to match patients' profiles and circumstances and prevention needs. As many high-risk behaviors can often be linked to other contextual factors such as unemployment, poverty, trauma, and psychosocial needs, clinical partners will work with CHAMP and other partners to strengthen referrals and mechanisms for patients to access IGA, vocational training, trauma counseling, legal support, and psychological and mental health care and support for at-risk clients, particularly HIV-positive patients.

IntraHealth will adapt and integrate a screening tool for clients to be used during CT sessions, follow-up counseling, and patient monitoring, particularly of asymptomatic patients and patients on ART. Checklists and job aids will be used to facilitate and standardize the counseling messages providers deliver to patients. IntraHealth will also adapt program-level indicators into existing reporting forms and tools for monitoring. The clinical package aims to provide integrated services, including AB messaging, to every client and is part of the EP strategy to strengthen prevention for positives and continue to reduce transmission of HIV. This activity addresses the key legislative issue of stigma reduction. This activity reflects the Rwandan national plan for HIV infection prevention and EP goal of averting 157,000 new infections by 2008.

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
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 (a subset of total reached with AB)	3,840	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	38,400	☐
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	130	☐

Target Populations:

Commercial sex workers
Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
Traditional birth attendants
Most at risk populations
Discordant couples
HIV/AIDS-affected families
People living with HIV/AIDS
Prisoners
Volunteers
Men (including men of reproductive age)
Women (including women of reproductive age)
HIV positive pregnant women
Caregivers (of OVC and PLWHAs)
Out-of-school youth
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

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: $ 3,100,000.00

Program Area Context:

The EP supports the CNTS through direct funding and through TA provided by the AABB. The EP strategy 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.

The EP activities in FY 2005 and FY 2006 have 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 are expected to be completed in FY 2006. 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 annually in Rwanda has increased from roughly 29,000 in 2004 to a projected 38,000 units for the end of calendar year 2006. Blood donations to CNTS remain 100% voluntary and non-remunerated and all blood units are screened for HIV. In FY 2006, 1.17% of bloods units donated were HIV-positive.

While the program has made excellent progress with EP support, the CNTS has also faced substantial challenges in its implementation of activities. GOR vehicle procurement policies delayed much-needed purchases in FY 2005 and FY 2006, slowing donor recruitment activities and provider training at district hospitals. In FY 2006, GOR procurement processes for equipment and supplies have also proven to be very complex and have delayed finalization of planned infrastructure improvements. In early FY 2007, CNTS expects to become an autonomous institution and anticipates that this change of institutional status will result in more efficient procurement.

Historically, the CNTS has relied heavily on rural blood donors to provide for most of the country's needs. In FY 2006, worsening food insecurity in many parts of the country has limited expected growth in blood donation, especially in the south and the east. The CNTS recruits donors at secondary schools to offset seasonal variation in blood donation due to the agricultural calendar (fewer donations during the growing season). Recent changes in the school year calendar have the potential to disrupt blood supplies as the growing season now coincides with school vacations. Efforts to increase urban blood donation rates in FY 2007 will be critical address to address this situation effectively.

Lastly, poor performance of the original EP TA provider to Rwanda led to a change in TA service provider in FY 2006. After two initial visits in July and August 2006, USG and GOR stakeholders fully expect AABB to be more responsive to Rwanda's identified needs.

Program Area Target:

Number of service outlets carrying out blood safety activities	40
Number of individuals trained in blood safety	213

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: Central (GHAI)
Program Area: Medical Transmission/Blood Safety
Budget Code: HMBL
Program Area Code: 03
Activity ID: 7223
Planned Funds: $ 2,700,000.00
Activity Narrative: This activity relates to HMBL (8860).

In FY 2007, the CNTS will continue activities to strengthen the national blood transfusion network. The CNTS will engage in ongoing procurement of needed supplies, continued monitoring, supervision and training activities, and focused efforts on assuring the quality of all aspects of transfusion-related services. The procurement of consumable supplies will remain a major emphasis area with materials purchased to support blood collection, transport, screening, processing and storage in 40 service outlets carrying out blood safety activities. Most procurement of equipment for infrastructure improvement will be completed in FY 2006. In order to increase the overall blood supply in FY 2007, CNTS will establish 30 new blood collection sites, and will recruit and train 50 new volunteers to conduct community mobilization and to organize blood collection drives in both new and existing collection sites.

In FY 2007, blood donor recruitment and organization will also be a major focus. In collaboration with the MINALOC, CNTS will foster the creation of 30 new local blood donor committees independent of the existing Red Cross structure. This is the first step in a long term process of creating a national network of local organizations of blood donors. CNTS will promote initial meetings of these groups as well as develop blood donor mobilization tools for their use. CNTS will also introduce a system for donor notification of positive screening test results, and will develop referral mechanisms to GFATM- and EP-supported clinical sites for initiating HIV care for those individuals notified of HIV-positive status. CNTS will launch new, innovative approaches to promote blood donation in urban areas, particularly Kigali, using television, radio and print media, as well as SMS text messaging.

In FY 2007, the data management system established in Kigali and Ruhengeri in FY 2006 will be expanded to Butare and will improve data collection for reporting and managing supplies and blood donor information. The 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 33 CNTS staff trained (AABB target) and 180 district and referral hospital staff trained in three training zones - Kigali, Butare, and Ruhengeri. AABB will provide the TA for these quality-related activities.

Continued Associated Activity Information

Activity ID: 2786
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: National Program for Blood Transfusion, Rwanda
Mechanism: Strengthening Blood Transfusion Services
Funding Source: N/A
Planned Funds: $ 0.00

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Community Mobilization/Participation	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets carrying out blood safety activities	40	☐
Number of individuals trained in blood safety	180	☐

Target Populations:

Doctors
Nurses
Other MOH staff (excluding NACP staff and health care workers described below)
Laboratory workers

Coverage Areas:

National

Table 3.3.03: Activities by Funding Mechanism

Mechanism: AABB
Prime Partner: American Association of Blood Banks
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: Central (GHAI)
Program Area: Medical Transmission/Blood Safety
Budget Code: HMBL
Program Area Code: 03
Activity ID: 8860
Planned Funds: $ 400,000.00
Activity Narrative: This activity relates to HMBL (7223).

During FY 2006, the USG team and its GOR counterparts agreed to drop Sanquin Consulting Services as the blood safety TA provider and replaced them with the AABB. The AABB's FY 2006 activities are focused on developing a joint work plan with CNTS to advance national strategic goals of the national blood transfusion program.

The AABB will provide TA to support the rapid strengthening of blood transfusion services in Rwanda. In FY 2007, the AABB will collaborate with the CNTS to develop and implement Rwanda-specific national standards on blood banking and transfusion medicine through a participatory process involving all key stakeholders. By the end of FY 2007, technical training sessions will be conducted to put the newly-developed standards into practice, improving the overall quality and consistency of the operational processes within the CNTS and ultimately improving the safety of the blood supply.

In FY 2007, technical trainings will focus on several critical areas to strengthen the CNTS, including donor screening and the related evaluation process, equipment operation and maintenance, infectious disease testing, blood donor recruitment, blood and blood component preparation, cold chain management, immunohematology, inventory management, labeling and quarantine management, data management, and documentation. The AABB and CNTS will conduct TOT for 33 training staff who will in turn train 180 district and reference hospital staff. Initial training sessions will be conducted by AABB staff or consultants, as appropriate, based on specific expertise required. By building this cadre of local trainers, CNTS will help ensure that technical capacity remains after the period of this project. The AABB will assist the CNTS in coordinating individualized trainings in management, supervision, quality management, and other specialized areas as needed. In addition, AABB will establish a resource center of reference materials for blood bank and transfusion medicine in Rwanda.

Emphasis Areas	% Of Effort
Policy and Guidelines	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets carrying out blood safety activities		☑
Number of individuals trained in blood safety	33	☐

Target Populations:

Doctors
Nurses
Other MOH staff (excluding NACP staff and health care workers described below)
Laboratory 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: **$ 0.00**

Program Area Context:

The 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 the 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.

Since beginning implementation in FY 2004, JSI has provided a comprehensive assistance package for improving medical injection safety and medical waste management in two health districts during a pilot phase and subsequently in18 additional districts when they scaled up their activities. The package of interventions includes procurement of safe injection equipment such as auto-disable syringes, safety boxes, needle cutters, and comprehensive training for all levels of medical providers. The EP injection safety activities for waste management have been closely coordinated in select districts with the waste management and infection control components of the WB MAP program to ensure an efficient use of resources available for injection safety. In FY 2006, injection safety and waste management activities were more closely coordinated among USG clinical partners through distribution of project-supported IEC materials, recommended procurement lists and guidance on best practices for injection safety and waste management. In FY 2007, the USG clinical partners will participate with the MMIS project in conducting joint supervisions and implementing joint trainings.

FY2007 activities will begin to address challenges related to sustaining the procurement process necessary to ensure safe injections and sound medical waste management. Activities will include increased collaboration with BUFMAR and CAMERWA, which are the two institutions responsible for medical supply procurement, to revise national essential drugs and commodities lists to include appropriate drug formulations and safe injection supplies.

Program Area Target:

Number of individuals trained in medical injection safety	4,902

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: Central (GHAI)
Program Area: Medical Transmission/Injection Safety
Budget Code: HMIN
Program Area Code: 04
Activity ID: 7209
Planned Funds: $ 0.00
Activity Narrative: In the first two years of this activity, a comprehensive assistance package for improving medical injection safety and medical waste management was piloted in two health districts and subsequently expanded to 18 additional districts.

The FY 2006 plan to expand activities to 23 districts was adjusted to 20 districts to reflect the national redistricting exercise which has resulted in a reduction in the number of districts from 40 to 30. Among JSI's key accomplishments in FY 2006 were the construction of 48 needle pits in targeted district health facilities, finalization of National Injection Safety Communication Strategic Plan, finalization, reproduction and distribution of IEC materials for providers and medical waste handlers, and TA to the WB MAP program for the construction of 8 improved DeMontfort Plus incinerators for medical waste management at district hospitals.

In FY 2007, JSI will continue scale-up the injection safety and medical waste management activities described above, including support for training, commodity procurement and BCC activities. JSI will conduct training in safe medical practices, including universal precautions, safe injection, and medical waste management, for 74 regional level trainers, who in turn will train 3,955 health workers and 345 medical waste handlers in 10 new districts. To facilitate safe disposal of needles in these same districts, 127 needle pits will be constructed at health facilities. Commodity procurement and management activities will continue in FY 2007. Twenty-eight supply managers at pharmacies and district hospitals will be trained in supply management of safe injection materials, including the use of newly developed logistics management tools. JSI will procure injection commodities for 10 districts in FY 2007. JSI will assist the GOR in implementing the national behavior change strategy to reduce unnecessary injections. Through a series of one-day sessions, 500 community 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.

JSI will help assure sustainability of commodity procurement mechanisms through continued TA to BUFMAR and CAMERWA and through assistance in revising the national essential drugs and commodities lists to include appropriate drug formulations and safe injection supplies.

Continued Associated Activity Information

Activity ID: 2804
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: John Snow, Inc.
Mechanism: Safe Injection
Funding Source: N/A
Planned Funds: $ 0.00

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 medical injection safety	4,902	☐

Target Populations:

Doctors
Nurses
Pharmacists
Laboratory workers
Other Health Care Worker

Coverage Areas:

National

Table 3.3.05: Program Planning Overview

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

Total Planned Funding for Program Area: $ 2,936,323.00

Program Area Context:

The EP supported three studies – the 2005 RDHS-III, PLACE and NCAS – in FY 2006 and the data from these studies are critical to improving the prevention program in Rwanda. The latest data shows a generalized epidemic of 3.1% nationwide with significant variations by geography, gender, and age groups. The 2005 RDHS-III indicates that 2.5% of young girls 20-24 are HIV positive, whereas only 0.5% of boys in the same age bracket are HIV positive; the highest prevalence rate among males at 7.1% is found among men age 40-44. Together, this data suggests that older men and younger women engage in trans-generational sex. This is supported by other assessments revealing that young, rural girls and OVC are at higher risk for HIV.

The new research also indicates that young men and women have few effective means of communicating with each other or with their parents over issues related to sexuality and reproductive health. Communication with trusted family and friends is important because it is one key component for sustained behavioral change. Effective prevention programs must focus on removing these communication barriers, educating young people on appropriate sexual health, and empowering them to negotiate safer sex or to delay sexual debut.

Discussing condom use is difficult given the conservative and religious social norms in Rwanda. Twelve years after the genocide, there is limited discussion about family planning and condoms are heavily stigmatized. As a result, condom use remains low, especially among women, who lack the ability to buy or negotiate condoms for fear of being labeled promiscuous. According to 2005 RDHS-III respondents, only 26% and 39.5% of sexually active females and males aged 15-24 used condoms at last high-risk sex with a non-cohabitating partner. According to the 2005 NCAS, the top four reasons for condom non-use among age 15-49 are trust in partner, stigma, insufficient social support, and low self-esteem. On the issue of access, the 2005 PLACE Study indicates that up to 90% of urbanites and only 30% of their rural counterparts can find condoms within 10 minutes of popular spots frequented by young people. These figures demonstrate a wider and more complex strategy is needed to effectively prevent HIV transmission.

The EP five-year strategy focuses on primary prevention, especially among MARPs. The strategy includes promotion of CT services, prevention and treatment of STIs, and integration of the role of alcohol and GBV into HIV/AIDS messages. This strategy will continue in FY 2007 with an added emphasis to influence social norms and improve social support for condom use.

In FY 2006, the EP has focused on primary prevention in communities. Many interventions target the general population and MARPs, including CSWs, refugees, military, police, older youth, prisoners and mobile workers along the major transport corridors. Community groups mobilized through CHF/CHAMP, FHI/ROADS and the refugee partners disseminated ABC messages through community discussions, workplace interventions, youth centers, peer education and community volunteers. The presence of mobile CT links EP HIV prevention efforts to facilities for select MARPs. By March 2006, the number of individuals reached by face-to-face, non-AB prevention efforts was 36,639 - far exceeding the target of 20,000. In a strategic effort to build local capacity to carry on prevention activities in communities, the EP collaborates and provides TA support to Rwandan NGOs to implement programs.

In April 2006, the GOR adopted and approved the National Condom Policy. Starting in FY 2006, the USG begins a collaborative effort with DfID and KfW. The EP targets MARPs with the social marketing of private sector condoms while the European donors focus on the public sector. The EP also increased the target population's knowledge of and access to condoms through counseling, mobile video screenings and an increased number of condom outlets.

In FY 2007, most of the existing activities will continue, but the EP has developed a more strategic approach based on recent data from the three EP supported studies. Community prevention will work

closely with CT promotion and clinical services. Messages will be delivered during mobile CT pre- and post-test counseling sessions, which will link individuals testing positive to HIV treatment and community care. The new emphasis on family-centered VCT, PIT, and prevention for positive campaigns incorporates prevention for individuals as well as their families and peers to slowly shift social norms to increase social support for condom use.

The EP will engage in more intensive advocacy and communications to change the social norms and improve social support for condoms with the goal of increasing both the acceptance and the use of condoms in Rwanda. Social marketing of condoms will shift from only counting the number of condoms sold to monitoring the coverage and quality of outlets in high transmission areas, adding indicators such as appropriate pricing, consistency of stock, point-of-sale support, easy outlet identification by consumers, and retailer knowledge. The EP will continue to participate in the multi-donor initiative, which supports condom procurement and distribution. The EP BCC and community prevention efforts will be implemented through a new RFA focused on prevention and through existing USG partners.

In addition to providing a more integrated prevention strategy at the community level, implementing partners will work closely with CNLS to monitor non-clinical indicators at the national and district levels. National policies related to prevention activities are currently adequate but, in January 2006, the GOR initiated decentralization of the Rwandan health care system and this process presents new challenges to educate, advocate and collaborate with the newly established district health offices.

This targeted primary prevention approach for message delivery in an integrated clinical and community package supports the EP Five-Year HIV/AIDS Strategy in Rwanda and the GOR National Plan for HIV Prevention (2005-2009).

Program Area Target:

Number of targeted condom service outlets	709
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	334,780
Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	4,075

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: GHAI
Program Area: Condoms and Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 7184
Planned Funds: $ 350,000.00
Activity Narrative: This activity relates to MTCT (7181), HVAB (7183), HVCT (7182), HBHC (7187), HKID(7186), OHPS (7189), and HVOP (7200, 8138).

Through financial support and technical and institutional capacity building for Rwandan partner organizations, the CHF/CHAMP is working to ensure Rwandans have equitable access to high quality, sustainable continuum of HIV & AIDS care services. CHAMP supports the provision of community services in all EP-supported districts, especially around EP-supported health facilities.

CHAMP mobilizes and supports community-based HIV prevention efforts, including prevention for positives and discordant couples, by providing technical and financial assistance to Rwandan CBOs and FBOs who will incorporate these messages into their programs for community and religious leaders, youth, families affected by HIV/AIDS, and OVC including CHH.

To date, CHAMP-supported partners have reached more than 4,000 individuals with prevention messages that went beyond abstinence and being faithful. CHAMP also trained more than 100 community volunteers to provide these messages. During FY 2006, CHAMP trained Rwandan partners to incorporate prevention messages, especially for high risk populations, into their community–based activities. CHAMP is producing IEC materials with other prevention messages and is conducting IEC sessions in EP supported districts.

In FY 2007, many of the general prevention activities will be transferred to the new prevention RFA being issued by USAID. However, CHAMP will continue to provide technical and financial support to Rwandan partner organizations to include appropriate and targeted prevention messages in their programs for OVC and PLWHA. These messages will include the linkages between alcohol use, violence and HIV; stigma reduction; abstinence; fidelity; condom awareness and use; partner reduction; shifting social norms; and, the importance of CT for the entire family.

CHAMP will continue to use and distribute IEC materials developed in FY 2006. CHAMP will also collaborate with other EP partners to implement best practices. These C/OP messages and tools will increase the effectiveness of Rwandan partner organizations to educate communities about risky behaviors and the correct and consistent use of condoms among appropriate target groups.

These efforts address key legislative issues related to gender and stigma and discrimination. This activity also reflects the Rwanda EP five-year strategy to target high risk groups.

Continued Associated Activity Information

Activity ID: 2808
USG Agency: U.S. Agency for International Development
Prime Partner: Community Habitat Finance International
Mechanism: CHAMP
Funding Source: GHAI
Planned Funds: $ 446,000.00

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 targeted condom service outlets		☑
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	30,000	☐
Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	2,000	☐

Target Populations:

Community-based organizations
Faith-based organizations
HIV/AIDS-affected families
Orphans and vulnerable children
People living with HIV/AIDS
Caregivers (of OVC and PLWHAs)

Key Legislative Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS programs

Reducing violence and coercion

Stigma and discrimination

Coverage Areas

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Bugesera

Gatsibo

Nyagatare

Rwamagana

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: Condoms and Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 7200
Planned Funds: $ 150,000.00

Activity Narrative: This activity relates to HVAB (7199), HVCT (7201), HKID (8727), HBHC (8142) and OHPS (8744).

The overall goal of the ROADS Project is to stem HIV transmission and mitigate the consequences of HIV/AIDS on vulnerable populations along major East African transport corridors. This multi-sectoral project will target high-risk mobile populations--drivers and their assistants, CSWs, members of the uniformed services and stop-over site communities--with regionally coordinated SafeTStop messages. It will also link these target populations with new or improved HIV/AIDS services and care tailored to meet their needs. Innovative elements of the SafeTStop model include essential HIV-related programming on alcohol, gender-based violence, food security and economic empowerment. The ROADS Project works in Kenya, Uganda, Djibouti, Southern Sudan, Rwanda, Burundi and the DRC.

Over the last year, the ROADS Project focused on three sites in Rwanda: Kigali-ville, Gatuna on the Uganda border and Cyangugu on the DRC border. FHI launched the SafeTStop campaign in November 2005 with participation from the three major transport associations in Rwanda (Truck drivers, Mini-bus drivers and Motorcycle Taximen) as well as from the Association of Truckers' Wives, the CNLS and the Ministry of Labor. ROADS has trained 132 peer educators from the associations who in turn reached more than 3,400 individuals with ABC messages, information on STIs, and VCT referral. In FY 2006, ROADS completed an assessment on alcohol and HIV as part of a three-country study requested by the ECSA Ministers. ROADS will finalize rapid assessments in all three SafeTStop sites to identify programming needs. ROADS will continue to train peer educators to convey HIV prevention messages including the risks associated with cross-generational sex and prevention for positives. The peer educators will be out-of-school youth, truck drivers, commercial sex workers, and other community members. ROADS will work in partnership with PSI and health facilities to provide mobile VCT services.

In FY 2007, ROADS will continue the above HIV prevention activities, training an additional 400 peer educators and reaching an estimated 40,000 people with HIV/AIDS information and referral to services. This group will receive comprehensive HIV prevention messages encouraging them to protect their health by abstaining from sex outside of marriage; remaining faithful to one partner; and consistent and correct condom use. The ROADS project plans to stock an estimated 50 condom distribution outlets in the three communities. Of the 400 peer educators, 300 will focus on ABC prevention education while 100 will be trained in AB prevention for youth. ROADS will ensure that at least 50 of the peer educators are HIV+ individuals who will be trained to provide HBC support to other HIV+ individuals, including truck drivers. Approximately 1,500 PLWHA truck drivers and community members will be reached with counseling, referrals and information about positive living, prevention for positives, nutrition, and ARV adherence. These PLWHA and their family members will also be offered a comprehensive menu of services including direct food assistance, health mutuelle membership, psychosocial support and home-based care as needed.

As a follow-up to the Alcohol Assessment and to address gender-based violence, ROADS will initiate a focused campaign with bar/restaurant/lodging owners, and local leaders to reduce alcohol abuse and domestic violence among truck drivers and men in the three communities. ROADS will also explore different alcohol-treatment options for patients on or about to initiate ART. ROADS will also work with TRAC to integrate alcohol and gender-based violence programming into CT, care and treatment programs. ROADS addresses the key legislative issues of gender, violence, and stigma reduction.

This program addresses the key legislative issues of gender, particularly increasing gender equity in HIV/AIDS programs, addressing male norms and behaviors , and reducing violence and coercion, and the issue of Stigma and discrimination. The program reflects the Rwanda EP five-year strategy and the National Prevention Plan by focusing prevention, care and treatment efforts on high-risk, mobile populations.

Continued Associated Activity Information

Activity ID: 4777
USG Agency: U.S. Agency for International Development
Prime Partner: Family Health International
Mechanism: Transport Corridor Initiative
Funding Source: GHAI
Planned Funds: $ 100,800.00

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
Workplace Programs	10 - 50

Targets

Target	Target Value	Not Applicable
Number of targeted condom service outlets	50	☐
Number of individuals reached through 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 through other behavior change beyond abstinence and/or being faithful	300	☐

Target Populations:

Business community/private sector
Commercial sex workers
Community-based organizations
Faith-based organizations
Discordant couples
Street youth
Truck drivers
Non-governmental organizations/private voluntary organizations
Orphans and vulnerable children
Volunteers
Out-of-school youth
Partners/clients of CSW

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Coverage Areas

North

Gicumbi

West

Rusizi

Kigali

Gasabo

Kicukiro

Table 3.3.05: Activities by Funding Mechanism

Mechanism: PSI Healthy Schools
Prime Partner: Population Services International
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Program Area: Condoms and Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 7228
Planned Funds: $ 100,000.00
Activity Narrative: This activity relates to HVAB (7226, 7265).

The overall goal of PSI's Healthy Schools Initiative is to reduce HIV/AIDS incidence among youth aged 15-24 by promoting abstinence and safer sexual behaviors, changing social norms among men and women, as well as improving communication among secondary school youth. According to the 2005 RDHS-III, the median age for sexual debut among Rwandans is 20.3 years for women and 20.8 years for men. Given this relatively late age of sexual debut, both abstinence and be faithful messages are appropriate interventions for youth in secondary schools.

During FY 2006, PSI collaborated with the MINEDUC to strengthen the HIV/AIDS competencies of teachers and anti-AIDS clubs by identifying thirty target schools and assessing their needs for training and support materials. PSI also created a BCC peer education Life Skills module and trained members of anti-AIDS clubs as peer educators. One component of the Life Skills curriculum is a module on gender, which focuses on techniques to strengthen girls' empowerment. The Healthy Schools Initiative also included abstinence BCC campaigns targeting youth, which utilized interpersonal communication sessions and mobile video shows to promote abstinence messages. PSI also developed a parent-child curriculum aimed at improving communication about HIV/AIDS and sexuality which is being used to train community-based facilitators to work with parents and religious leaders.

In FY 2006, PSI's focused, high-intensity prevention interventions reached 12,000 students with AB messages. This accounts for approximately 4% of Rwandan secondary school youth. National scale-up of this program is not feasible due to a high program cost per student. This activity has thus been altered slightly for FY 2007 so that a greater percentage of Rwandan youth (30-50%) will be reached with prevention messages.

In FY 2007, PSI will target a larger portion of Rwandan school youth with prevention messages, using mid-level media in at least 200 secondary schools. Mobile video shows will be presented at schools in two parts. The first part of the presentation will target all the secondary school youth and will focus on abstinence and be faithful messages. The second part of the show will target the older students in the school and will incorporate messages about consistent and safe condom use to protect against HIV transmission. Additionally, the emphasis will be on improving communication between boys and girls to strengthen girls' negotiation skills, increase their ability to resist peer pressure, and emphasize the risks of cross-generational and transactional sex. Two teams will be deployed to present the mobile shows in all five provinces of the country. The program will maximize coverage of these prevention activities and reach at least 100,000 youth during FY 2007.

As a second component of this program, PSI will continue production of the ABAJENE! youth call-in radio shows to reinforce the prevention messages communicated during mobile presentations. The ABAJENE! youth magazine will also be produced quarterly and disseminated to 75,000 youth in secondary schools. Assuming that each magazine will be read by at least four youth, the program intends to reach at least 300,000 school students.

The Healthy Schools Initiative addresses the key legislative issues of gender, particularly male norms, and stigma reduction. This activity also reflects the ideas presented in the EP Five-Year HIV/AIDS Strategy in Rwanda, and the GOR National Prevention Plan by expanding abstinence programs at secondary schools

Continued Associated Activity Information

Activity ID: 4837
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Population Services International
Mechanism: HIV/AIDS School Based Program-Procurement
Funding Source: GHAI
Planned Funds: $ 200,000.00

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

Targets

Target	Target Value	Not Applicable
Number of targeted condom service outlets	0	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	48,000	☐
Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	45	☐

Target Populations:

Secondary school students

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Stigma and discrimination

Coverage Areas

North

South

East

West

Kigali

Table 3.3.05: Activities by Funding Mechanism

Mechanism: PSI-DOD
Prime Partner: Population Services International
USG Agency: Department of Defense
Funding Source: GHAI
Program Area: Condoms and Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 7229
Planned Funds: $ 60,000.00
Activity Narrative: This activity relates to HVAB (7230) and HVCT (7231).

PSI and the DMS work together to promote HIV prevention among members of the RDF. Soldiers' living situation, mobility and age make them vulnerable to HIV. While many soldiers practice sexual abstinence and fidelity, the distance from their families and spouses can make it difficult to maintain stable relationships. A KAP survey conducted by PSI in 2004 (in Gitarama, Butare and Kigali-rural brigades) indicated that out of 1,171 soldiers, 60% were single, and 90% were aged between 20 and 34. The DMS distributes about 1,000,000 condoms to soldiers annually.

In FY 2006, this program reached at least 15,000 members of the RDF with primary prevention messages, including condom use and prevention of alcohol abuse and GBV. The program selects lower-level military leaders as TOTs, starting with section commanders and leaders of anti-AIDS-clubs, with the aim of promoting "condom preparedness" during parades and briefing moments. However, there is still a need to address the stigma associated with condom use. PSI and the DMS will promote correct and consistent condom use among the military.

In FY 2007, these activities will continue and PSI will provide TA to the DMS and the brigades to establish and build capacity of local anti-AIDS-clubs to promote safer sexual behaviors, including balanced prevention messages. PSI will train 100 anti-AIDS-club members as peer educators to promote correct and consistent condom use and to address the link between alcohol, sexual risky behaviors and GBV. By transferring skills and competencies in ABC messaging to anti-AIDS-clubs at brigade level, PSI will strengthen local capacity and decentralization of HIV service delivery and prevention (via BCC) within the military system. This program will reach at least 20,000 members of the RDF with prevention messages.

PSI will provide technical assistance to the DMS, the medical brigade doctors and representatives of the anti-AIDS-clubs to develop a series of short movies to demonstrate correct condom use, discuss the stigma of acquiring condoms (in military and non-military settings), promote condom negotiation skills with partners, and demonstrate how alcohol use can lead to negative consequences. This program will also use IEC materials that promote condom use by demonstrating and outlining all of the reasons for using condoms with regular and non-regular partners. During military mobile CT events (both inside and around military camps), the implementer will present educational films and then lead open discussions with the anti-AIDS-clubs on the barriers and solutions to condom use, using a Q&A approach, condom demonstrations, competitions, role-plays and sketches specific to the military. By FY 2008, the EP aims to reach all military personnel with prevention messages.

These activities address the key legislative issues of gender, especially male norms, and stigma reduction. The activity supports the Rwanda EP five-year strategy by collaborating with the GOR to implement prevention activities for the military.

Continued Associated Activity Information

Activity ID: 2803
USG Agency: Department of Defense
Prime Partner: Population Services International
Mechanism: PSI-DOD

Funding Source: GHAI
Planned Funds: $ 35,000.00

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

Targets

Target	Target Value	Not Applicable
Number of targeted condom service outlets	0	☐
Number of individuals reached through 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 through other behavior change beyond abstinence and/or being faithful	100	☐

Key Legislative Issues

Reducing violence and coercion

Addressing male norms and behaviors

Stigma and discrimination

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: GHAI
Program Area: Condoms and Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 7232
Planned Funds: $ 0.00

Activity Narrative: [CONTINUING ACTIVITY FROM FY 2006 -- NO NEW FUNDING IN FY 2007] 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 $200,000 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.

Continued Associated Activity Information

Activity ID: 4877
USG Agency: U.S. Agency for International Development
Prime Partner: Population Services International
Mechanism: PSI Bilateral

Funding Source: GHAI
Planned Funds: $ 233,600.00

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 targeted condom service outlets	250	☐
Number of individuals reached through 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 through other behavior change beyond abstinence and/or being faithful	10	☐

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: Central Contraceptive Procurement
Prime Partner: US Agency for International Development
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Condoms and Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 7251
Planned Funds: $ 450,000.00
Activity Narrative: This activity relates to HVOP (7200, 7229, 8134, 8135, 8138, 8711, 8132, 8133, 8137).

The EP and KfW procure Prudence Plus brand condoms for private sector distribution, and UNFPA procures generic condoms for the public sector as part of Rwanda's FP program. In FY 2006, the EP, through the CCP mechanism, procured 12 million socially marketed Prudence condoms in partnership with KfW as part of an effort to increase demand and use of socially marketed condoms among targeted high-risk populations.

In FY 2007, the EP will support the procurement of an estimated 13 million Prudence condoms to be socially marketed by the recipient of the prevention RFA issued by USAID in FY 2007 (see activity 8138). In addition, the CCP will procure an additional 2 million generic condoms to target MARPs at military health brigades and hospitals, refugee camps, and facilities reached through the ROADS project. The EP will collaborate with GFATM and UNFPA to increase the availability of condoms throughout Rwanda in FY 2007. The CCP is a key partner in condom procurement; however, the targets for distribution and outreach will be attributed to EP partners providing direct services. As a result, there are no direct targets for this mechanism.

As part of the Rwanda strategic plan, private sector condoms will be socially marketed by the EP partners. Public sector condoms will be managed by the GOR, with quantification and logistical TA provided by the follow-on project to DELIVER.

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.

Continued Associated Activity Information

Activity ID: 4876
USG Agency: U.S. Agency for International Development
Prime Partner: US Agency for International Development
Mechanism: Central Contraceptive Procurement
Funding Source: GHAI
Planned Funds: $ 814,000.00

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100

Targets

Target	Target Value	Not Applicable
Number of targeted condom service outlets		☑
Number of individuals reached through 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 through other behavior change beyond abstinence and/or being faithful		☑

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: GHAI
Program Area: Condoms and Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 8117
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY 2006 -- NO NEW FUNDING IN FY 2007]
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.

PLUS-UP ADDITION: Under this activity, FHI will provide technical assistance to TRAC for the design, execution and analysis of a survey on sexual and risk behaviors among PLWHA in Rwanda (see description in TRAC activity). Once the survey results have been analyzed, FHI will collaborate with TRAC and national network of PLWHA (RRP+) to 1) conduct an inventory of "prevention for positives" IEC materials currently available in the country; 2) identify critical gaps in the content of these IEC materials; 3) design clinical and community IEC materials to fill these gaps; 4) develop a training module on prevention for positives for clinical settings (to be integrated with the national care and treatment training curriculum); and 5) incorporate the findings of the behavioral survey into the national care and treatment norms and guidelines. Clinical IEC materials will be printed, reproduced and distributed by TRAC, while community IEC materials will be produced and distributed by CHAMP in cooperation with RRP+.

Continued Associated Activity Information

Activity ID: 4765
USG Agency: U.S. Agency for International Development
Prime Partner: Family Health International
Mechanism: FHI Bridge
Funding Source: GHAI
Planned Funds: $ 175,000.00

Emphasis Areas

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 targeted condom service outlets	0	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	0	☐
Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	0	☐

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 (prior to 2007)

Table 3.3.05: Activities by Funding Mechanism

Mechanism: Biodiversity
Prime Partner: International Resources Group
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Condoms and Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 8131
Planned Funds: $ 50,000.00
Activity Narrative: This activity relates to HVOP (7184), HVAB (7183, 8124), HKID (7186), and HBHC (7187).

The Biodiversity project is a USAID four-year, $3.8 million project which will focus on the Nyungwe Forest National Park and its surrounding buffer areas in southwestern Rwanda. The project's primary objective is to encourage sustainable rural economic growth through the development of a tourism sector that is compatible with existing and potential community development activities. The project will focus 20% of its resources on community based health activities to raise awareness of the interlinking issues of population, health and the environment. The Biodiversity Project will work in five districts with some of the highest population densities in the country (250-500/km2) reaching approximately 300,000 people. More than 90% of the people living in this catchment area are farmers. The people living around Nyungwe Park are highly marginalized with low education levels, large families, poor housing, frequent food insecurity, and limited access to basic health care and infrastructure. The populations living within 10 km of the Nyungwe Forest National Park are considered high risk because they will experience an influx of migration from private enterprises and tourists engaging in ecotourism opportunities in and around the park. These populations have little access to information about HIV and will likely see an increase in income through the economic benefits of tourism, as well as increases in outside populations drawn to the Nyungwe area for work and livelihood.

With $200,000 in Family Planning and Infectious Disease funding and a total of $150,000 in the EP funding, the project will provide information about family planning, malaria prevention, and HIV/AIDS prevention to the populations around Nyungwe Park. Communities will be encouraged to seek antenatal services, VCT, and facility-based deliveries. They will also receive HIV prevention messages that include information on consistent, correct condom use as well as the role of alcohol and GBV in HIV transmission. The Biodiversity project will raise awareness of condom distribution through outlets and will use existing IEC materials, mobile video screenings, interpersonal communications, and community drama. This project will train an estimated 300 community volunteers to deliver these messages and assist with the community events which will reach an estimated 20,000 individuals with direct ABC messages. These events will reinforce the HIV prevention information provided at the health facilities in these communities. The Biodiversity project will work to strengthen referrals to VCT and other HIV/AIDS services and the linkages between the health facility and the community.

Biodiversity will use IEC materials and messages approved by the CNLS BCC Steering Committee. The project will coordinate closely with CHAMP and the Child Survival Grants Project – Concern, IRC and World Relief – which are working in some of the five Biodiversity districts. This activity supports the integration of HIV/AIDS and health through community-based services.

The activity supports the key legislative issue of stigma and discrimination, and wraps around non-HIV and environment activities. This activity reflects the EP Five Year Strategy of involving the private sector and 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

Targets

Target	Target Value	Not Applicable
Number of targeted condom service outlets	0	☐
Number of individuals reached through 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 through other behavior change beyond abstinence and/or being faithful	300	☐

Target Populations:

Adults
Business community/private sector
Community leaders
Community-based organizations
Faith-based organizations
Non-governmental organizations/private voluntary organizations
Volunteers

Key Legislative Issues

Stigma and discrimination

Wrap Arounds

Other

Table 3.3.05: 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:	GHAI
Program Area:	Condoms and Other Prevention Activities
Budget Code:	HVOP
Program Area Code:	05
Activity ID:	8133
Planned Funds:	$ 37,807.00
Activity Narrative:	This activity relates to HVAB (8186) and HBHC (7165, 7177).

In FY 2006, Columbia University began providing prevention for positives to 22,000 PLWHA enrolled in care at 35 sites. Social workers and nurses conducted education sessions, and peer educators at 10 district hospitals received training to promote CT among PLWHA association members and their families.

In FY 2007, Columbia University will continue the activity, expand the clinical services during post-test counseling for all clients, and add follow-up counseling with HIV-positive patients and their family members. Appropriate prevention messages will be integrated into the clinical setting and home based care, focusing on safer sex practices such as correct and consistent condom use, alcohol reduction and the link between HIV and GBV. These messages will reach 32,000 patients enrolled in HIV care at 35 existing and seven additional clinical sites. The messages will also reach 9,000 family members. A total of 250 nurses, social workers and community volunteers will be trained to conduct the education in the community and enrolled patients will be encouraged to bring their family members to HIV prevention sessions. Members of PLWHA associations and their families in the catchment area will also be encouraged to access those sessions.

During each interaction with the health facility – whether for pharmacy visit, clinical staging, CD4 count or health promotion meetings – social workers and case managers will provide HIV prevention messages and condoms with supportive CNLS-approved IEC materials. A condom demonstration session will be performed at consultations for all PLWHA, and at the CT session for their family members who are over age 14. Different messages will be used to match patients' profiles, circumstances, and prevention needs. Emphasis for this activity will be placed on reaching HIV-positive discordant couples and ART patients. Unmarried sexually active men and women who are HIV-negative but practice risky behaviors will also be counseled and supported to adopt risk reduction behaviors and the appropriate, consistent use of condoms.

As many risky behaviors can often be linked to other contextual factors such as unemployment, poverty, trauma, and psychosocial needs, Columbia will work with CHAMP and other partners to strengthen referrals and mechanisms for patients to access IGA, vocational training, trauma counseling, legal support, and mental health care and support for HIV-positive patients.

This activity addresses the key legislative issues of gender, particularly violence reduction and male norms. This activity reflects the five-year EP strategy and the Rwandan national plan for HIV infection prevention and EP for averting 157,000 new infections by 2010.

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
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of targeted condom service outlets	42	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	51,000	☐
Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	250	☐

Target Populations:

Commercial sex workers
Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
Most at risk populations
Discordant couples
Street youth
People living with HIV/AIDS
Prisoners
HIV positive pregnant women
Other Health Care Worker

Key Legislative Issues

Addressing male norms and behaviors

Reducing violence and coercion

Coverage Areas

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

Table 3.3.05: Activities by Funding Mechanism

Mechanism: Deliver follow-on
Prime Partner: John Snow, Inc.
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Condoms and Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 8134
Planned Funds: $ 100,000.00
Activity Narrative: This activity relates to HVOP (7251, 8132, 8133, 8135, 8137, 8138, 8711) and HTXS (7214).

The EP supports the procurement and distribution of ARV and contraceptive commodities for HIV positive families. PFSCM, RPM+, and DELIVER are the three EP-supported partners to advance this goal. PFSCM focuses on ARV procurement and central level support; RPM+ works with district pharmacies and warehousing; and DELIVER has supported contraceptive commodities and public sector distribution of condoms. In FY 2007, a new follow-on mechanism for DELIVER will be awarded as the original Cooperative Agreement ends.

The new implementer is expected to work with PFSCM, RPM+ and the GOR on quantification and reporting. The new implementer will support the integration of contraceptive commodity in HIV. The follow-on recipient will also coordinate with other EP partners to avoid duplication of training and district activities.

In FY 2006, DELIVER supported the public sector contraceptive commodities and condom distribution program. The tasks included quantification, customs clearance, distribution and district level support and training in contraceptive logistics. Public sector condoms are currently provided by UNFPA and GFATM.

In FY 2007, the EP will provide additional support to the public sector commodity system in collaboration with other donors. The goal is to ensure condom availability at public sector clinical facilities. Since military facilities and refugee and transit camps are not part of the public sector distribution, the new implementer will ensure adequate provision of commodities to these sites. To accurately project condom quantification, the new implementer will conduct a baseline assessment of condom uptake in those facilities. The new implementer will provide trend analyses by HIV-positives, broken down by gender and type of patient (ART vs. non-ART) to monitor EP’s prevention for positives efforts. The new implementer will also adapt distribution reporting tools to be used by all EP clinical sites including military and refugee facilities. The EP partners will integrate these data collection and tools into their site-level reporting. Overall program funding will be cost-shared with USAID CSH funds to support a local technical advisor, tools adaptation and dissemination, and coordination and assessment activities.

This activity addresses key legislative issues of gender, particularly through gender-based data collection, and wraps around CSH funds. This activity reflects the Rwanda EP five-year strategy and the GOR national plan by increasing the availability and accessibility of condoms through improved supply chain management systems.

Emphasis Areas	% Of Effort
Logistics	51 - 100
Needs Assessment	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

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

Key Legislative Issues

Gender

Wrap Arounds

Coverage Areas:

National

Table 3.3.05: Activities by Funding Mechanism

Mechanism: HIV Support to RDF
Prime Partner: Drew University
USG Agency: Department of Defense
Funding Source: GHAI
Program Area: Condoms and Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 8135
Planned Funds: $ 36,712.00
Activity Narrative: This activity relates to HTXS (7190), HBHC (7191), HVAB (8125), HVCT (8165) and HVTB (8146).

The RDF supports three military hospitals and three brigade clinics throughout the country. In FY 2005, Drew University began working in two military hospitals and three brigade clinics with EP support. This support included TA and training on ARV treatment, palliative care, M&E, and lab infrastructure. This support has been expanded to cover the entire clinical package – ARV services, TB/HIV, PMTCT, palliative care and prevention for positives. In collaboration with CHAMP, Drew will link to community services surrounding the military facilities, especially for OVC. Drew will receive drug procurement from PFSCM. In line with national policy, the military hospitals will use PBF as incentives for facilities.

In FY 2007, Drew University will work with the RDF to improve HIV care for 2,000 military personnel, their partners and families, and community members who live in the surrounding areas. Drew University will provide TA to the RDF to design a prevention campaign targeting PLWHA receiving HIV care and treatment at RDF sites. The overall goal is to reduce HIV transmission among discordant couples, and prevent new HIV infections between PLWHA and HIV negative individuals.

Through workshops for PLWHA, Drew University, in collaboration with PSI, will train RDF providers to integrate condoms and to promote the reduction of sexual partners and correct and consistent condom use.

Drew University will work with the RDF to train members of PLWHA associations to become peer educators in order to strengthen their capacity in treatment adherence, prevention of HIV transmission, and link HIV to alcohol and violence. Drew University will link civil-military associations of PLWHA to national umbrella of PLWHA associations.

This activity supports the key legislative issues of gender, particularly male norms, reducing violence, and stigma and discrimination. This activity reflects the Rwanda National Plan for HIV infection prevention and the Rwanda EP five-year strategy for averting 157,000 new infections by 2010.

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

Targets

Target	Target Value	Not Applicable
Number of targeted condom service outlets	6	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	8,000	☐
Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	100	☐

Target Populations:

Military personnel

Key Legislative Issues

Addressing male norms and behaviors

Stigma and discrimination

Coverage Areas

Kicukiro

Nyamagabe

Gatsibo

Table 3.3.05: Activities by Funding Mechanism

Mechanism: Refugees UNHCR
Prime Partner: United Nations High Commissioner for Refugees
USG Agency: Department of State / Population, Refugees, and Migration
Funding Source: GHAI
Program Area: Condoms and Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 8711
Planned Funds: $ 25,000.00

Activity Narrative: This activity is linked to MTCT (8696), HVAB (8700), HBHC (8718), HVTB (8670), HVCT (8732), and HTXS (8737).

Rwanda is host to nearly 50,000 refugees in four camps around the country. Refugee populations are considered at higher risk for diseases, particularly HIV, as well as other forms of violence, economic and psychological distress. While much is currently unknown about prevalence rates in the camp populations in Rwanda, recent service statistics of newly implemented VCT and PMTCT programs in two camps show a prevalence of 5% among CT clients. Since 2005, the EP has provided refugees with HIV/AIDS prevention and care services with linkages and referrals to local health facilities for treatment.

In FY 2007, the USG will centralize its support by funding UNHCR directly to expand the package of services for the prevention, care, and treatment of PLWHA. In addition, UNHCR will support a fourth refugee camp with C/OP promotion and BCC messages to reduce stigma and risk behaviors and encourage testing. Funds will also be leveraged from GLIA in the two large camps and OPEC to complement USG EP-supported services.

This activity will support the expansion of clinical services to include risk reduction and behavior change messages, including condom education and distribution to PLWHA and their family members. The 2004 UNHCR BSS and the FHI-supported RH assessment found high risk behaviors among refugee camp populations, including multiple partners, transactional sex, male cultural and societal norms that encourage high-risk behaviors and GBV, very low condom use, and alcohol abuse. UNHCR will target HIV-positive refugee patients, including discordant and married HIV-positive couples; unmarried HIV-positive refugee men and women; ART patients. Health providers and volunteers will also target C/OP messages to high-risk populations in clinics and camps-at-large. Target populations include CT clients who test negative, non-married and unemployed men, women- and out-of-school youth at-risk, STI clients, CSWs, and refugees with demonstrated high-risk behaviors such as alcohol abuse and a history of GBV. Health care providers and volunteers will use client contacts to deliver key prevention messages, which will be tailored to match to patients' profiles and circumstances.

UNHCR will adapt and integrate a screening tool for HIV-negative and positive clients to be used during CT and clinical sessions. Similar to the AB activities, health providers will also be trained or refresher trained to recognize signs of alcohol abuse and GBV and will integrate related messages and referrals into their counseling sessions.

In addition, UNHCR will support BCC messages in all four refugee camps. In Kiziba and Gihembe refugee camps, UNHCR will refer CSWs, vulnerable women, and youth-at risk to IGA and microfinance activities supported by GLIA funds. The EP funds will support C/OP activities in Nyabiheke and Kigeme refugee camps. BCC will target high-risk and vulnerable refugee populations and use anti-SIDA clubs, peer educators, community forums, and relevant IEC materials. Key messages will promote risk reduction behaviors, condom use, and address social norms, GBV, and alcohol abuse.

To monitor and track the reach of these messages and condom uptake, UNHCR will integrate program-level indicators, including DELIVER-supported condom distribution and tracking indicators into existing reporting forms and tools. USG will leverage UNFPA and GFATM public sector condoms for the camps.

This activity supports the key legislative issues of gender and stigma and discrimination. This activity reflects the Rwanda EP five-year strategy and the GOR National Plan for HIV Prevention (2005-2009) by strengthening integrated health communication (BCC and IEC) campaigns to prevent transmission of HIV to high-risk groups, promote condom use among at-risk and MARP populations, and increase demand for high quality CT services.

Emphasis Areas

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 targeted condom service outlets	4	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	7,780	☐
Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	120	☐

Target Populations:

Commercial sex workers
Community leaders
Community-based organizations
Nurses
Discordant couples
Refugees/internally displaced persons
People living with HIV/AIDS
Pregnant women
Volunteers
Men (including men of reproductive age)
Women (including women of reproductive age)
HIV positive pregnant women
Widows/widowers
Out-of-school youth
Partners/clients of CSW
Other Health Care Worker

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 (prior to 2007)

Kibuye (prior to 2007)

Umutara (Mutara) (prior to 2007)

Gicumbi

Gatsibo

Karongi

Table 3.3.05: Activities by Funding Mechanism

Mechanism: FHI New Bilateral
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Condoms and Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 15222
Planned Funds: $ 258,134.00
Activity Narrative: This activity relates to HVOP (7251, 8133, 8134), MTCT (8698), HVAB (8129), HBHC (8144), HVTB (8147), HVCT (8168), and HTXS (8172). In FY 2006, all USAID clinical partners are providing a standard package of services including PMTCT, CT, OI and other palliative care, and ART. In order to improve prevention for positives programming, FHI is providing TA to TRAC to assess sexual and risk behaviors among PLWHA and their networks. FHI will use this information to revise clinical and community IEC materials to fill gaps in existing prevention for positives and adapt a training module for prevention messaging in clinical settings. The revised materials will be piloted and integrated into the national care and treatment training curriculum to be used by all clinical partners in FY 2007.

In FY 2007, USAID awarded three cooperative agreements - one of the three to FHI - that will expand quality clinical services, including prevention messages. FHI will expand services to include C/OP messages during post-test of all clients and follow-up counseling with HIV-positive patients and their family members. Appropriate prevention messages will be integrated into the clinical setting within health facilities and home based care. Health care providers, case managers and community volunteers will use client contacts to deliver key prevention messages that are tailored to individual groups. Different messages will be used to match patients' profiles, circumstances and prevention needs. Emphasis for this activity will be placed on reaching HIV-positive discordant couples and ART patients. Unmarried sexually active men and women who are HIV-negative but who practice high risk behaviors will also be counseled and supported to adopt risk reduction behaviors as well as appropriate and consistent use of condoms.

As many high-risk behaviors can often be linked to other contextual factors such as unemployment, poverty, trauma, and psychosocial needs, clinical partners will work with CHAMP and other partners to strengthen referrals and mechanisms for patients to access IGA, vocational training, trauma counseling, legal support, and mental health care and support for HIV-positive patients. The partners will adapt and integrate a screening tool for HIV-negative and positive clients to be used during CT sessions, follow-up counseling, and patient monitoring, particularly asymptomatic patients and patients on ART. Checklists and job aids will be used to facilitate and standardize the counseling messages providers deliver to patients. To monitor and track reach of these messages and condom uptake, the clinical partners will work with DELIVER to integrate C/OP reporting and condom distribution and tracking indicators into standardized reporting forms. Public sector condoms will be procured through GFATM and UNFPA. Additional condoms may be procured through CCP as necessary.

The clinical package aims to provide integrated services, including C/OP services, to every client and is part of the EP strategy to strengthen prevention for positives and continue to reduce transmission of HIV. This activity addresses the key legislative issues of gender, particularly violence reduction and male norms. This activity reflects the five-year EP strategy and the Rwandan national plan for HIV infection prevention and EP for averting 157,000 new infections by 2010.

Emphasis Areas

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

Targets

Target	Target Value	Not Applicable
Number of targeted condom service outlets	43	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	27,000	☐
Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	110	☐

Target Populations:

Commercial sex workers
Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
Traditional birth attendants
Discordant couples
Street youth
HIV/AIDS-affected families
People living with HIV/AIDS
Prisoners
Volunteers
HIV positive pregnant women
Partners/clients of CSW

Key Legislative Issues

Addressing male norms and behaviors

Reducing violence and coercion

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Table 3.3.05: Activities by Funding Mechanism

Mechanism: EGPAF New Bilateral
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Condoms and Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 15223
Planned Funds: $ 515,897.00
Activity Narrative: This activity relates to HVOP (7251, 8133, 8134), MTCT (8698), HVAB (8129), HBHC (8144), HVTB (8147), HVCT (8168), and HTXS (8172). In FY 2006, all USAID clinical partners are providing a standard package of services including PMTCT, CT, OI and other palliative care, and ART. In order to improve prevention for positives programming, FHI is providing TA to TRAC to assess sexual and risk behaviors among PLWHA and their networks. FHI will use this information to revise clinical and community IEC materials to fill gaps in existing prevention for positives and adapt a training module for prevention messaging in clinical settings. The revised materials will be piloted and integrated into the national care and treatment training curriculum to be used by all clinical partners, including EGPAF, in FY 2007.

In FY 2007, USAID awarded three cooperative agreements, one of the three to EGPAF, that will expand quality clinical services, including prevention messages. EGPAF will expand services to include C/OP messages during post-test of all clients and follow-up counseling with HIV-positive patients and their family members. Appropriate prevention messages will be integrated into the clinical setting within health facilities and home based care. Health care providers, case managers and community volunteers will use client contacts to deliver key prevention messages that are tailored to individual groups. Different messages will be used to match patients' profiles, circumstances and prevention needs. Emphasis for this activity will be placed on reaching HIV-positive discordant couples and ART patients. Unmarried sexually active men and women who are HIV-negative but who practice high risk behaviors will also be counseled and supported to adopt risk reduction behaviors as well as appropriate and consistent use of condoms.

As many high-risk behaviors can often be linked to other contextual factors such as unemployment, poverty, trauma, and psychosocial needs, clinical partners will work with CHAMP and other partners to strengthen referrals and mechanisms for patients to access IGA, vocational training, trauma counseling, legal support, and mental health care and support for HIV-positive patients. The partners will adapt and integrate a screening tool for HIV-negative and positive clients to be used during CT sessions, follow-up counseling, and patient monitoring, particularly asymptomatic patients and patients on ART. Checklists and job aids will be used to facilitate and standardize the counseling messages providers deliver to patients. To monitor and track reach of these messages and condom uptake, EGPAF will work with DELIVER to integrate C/OP reporting and condom distribution and tracking indicators into standardized reporting forms. Public sector condoms will be procured through GFATM and UNFPA. Additional condoms may be procured through CCP as necessary.

The clinical package aims to provide integrated services, including C/OP services, to every client and is part of the EP strategy to strengthen prevention for positives and continue to reduce transmission of HIV. This activity addresses the key legislative issues of gender, particularly violence reduction and male norms. This activity reflects the five-year EP strategy and the Rwandan national plan for HIV infection prevention and EP for averting 157,000 new infections by 2010.

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

Targets

Target	Target Value	Not Applicable
Number of targeted condom service outlets	26	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	15,000	☐
Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	120	☐

Target Populations:

Commercial sex workers
Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
Traditional birth attendants
Discordant couples
Street youth
HIV/AIDS-affected families
People living with HIV/AIDS
Prisoners
Volunteers
HIV positive pregnant women
Partners/clients of CSW

Key Legislative Issues

Addressing male norms and behaviors

Reducing violence and coercion

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Table 3.3.05: Activities by Funding Mechanism

Mechanism: IntraHealth New Bilateral
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Condoms and Other Prevention Activities
Budget Code: HVOP
Program Area Code: 05
Activity ID: 15224
Planned Funds: $ 152,773.00
Activity Narrative: This activity relates to HVOP (7251, 8133, 8134), MTCT (8698), HVAB (8129), HBHC (8144), HVTB (8147), HVCT (8168), and HTXS (8172). In FY 2006, all USAID clinical partners are providing a standard package of services including PMTCT, CT, OI and other palliative care, and ART. In order to improve prevention for positives programming, FHI is providing TA to TRAC to assess sexual and risk behaviors among PLWHA and their networks. FHI will use this information to revise clinical and community IEC materials to fill gaps in existing prevention for positives and adapt a training module for prevention messaging in clinical settings. The revised materials will be piloted and integrated into the national care and treatment training curriculum to be used by all clinical partners, including IntraHealth, in FY 2007.

In FY 2007, USAID awarded three cooperative agreements - one of the three to IntraHealth - that will expand quality clinical services, including prevention messages. As an award recipient under the RFA, IntraHealth will expand services to include C/OP messages during post-test of all clients and follow-up counseling with HIV-positive patients and their family members. Appropriate prevention messages will be integrated into the clinical setting within health facilities and home based care. Health care providers, case managers and community volunteers will use client contacts to deliver key prevention messages that are tailored to individual groups. Different messages will be used to match patients' profiles, circumstances and prevention needs. Emphasis for this activity will be placed on reaching HIV-positive discordant couples and ART patients. Unmarried sexually active men and women who are HIV-negative but who practice high risk behaviors will also be counseled and supported to adopt risk reduction behaviors as well as appropriate and consistent use of condoms.

As many high-risk behaviors can often be linked to other contextual factors such as unemployment, poverty, trauma, and psychosocial needs, clinical partners will work with CHAMP and other partners to strengthen referrals and mechanisms for patients to access IGA, vocational training, trauma counseling, legal support, and mental health care and support for HIV-positive patients. The partners will adapt and integrate a screening tool for HIV-negative and positive clients to be used during CT sessions, follow-up counseling, and patient monitoring, particularly asymptomatic patients and patients on ART. Checklists and job aids will be used to facilitate and standardize the counseling messages providers deliver to patients. To monitor and track reach of these messages and condom uptake, IntraHealth will work with DELIVER to integrate C/OP reporting and condom distribution and tracking indicators into standardized reporting forms. Public sector condoms will be procured through GFATM and UNFPA. Additional condoms may be procured through CCP as necessary.

The clinical package aims to provide integrated services, including C/OP services, to every client and is part of the EP strategy to strengthen prevention for positives and continue to reduce transmission of HIV. This activity addresses the key legislative issues of gender, particularly violence reduction and male norms. This activity reflects the five-year EP strategy and the Rwandan national plan for HIV infection prevention and EP for averting 157,000 new infections by 2010.

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

Targets

Target	Target Value	Not Applicable
Number of targeted condom service outlets	36	☐
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	18,000	☐
Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	130	☐

Target Populations:

Commercial sex workers
Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
Traditional birth attendants
Discordant couples
Street youth
HIV/AIDS-affected families
People living with HIV/AIDS
Prisoners
Volunteers
HIV positive pregnant women
Partners/clients of CSW

Key Legislative Issues

Addressing male norms and behaviors

Reducing violence and coercion

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

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: $ 8,766,204.00

Program Area Context:

There are currently approximately 190,000 HIV-positive people in need of HIV prevention, care and treatment services in Rwanda. At the end of FY 2007, 129,000 HIV-positive Rwandans will receive services through support from the EP, GFATM, MAP, Clinton Foundation and other donors, of which 90,100 will be reached through EP support.

Since FY 2004, the EP has supported a comprehensive range of palliative care services that include preventive, medical, psychological, spiritual and social care services at clinic and community levels for HIV-positive adults and children and affected family members. The emphasis on prevention, care and treatment for PLWHA has been somewhat limited to the provision of services in the clinical setting, with ill-defined linkages to community care and integration of clinical care in the community setting. Currently, clinical services include the provision of cotrimoxazole for eligible adults and exposed infants according to national guidelines, referral for CD4, diagnosis and treatment of OIs, adherence counseling, clinical monitoring and related laboratory services, nutritional assessment and support, and referrals for community-based care and support services. Psychological, spiritual and social care services have been primarily community-based activities, conducted through PLWHA associations and have included: OVC services including the provision of school fees and materials, IGA activities for child-headed households (particularly girls vocational training) and food support; HBC for eligible (bedridden) PLWHA; support for clinically eligible PLWHA to wrap around programs including Title II and WFP; provision of ITNs; and spiritual support through church leaders and volunteers.

The GOR defines palliative care as the relief of pain and suffering at the end-of-life, and primarily supports non-clinical community- and home-based care and support services. A national palliative care policy does not yet exist, although one is in development, and the country has not yet adopted a policy on the use of opioids for pain management at facility or community level. The EP is working closely with the GOR to develop a national palliative care strategy, advocating for revision of the palliative care definition and increasing access to pain-relief medications. In FY 2005, EP awarded a multi-year bilateral agreement for community-based services to CHAMP, which emphasizes capacity building of local CBOs and FBOs, strengthening community and home-based care and support through a standardized package of services and kits for HBC, OVC support, increased community participation, and strengthening of PLWHA associations. In FY 2006, USG/Rwanda asked CHAMP to support the GOR in the development of a national palliative care policy, and to define a mechanism for establishing linkages between health facilities and communities, including adaptation of referral tools, patient monitoring cards, and supporting community-clinic discussions.

In FY 2007, the EP will strengthen palliative care services at all levels of the health care system, including community- and home-based care services to ensure that a comprehensive package of care is delivered, using a family-centered approach. The package of facility-based services described above will be expanded in FY 2007 to include a broad range of adult and pediatric preventive care and other palliative care services including universal provision of CTX to all PLWHA, procurement of diagnostic kits and training of health providers for improved diagnosis and management of OIs, improvement of pain management through increased access to opioids. The EP will also strengthen nutritional services, including nutrition counseling, evaluation and treatment of malnutrition in PLWHA, through procurement of micronutrient and multivitamin supplements and linkages to food programs. In addition, EP will ensure provision of psychological support services through training of health care providers in age-appropriate counseling, counseling for trauma and GBV in HIV-positive women and girls, counseling for positive living, disclosure of HIV status and testing of family members, and improved prevention counseling for HIV-positives through the provision of targeted risk reduction and behavior change messages.

EP partners will continue to work with communities and health facilities to strengthen and expand facility-community linkages through the placement of a case manager in each health facility to establish

linkages with community-based care and support services through use of referral tools and management information systems to track and monitor access to these services. The case managers will maintain a list of all community-based services in their catchment areas to facilitate referrals and access. Through CHAMP, USG will continue to strengthen its community-based care and support services through training of volunteers in the provision of palliative care services, including basic medical care in the home setting, training of caregivers in basic medical care, risk-reduction and prevention counseling of PLWHA and their family members, and referrals for clinic-based medical services as the need arises. CHAMP will leverage standardized HBC kits through a DRI donation agreement for distribution to PLWHA. In FY 2007, the EP will contribute to and further leverage Title II food wraparound for clinically-eligible PLWHA, HIV-positive children and infants, and families, and support the strengthening of local food production activities. Moreover, CHAMP will help strengthen nutritional care and support for HIV-positive people at the community level, particularly infants and children, including training of volunteers in growth monitoring, nutritional assessments, nutrition counseling, and referral for management of malnutrition. In collaboration with PMI and GFATM, EP will distribute ITNs to PLWHA through HBC programs, OVC programs, and other community-based support services. To increase retention, promote sustainability and motivate volunteers, the GOR has expanded their performance-based financing mechanism to community-based service providers, where community volunteers are reimbursed for their outputs based on pre-defined goals and quality of service delivery. EP will integrate PBF into its community activities with TA from MSH/PBF to community-based partners and the GOR.

In FY 2007, USG will procure all palliative care related commodities through PFSCM, including drugs for the prevention and treatment of OIs, and laboratory and diagnostic kits for improved and expanded OI diagnosis. PFSCM will support CAMERWA to monitor the quality of OI drugs being imported in the country. RPM+, in collaboration with PFSCM, will support sites in monitoring and tracking OI drugs and consumption patterns through strengthened LMIS between sites, district pharmacies and CAMERWA, including revision of drug and patient monitoring tools, establishment of a computerized LMIS between district pharmacies and CAMERWA, and training of nurse pharmacists and district pharmacists in OI drug quantification, inventory tracking, and pipeline analysis and forecasting.

Although it is envisioned that the palliative care policy will be finalized during FY 2006, there may be continued need to support policy development, particularly for the integration of basic medical care at community level, and a policy on use of opioids for pain management. USG and its partners will continue to engage the GOR on and advocate for improvement and policy change in these issues.

Program Area Target:

Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	170
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	90,100
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	4,521

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: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 7146
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007] 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.

Continued Associated Activity Information

Activity ID:	4873
USG Agency:	U.S. Agency for International Development
Prime Partner:	African Humanitarian Action
Mechanism:	Refugees AHA
Funding Source:	GHAI
Planned Funds:	$ 8,000.00

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
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	1	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	500	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)		☑

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

Karongi

Table 3.3.06: Activities by Funding Mechanism

Mechanism: Refugees - Rwanda
Prime Partner: American Refugee Committee
USG Agency: Department of State / Population, Refugees, and Migration
Funding Source: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 7152
Planned Funds: $ 0.00

Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007] 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.

Continued Associated Activity Information

Activity ID: 4865
USG Agency: Department of State / Population, Refugees, and Migration
Prime Partner: American Refugee Committee
Mechanism: Refugees - Rwanda
Funding Source: GHAI

Planned Funds: $ 10,000.00

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
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	2	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	750	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)		☑

Key Legislative Issues

Addressing male norms and behaviors

Stigma and discrimination

Coverage Areas

Gicumbi

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: Central (GHAI)
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 7160
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007] 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.

Continued Associated Activity Information

Activity ID: 4838
USG Agency: HHS/Health Resources Services Administration
Prime Partner: Catholic Relief Services
Mechanism: AIDS Relief
Funding Source: N/A
Planned Funds: $ 0.00

Emphasis Areas

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Human Resources	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 service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	2	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	2,100	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)		☑

Target Populations:

Doctors
Nurses
HIV/AIDS-affected families
People living with HIV/AIDS
HIV positive pregnant women
Other MOH staff (excluding NACP staff and health care workers described below)
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Gicumbi

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:	GHAI
Program Area:	Palliative Care: Basic Health Care and Support
Budget Code:	HBHC
Program Area Code:	06
Activity ID:	7163
Planned Funds:	$ 221,340.00

Activity Narrative: This activity relates to activities in MTCT (8185), HVAB (8187), HBHC (7187, 7220, 7245, 8141, 8716), HVTB (7162), HKID (7156, 8148, 8150, 8152), HTXS (7158, 7161, 7213), HLAB (8189).

In FY 2006, CRS began providing basic palliative care to 6,535 PLWHA at eight sites. The package includes clinical staging and baseline CD4 count for all patients, follow-up CD4 every six months, management of OIs and other HIV-related illnesses, including OI diagnosis and treatment, and routine provision of CTX prophylaxis for eligible adults, children and exposed infants based on national guidelines, basic nutritional counseling and support, positive living and risk reduction counseling, pain and symptom management, and end-of-life care. In addition, CRS provides psychosocial counseling including counseling and referrals for HIV-positive female victims of domestic violence. To ensure a comprehensive package of care across a continuum, CRS through the partnership with CHAMP and other community services providers, refers patients enrolled in care to community-based palliative care services based on their individual need, including adherence counseling, spiritual support, stigma reducing activities, OVC support, IGA activities, and HBC services for end-of-life care.

In FY 2007, CRS will expand its package of palliative care services for the existing 6,535 patients and an additional 3,665 new patients at eight existing sites and six new sites, with an emphasis on quality of care, continuum of care through operational partnerships, and sustainability of services through PBF. Under this expanded package, CRS will provide a full range of adult and pediatric preventive care, clinical care, psychological support, spiritual and legal support services across a continuum of care, including provision of CTX prophylaxis for PLWHA and exposed infants in line with national guidelines, strengthened nutritional services through training and provision of nutritional care, including counseling, nutritional assessments using anthropometric indicators, and management of malnutrition through provision of micronutrient and multivitamin supplements, and links to Title II food support for clinically eligible PLWHA and children in line national nutrition guidelines. CRS will also support referrals for all PLWHA and their families for malaria prevention services, including for the provision of ITNs, in collaboration with CHAMP, GFATM and PMI; and referral of PLWHA and their families to CHAMP CBOs and other community-service providers for distribution of water purification kits and health education on hygiene. In addition, in collaboration with TRAC and CHAMP, CRS will ensure the provision of strengthened psychological and spiritual support services for PLWHA at clinic and community levels through expanded TRAC training in psychological support for all CRS-supported health facilities and community-based providers, including GBV counseling, positive living, and counseling on prevention for positives.

CRS will provide referrals for routine CD4, the prevention, diagnosis and treatment of OIs, and ongoing follow-up care for all PMTCT, VCT, TB and ART clients through strengthened linkages and referral systems between these services at clinic level. Through PFSCM, CRS will provide diagnostic kits, CD4 tests, and other exams for clinical monitoring, and will work with PFSCM for the appropriate storage, stock management, and reporting of all OI-related commodities.

In order to ensure continuum of HIV care, CRS, in collaboration with CHAMP, will recruit case managers at each of the supported sites. These case managers with training in HIV patient follow-up will ensure the proper referral of patients through the different services within the health system and the community. CRS-supported sites will assess individual PLWHA needs, organize monthly clinic-wide case management meetings to minimize follow-up losses of patients, and provide direct oversight of community volunteers. In addition, these case managers will train 160 community volunteers and provide them with necessary tools to provide services to patients in the community. The community volunteers will be motivated through community PBF based on the number of patients they assist and quality of services provided. CRS will work with CHAMP to develop effective referral systems between clinical care providers and psycho-social and livelihood support services, through the use of patient routing slips for referrals and counter referrals from community to facilities and vice versa. Depending on the needs of individuals and families, health facilities will refer PLWHA to community-based HBC services, adherence counseling, spiritual support through church-based programs, stigma reducing activities, CHAMP-funded OVC support, IGA activities, particularly for PLWHA female- and child-headed households, legal support services, and community-based pain management

and end-of-life care in line with national palliative care guidelines.

Increasing pediatric patient enrollment is a major priority for all USG clinical partners in FY 2007. Case managers will ensure referrals to care services for pediatric patients identified through PMTCT programs, PLWHA associations, malnutrition centers, and OVC programs. To do this, the case managers will have planning sessions with facilities and community-based service providers, and OVC services providers for more efficient use of patient referrals slips to ensure timely enrollment in care and treatment for children diagnosed with HIV/AIDS. Case managers will conduct regular case reviews with other partners included in the referral system to review the effectiveness of the system, identify challenges and design common strategies to overcome any barrier to pediatric patients routing between services. In addition, adult patients enrolled in care will be encouraged to have their children tested and positive ones taken to HIV care and treatment sites. To expand quality pediatric care, Rwanda's few available pediatricians will train other clinical providers, using the innovative Columbia UTAP model developed in FY 2006 and continuing in FY 2007. CRS will support health facilities to refer HIV-positive children to OVC programming for access to education, medical, social and legal services. CRS will also support sites to identify and support women who may be vulnerable when disclosing their status to their partner, and include in counseling the role of alcohol in contributing to high-risk behaviors.

PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, CRS will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of palliative care and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool.

In the context of decentralization, DHTs now play a critical role in the oversight and management of clinical and community service delivery. CRS will strengthen the capacity of two DHTs to coordinate an effective network of palliative care and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities.

This activity addresses the key legislative areas of gender, wrap around for food, microfinance and other activities, and stigma and discrimination through increased community participation in care and support of PLWHA.

Continued Associated Activity Information

Activity ID: 4989
USG Agency: HHS/Health Resources Services Administration
Prime Partner: Catholic Relief Services
Mechanism: Catholic Relief Services Supplemental
Funding Source: GHAI
Planned Funds: $ 56,300.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Food/Nutrition	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	13	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	10,200	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	160	☐

Target Populations:

Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
People living with HIV/AIDS
Volunteers
HIV positive pregnant women
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Food

Stigma and discrimination

Microfinance/Microcredit

Coverage Areas

Burera

Gicumbi

Gatsibo

Nyamasheke

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: Central (GHAI)
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 7165
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY 2006 - NO NEW FUNDING IN FY 2007]

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.

Continued Associated Activity Information

Activity ID: 2788
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Columbia University Mailman School of Public Health

Mechanism: Columbia/MCAP
Funding Source: N/A
Planned Funds: $ 0.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Human Resources	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 service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	28	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	15,000	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)		☑

Target Populations:

Doctors
Nurses
HIV/AIDS-affected families
People living with HIV/AIDS
Caregivers (of OVC and PLWHAs)
Other MOH staff (excluding NACP staff and health care workers described below)
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Karongi

Rubavu

Kicukiro

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: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 7177
Planned Funds: $ 454,300.00

Activity Narrative: This activity relates to activities in MTCT (8185), HVAB (8187), HBHC (7187, 7220, 7245, 8141, 8716), HVTB (7162), HKID (7156, 8148, 8150, 8152), HTXS (7158, 7161, 7213), HLAB (8189).

In FY 2006, Columbia provided basic palliative care to 22,000 PLWHA at 35 sites. The package includes clinical staging and baseline CD4 count for all patients, follow-up CD4 every six months, management of OIs and other HIV-related illnesses, including OI diagnosis and treatment, and routine provision of CTX prophylaxis for eligible adults, children and exposed infants based on national guidelines, basic nutritional counseling and support, positive living and risk reduction counseling, pain and symptom management, and end-of-life care. In addition, Columbia provides psychosocial counseling including counseling and referrals for HIV-positive female victims of domestic violence. To ensure a comprehensive package of care across a continuum, Columbia through the partnership with CHAMP and other community services providers, refers patients enrolled in care to community-based palliative care services based on their individual need, including adherence counseling, spiritual support, stigma reducing activities, OVC support, IGA activities, and HBC services for end-of-life care.

In FY 2007, Columbia will expand its package of palliative care services for the 22,000 existing patients in care and add 10,000 new patients at 35 existing and seven new sites, with an emphasis on quality of care, continuum of care through operational partnerships, and sustainability of services through PBF. Under this expanded package, Columbia will provide a full range of adult and pediatric preventive care, clinical care, psychological support, spiritual and legal support services across a continuum of care, including provision of CTX prophylaxis for PLWHA and exposed infants in line with national guidelines, strengthened nutritional services through training and provision of nutritional care, including counseling, nutritional assessments using anthropometric indicators, and management of malnutrition through provision of micronutrient and multivitamin supplements, and links to Title II food support for clinically eligible PLWHA and children in line national nutrition guidelines. Columbia will also support referrals for all PLWHA and their families for malaria prevention services, including for the provision of ITNs, in collaboration with CHAMP, GFATM and PMI; and referral of PLWHA and their families to CHAMP CBOs and other community-service providers for distribution of water purification kits and health education on hygiene. In addition, in collaboration with TRAC and CHAMP, Columbia will ensure the provision of strengthened psychological and spiritual support services for PLWHA at clinic and community levels through expanded TRAC training in psychological support for all Columbia-supported health facilities and community-based providers, including GBV counseling, positive living, and counseling on prevention for positives.

Columbia will provide referrals for routine CD4, the prevention, diagnosis and treatment of OIs, and ongoing follow-up care for all PMTCT, VCT, TB and ART clients through strengthened linkages and referral systems between these services at clinic level. Through PFSCM, Columbia will provide diagnostic kits, CD4 tests, and other exams for clinical monitoring, and will work with PFSCM for the appropriate storage, stock management, and reporting of all OI-related commodities.

In order to ensure continuum of HIV care, Columbia, in collaboration with CHAMP, will recruit case managers at each of the supported sites. These case managers with training in HIV patient follow-up will ensure the proper referral of patients through the different services within the health system and the community. Columbia-supported sites will assess individual PLWHA needs, organize monthly clinic-wide case management meetings to minimize follow-up losses of patients, and provide direct oversight of community volunteers. In addition, these case managers will train 294 community volunteers and provide them with necessary tools to provide services to patients in the community. The community volunteers will be motivated through community PBF based on the number of patients they assist and quality of services provided. Columbia will work with CHAMP to develop effective referral systems between clinical care providers and psycho-social and livelihood support services, through the use of patient routing slips for referrals and counter referrals from community to facilities and vice versa. Depending on the needs of individuals and families, health facilities will refer PLWHA to community-based HBC services, adherence counseling, spiritual support through church-based programs, stigma reducing activities, CHAMP-funded OVC support, IGA activities, particularly for PLWHA

female- and child-headed households, legal support services, and community-based pain management and end-of-life care in line with national palliative care guidelines.

Increasing pediatric patient enrollment is a major priority for all USG clinical partners in FY 2007. Case managers will ensure referrals to care services for pediatric patients identified through PMTCT programs, PLWHA associations, malnutrition centers, and OVC programs. To do this, the case managers will have planning sessions with facilities and community-based service providers, and OVC services providers for more efficient use of patient referrals slips to ensure timely enrollment in care and treatment for children diagnosed with HIV/AIDS. Case managers will conduct regular case reviews with other partners included in the referral system to review the effectiveness of the system, identify challenges and design common strategies to overcome any barrier to pediatric patients routing between services. In addition, adult patients enrolled in care will be encouraged to have their children tested and positive ones taken to HIV care and treatment sites. To expand quality pediatric care, Rwanda's few available pediatricians will train other clinical providers, using the innovative Columbia UTAP model developed in FY 2006 and continuing in FY 2007. Columbia will support health facilities to refer HIV-positive children to OVC programming for access to education, medical, social and legal services. Columbia will also support sites to identify and support women who may be vulnerable when disclosing their status to their partner, and include in counseling the role of alcohol in contributing to high-risk behaviors.

PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, USAID partners will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of palliative care and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool.

In the context of decentralization, DHTs now play a critical role in the oversight and management of clinical and community service delivery. Columbia will strengthen the capacity of two DHTs to coordinate an effective network of palliative care and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities.

This activity addresses the key legislative areas of gender, wrap around for food, microfinance and other activities, and stigma and discrimination through increased community participation in care and support of PLWHA.

Continued Associated Activity Information

Activity ID:	2799
USG Agency:	HHS/Centers for Disease Control & Prevention
Prime Partner:	Columbia University Mailman School of Public Health
Mechanism:	Columbia MCAP Supplement
Funding Source:	GHAI
Planned Funds:	$ 300,000.00

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	51 - 100
Food/Nutrition	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	42	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	32,000	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	480	☐

Target Populations:

Doctors
Nurses
Pharmacists
HIV/AIDS-affected families
People living with HIV/AIDS
Prisoners
Volunteers
HIV positive pregnant women
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

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

Other

Coverage Areas

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

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:	GHAI
Program Area:	Palliative Care: Basic Health Care and Support
Budget Code:	HBHC
Program Area Code:	06
Activity ID:	7187
Planned Funds:	$ 2,550,000.00

Activity Narrative: This activity relates to activities in MTCT (7181), HVAB (7183), HVOP (7184), HVCT (7182), HBHC (7187, 7160, 7163, 7165, 7177, 8141, and 8144), HKID (7186) and OHPS (7189, 8181).

The Community HIV/AIDS Mobilization Program (CHAMP), through financial support and technical and institutional capacity building for Rwandan partner organizations, is working to ensure Rwandan communities have equitable access to high quality, sustainable continuum of HIV & AIDS care services. CHAMP supports the provision of community services in all EP-supported districts, especially around EP-supported health facilities.

CHAMP works with three Rwandan umbrella organizations which collectively support over 1,000 associations representing women, PLWHA and the religious community, and six other Rwandan partner organizations. CHAMP provides financial and technical assistance to these organizations to provide comprehensive, quality services to PLWHA. In addition to building their technical capacity, CHAMP works with these organizations (and their member associations as appropriate) to build their capacity to manage programs, finances, and human resources with the ultimate goal of directly receiving donor funding in the future.

In FY 2006, CHAMP is providing over 20,000 PLWHA with a package HIV-related palliative care services, including income generating activities, psychosocial and spiritual support, improved nutrition and links to food assistance, community gardens, HIV prevention, HBC, and legal and human rights support. CHAMP is training 3,000 volunteer caregivers (primarily family members and members of PLWHA associations) in communities to provide these services. CHAMP is supporting the finalization and implementation of a national palliative care policy and is providing technical input to the national palliative care TWG.

In FY 2007, CHAMP will continue to provide a menu of community-based services to PLWHA with a focus on expanding availability, improving quality, and strengthening referrals. CHAMP will work closely with clinic-based case managers to ensure PLWHA and their families receive a comprehensive package of services. Case managers in the health facilities will support PLWHA receiving clinical care to ensure follow-up and continuity of clinical services as well as link them to community services. CHAMP-supported community groups will provide a variety of services for PLWHA and the availability of these services will be documented and shared so that case managers and other clinic-based staff will be able to easily refer clients to these activities. Community-based services will also include referral to health facilities, especially for testing and care. CHAMP will ensure that communities are aware of and have access to other USG-supported clinical and community initiatives such as PMI, child survival and health programs, and food assistance. CHAMP-supported partners will reach 22,000 individuals with a comprehensive menu of services in FY 2007.

In FY 2007, CHAMP will train or offer refresher training to 3,000 community volunteers and caregivers and provide support to those caregivers trained previously. In order to ensure sustainability of these programs, CHAMP will use a training of trainers approach, building the knowledge and capacity of the staff of partner organizations and their association members 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 households to OVC community services as necessary and encouraging parents and guardians to test their children. In this way, volunteers will help identify more HIV-positive children and family members and link them to appropriate care and treatment. CHAMP will also work to increase male involvement in providing care as well as support women and girls as they tend to be the majority of primary care givers. CHAMP will work closely with the Rwandan Association of Trauma Counselors (ARCT) to build the capacity of CHAMP partner organizations to provide quality counseling services and psychosocial support.

CHAMP will also provide support to the Palliative Care Association of Rwanda (PCAR) to build their capacity to ensure the future of quality palliative care services in Rwanda. PCAR has received limited technical and financial support from the African Palliative Care Association (APCA) in Uganda to train palliative care service providers and advocate for a supportive environment for community-based care. CHAMP will support PCAR with

technical, administrative, financial and managerial capacity building.

CHAMP will work with its partners and the GOR to conduct appropriate M&E, data collection and use, and management of resources in order to improve the quality of HIV care and support services at the community level. CHAMP will continue to support existing local partners and add additional partners in FY 2007.

This activity addresses the key legislative issues of gender, stigma and discrimination and wrap-arounds, especially of food and income generation. This activity supports the EP five-year strategy to integrate HIV prevention, care and treatment, expand pediatric HIV care, and mobilize community coordinated action.

Continued Associated Activity Information

Activity ID: 2811
USG Agency: U.S. Agency for International Development
Prime Partner: Community Habitat Finance International
Mechanism: CHAMP
Funding Source: GHAI
Planned Funds: $ 1,552,000.00

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Food/Nutrition	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)		☑
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	22,000	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	3,000	☐

Target Populations:

Community leaders
Community-based organizations
Faith-based organizations
HIV/AIDS-affected families
People living with HIV/AIDS
Caregivers (of OVC and PLWHAs)
Religious leaders

Key Legislative Issues

Gender

Stigma and discrimination

Food

Microfinance/Microcredit

Coverage Areas

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Bugesera

Gatsibo

Nyagatare

Rwamagana

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

Table 3.3.06: Activities by Funding Mechanism

Mechanism: HIV Support to RDF
Prime Partner: Drew University
USG Agency: Department of Defense
Funding Source: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 7191
Planned Funds: $ 357,123.00

Activity Narrative: With this additional funding, Drew University will continue to improve the capacity of the Rwandan Defense Force to provide HIV treatment and care for military personnel, their partners and families, and community members who live in the surrounding areas. Throughout the twelve (12) RDF brigades, Drew University will provide technical assistance to RDF to strengthen linkages between community-based and clinic-based HIV care services. At brigade and/or community levels, this additional funding will allow Drew to support the formation of civil-military allied associations of HIV+ people. In addition, Drew will train an additional 110 association members in provision of home-based care, provide nutritional counseling and support, provide training for HIV prevention for positives and caregivers, distribution and use of care packages, support income generating activities, train members on adherence and refer HIV+ cases to health facilities in order to reach an additional 1,200 PLWHA.

This activity relates to activities in HTXS (7190), HBHC (7191, 8716), HVAB (8125), HVOP (8135), HVCT (8165), HVTB (8146), HLAB (8189)

In the RDF health network there are three military hospitals and five brigade clinics throughout the country. Drew University began working in two military hospitals and three brigade clinics in FY 2005 with EP support. The support modalities include TA and training on ARV and palliative care, M&E, and laboratory infrastructure. Drew collaborates with CHAMP for services in military communities such as OVC support, and receives drug procurement from PFSCM. In line with national policies, the hospitals incorporate performance-based financing as incentives for facilities.

In FY 2006, Drew University is improving the capacity of the RDF to provide HIV treatment and care to 1,300 military personnel, their partners and families, and community members who live in the surrounding areas. The package includes clinical staging and baseline CD4 count for all patients, follow-up CD4 count every six months, prevention of OIs through CTX prophylaxis to eligible patients, psychosocial counseling including referrals for HIV-positive victims of domestic violence and referrals of PLWHA in care to community-based palliative care services.

In FY 2007, Drew University will provide the same package of palliative care to 2,530 PLWHA enrolled at three military hospitals and three brigade clinics. Drew University will provide TA to RDF to strengthen linkages between community-based and clinic-based HIV care services. At brigade and community levels, Drew will support the formation of civil-military allied associations of PLWHA and train members in provision of a range of services. These HBC services include nutritional counseling, assessment and management of malnutrition through provision of micronutrient and multivitamin supplements and links to Title II partners for food wrap-around for clinically eligible PLWHA, provision of HIV prevention counseling for positives, and training of caregivers in the management of PLWHA.

In addition, peer educators will be trained to provide social support to brigade and community members through interactive, experience-sharing group workshops. These workshops will be organized to increase treatment adherence and share success stories witnessed during the course of HIV care therapy. At the clinic level, Drew University will train providers in, and increase access to STI, OI and mental health diagnosis and treatment, by integrating these services into three brigade-level clinics. Forty individuals will be trained to provide HIV-related palliative care. In line with national policies to promote sustainability, the hospitals will begin performance-based financing activities.

In collaboration with CHAMP, GFATM and PMI, Drew University will refer 2,530 PLWHA and their families for malaria prevention services including provision of bed nets.

Drew University will assist the RDF to strengthen referral to community-based support groups for improved treatment adherence and increased access to non-clinical HIV care services. Ngarama military hospital will provide a full package of HIV care services. Drew University will assist the RDF to decentralize and integrate HIV basic health care services in three brigade clinics at Musanze in the north, Ngoma in the east and Muhanga.

Through PFSCM, Drew provides OI-related drugs, CD4 testing, and OI diagnostics for the clinical management of PLWHA enrolled in care. Drew will work with PFSCM and RPM-Plus

to ensure appropriate stock management, inventory control, and storage for all USG-procured commodities at Drew-supported sites.

Continued Associated Activity Information

Activity ID:	2752
USG Agency:	Department of Defense
Prime Partner:	Drew University
Mechanism:	HIV Support to RDF
Funding Source:	GHAI
Planned Funds:	$ 265,125.00

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

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	6	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	3,730	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	150	☐

Target Populations:

HIV/AIDS-affected families

Military personnel

Key Legislative Issues

Addressing male norms and behaviors

Stigma and discrimination

Coverage Areas

Gatsibo

Nyamasheke

Kicukiro

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: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 7197
Planned Funds: $ 150,217.00

Activity Narrative: This extension will continue the activities of a current implementer to prevent treatment interruption. During the extension, implementer will make transition to follow-on awardee expected to be determined in late May.
[CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2006]
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.
****PLUS-UP****
$351,000 - GOR PMTCT guidelines encourage rapid cessation of breastfeeding for HIV-exposed infants at 6 months or as soon as feasible (AFASS). HIV-exposed infants who are weaned are at high risk of malnutrition and will require appropriate feeding methods during the weaning period. This is especially true if HIV exposed infants test negative at two months of age. All implementing PMTCT partners providing basic care services will work with WFP and Title II resources to leverage funding for food supplements during FY2006. This plus-up funding will support 1000 infants with infant formula for all USG partners providing PMTCT services.

Continued Associated Activity Information

Activity ID: 5111
USG Agency: U.S. Agency for International Development
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
Mechanism: Call to Action/EGPAF
Funding Source: GHAI
Planned Funds: $ 460,120.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	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 service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	20	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	6,300	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)		☑

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Food

Coverage Areas

Gicumbi

Gasabo

Kicukiro

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: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 7206
Planned Funds: $ 24,143.00

Activity Narrative: This extension will continue the activities of a current implementer to prevent treatment interruption. During the extension, implementer will make transition to follow-on awardee expected to be determined in late May.
[CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007]
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.

Continued Associated Activity Information

Activity ID: 5112
USG Agency: U.S. Agency for International Development
Prime Partner: IntraHealth International, Inc
Mechanism: Capacity
Funding Source: GHAI
Planned Funds: $ 309,040.00

Emphasis Areas

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
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	16	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	6,150	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)		☑

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

Gicumbi

Kamonyi

Muhanga

Nyamagabe

Rwamagana

Karongi

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: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 7215
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007] 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.

Continued Associated Activity Information

Activity ID: 5116
USG Agency: U.S. Agency for International Development
Prime Partner: Management Sciences for Health
Mechanism: RPM+
Funding Source: GHAI
Planned Funds: $ 10,000.00

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

Target Populations:

People living with HIV/AIDS
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Coverage Areas

Gikongoro (prior to 2007)

Gicumbi

Muhanga

Nyamagabe

Karongi

Rubavu

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 7220
Planned Funds: $ 559,680.00

Activity Narrative: This activity relates to HBHC (8144, 7165, 7177, 7160, 7163), MTCT (7219), HVTB (7221), HVCT (7217), HTXS (7222), HVSI (8741).

Performance-based financing is an innovative approach to financing of health services that enhances quality of services and leads to greater efficiency and sustainability. Financial incentives provided by performance-based funding motivate health facilities to improve performance through investments in training, equipment, personnel and payment systems that better link individual pay to individual performance. PBF financing is directly applied to basic health care and other HIV indicators at the facility level. As a result of successful pilots implemented by CordAID, GTZ and BTC, the MOH has endorsed national scale-up of performance-based financing for all health services. The USG, in partnership with the World Bank, BTC and other donors, is supporting national implementation of performance-based financing of health services.

In FY 2006, MSH/PBF supported the GOR in collaboration with key donors to develop a national strategy, policy, and implementation model of performance-based financing that applies to all health assistance. The initial strategy for EP-supported PBF activities was to transfer USG site support from a traditional inputs–based model to a purely output purchases model as sites achieved a certain level of technical competence. However, the implementation of COP06 activities brought a change in the USG team's thinking about this approach. Few, if any USG supported sites were found to be ready for complete graduation to an exclusively PBF model. While PBF clearly increases performance, technical assistance and basic input support is still needed, especially in the current context of rapid decentralization and accelerated national roll-out of the PBF model by the GOR. Therefore, an adjusted strategy has been developed that provides a combination of both input and output financing to all EP-supported sites. The combination of financing modalities will properly motivate health facilities for higher performance while providing necessary resources and tools to meet the established targets.

In FY 2007, MSH/PBF will continue to provide support to the MOH Performance Based Financing department and the national PBF TWG. In addition, MSH/PBF will provide TA to DHTs in all PEPFAR districts and to USG implementing partners to effectively shift some of their input financing to output-based financing for basic health care and other indicators in accordance with national policy. MSH/PBF will also provide output financing to health facilities in 6 districts (where other clinical partners will only provide input financing) through direct performance sub-contracts with health centers and district hospitals for basic health care and other indicators. Output financing involves the purchase of a certain quantity of indicators with a performance incentive for the production of more than agreed upon quantities of services. Full or partially reduced payment of basic health care and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool.

At the health center level, MSH/PBF will use a 'fixed price plus award fee' contract model to purchase a quantity of basic health care and other HIV indicators with a performance incentive. Examples of basic health care indicators include the number of HIV+ clients who tested their CD4 levels six-monthly, number of HIV+ clients treated with CTX each month, number of HIV+ women who are using FP, number of HIV+ clients who have been screened for STDs. Performance on these indicators will be measured during monthly control activities jointly conducted by the MSH/PBF district coordinator and the district's Family Health Unit and quality of services will be evaluated through the existing national supervisory and quality assurance mechanisms. The quantity and quality scores will be merged during the quarterly District PBF Steering Committee meetings and the final payments will be approved.

At the district hospital level, MSH/PBF will have sub-contracts with slightly different purpose and scope from that of health centers. In addition to the focus on increasing better quality service outputs, there is an emphasis on quality assurance, self-evaluation, and review by peers similar to an accreditation scheme. There will be payment for indicators from the National District Hospital PBF Scheme which reinforces the supervisory role hospitals play in district health networks.

At the District level, MSH/PBF will support the national model by 1) placing a district coordinator within the Family Health Unit to work with national family health steering

committee during data collection/entry and control of indicators, 2) facilitating the quantity control function by providing TA and paying associated costs, and 3) support secretarial functions for the Family Health Unit at the District level. Support to the District is critical for the proper functioning of the national PBF model since monthly HIV/AIDS invoice approved by the health center PBF management committee (COGE) and MSH are presented to the district steering committee for merging with quality index and final approval before payments are made.

Performance-Based financing of basic health care and other HIV services is a critical step to achieving the goal of sustainable, well-managed, high quality, and cost-effective basic health care service delivery in a comprehensive HIV/AIDS treatment network. This financing modality supports the Rwanda EP five-year strategy for increasing institutional capacity for a district managed network model of HIV clinical treatment and care services.

Continued Associated Activity Information

Activity ID: 2815
USG Agency: U.S. Agency for International Development
Prime Partner: Management Sciences for Health
Mechanism: HIV/AIDS Performance Based Financing
Funding Source: GHAI
Planned Funds: $ 628,000.00

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, Quality Improvement and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care supported with performance-base financing	161	☐
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	0	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	0	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	0	☐

Target Populations:

Faith-based organizations
HIV/AIDS-affected families
International counterpart organizations
People living with HIV/AIDS
Policy makers
Prisoners
Volunteers
Other MOH staff (excluding NACP staff and health care workers described below)
Public health care workers
Implementing organizations (not listed above)
HIV positive children (5 - 14 years)

Key Legislative Issues

Gender

Coverage Areas

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Karongi

Rutsiro

Ngororero

Nyabihu

Nyamasheke

Rubavu

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 7245
Planned Funds: $ 100,000.00
Activity Narrative: This activity relates to activities in MTCT (8697), HBHC (7163, 8718, 7177, 7187, 7220, 8141, 8144, 8716), HTXS (7246).

In FY 2006, the EP supports TRAC for central activities to ensure quality of HIV palliative care. TRAC created a forum for information exchange between facility-based palliative care service providers to identify weaknesses and constraints as well as methods for program improvement (this includes quarterly workshops for health center staff, district supervisors, TRAC and DSS). TRAC defines the roles of different types of health facilities in OI service delivery in accordance with the network model (i.e. health center versus hospital) and monitors OI service delivery sites to determine the sustainability of activities.

In addition, in order to integrate all palliative care at both facility and community levels to ensure a continuum of care, the EP supported national policy and guidelines adaptation on palliative in FY 2006. TRAC is also revising and integrating into the national HIV training curriculum a module on psychosocial support as well as nutritional assessment, counseling and management of malnutrition. By the end of FY 2006, TRAC will have designed palliative care-related tools, including PLWHA case management tools, patient assessment and follow-up forms and referrals and counter-referral forms from facility to community and vice versa. In addition TRAC will have finalized the list of OI drugs, including use of opioids at clinic and community level for pain management.

In FY 2007, the EP will support TRAC to use the guidelines, curricula and tools developed in FY 2006 to conduct training of trainers' sessions on palliative care for 100 nurses, social workers, HIV case managers, and nutritionists. In addition, USG will support TRAC through a national nutrition advisor position to oversee all nutrition programming activities at central level and supervision of training and nutrition activities implementation at site and community levels. TRAC will supervise decentralized training on palliative care both for facility-based providers and community-based providers. TRAC will also design, in collaboration with PBF and the MOH Community Health Unit, key HIV program-related indicators to monitor for PBF at community level. Lastly, TRAC in collaboration with PFSCM, will provide timely and accurate data on OI drug and diagnostics consumption, and OI-related morbidity and mortality to the CPDS for drugs and reagent quantification.

These activities support the EP five-year strategic goals of promotion of a continuum of HIV care and Rwandan national plan for palliative care.

Continued Associated Activity Information

Activity ID: 2744
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Treatment and Research AIDS Center
Mechanism: TRAC Cooperative Agreement
Funding Source: GHAI
Planned Funds: $ 0.00

Emphasis Areas	% Of Effort
Linkages with Other Sectors and Initiatives	10 - 50
Policy and Guidelines	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)		☑
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)		☑
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	100	☐

Target Populations:

Doctors
Nurses
Pharmacists
Other Health Care Worker
Doctors
Laboratory workers
Nurses
Pharmacists
Other Health Care Workers

Coverage Areas:

National

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: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 7254
Planned Funds: $ 35,000.00
Activity Narrative: USAID/Rwanda has been providing local and international technical assistance to GOR agencies and limited direct grants to local NGOs since FY 2004.

In FY 2007, the EP will expand this to further build local capacity. USAID anticipates continuing direct financial and technical support to Rwanda NGOs in sponsoring or attending conferences, workshops and technical meetings on HIV treatment. USAID will also support direct TA to other GOR agencies as needed, in particular CNLS which oversees community and home-based care activities in Rwanda.

Continued Associated Activity Information

Activity ID: 4968
USG Agency: U.S. Agency for International Development
Prime Partner: US Agency for International Development
Mechanism: USAID Rwanda Mission
Funding Source: GHAI
Planned Funds: $ 35,000.00

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 supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)		☑
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)		☑
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)		☑

Target Populations:

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

Coverage Areas:

National

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: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 7273
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY 2006 -- NO NEW FUNDING IN FY 2007]

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, $700,000 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.

****Plus-up Activity****
$100,000 – World Relief will provide food for therapeutic feeding to ART patients through Home Based Care (HBC) programs, PLWHA associations, and other community support programs on a six-month time limit. WR will leverage additional food provisions through the World Food Program (WFP), Title II Food for Peace and other sources, for PLWHA, particularly those on ART. Recipients will also receive nutritional education and be linked with support services to promote sustainable economic and health outcomes. 500 malnourished PLWHA will receive therapeutic feeding support and nutritional education and will be linked to economic support activities

The program will ensure care givers, PLWHA and OVC are linked to appropriate business development services, microfinance, vocational training, and other income generation activities. In particular, expanding income generating activities (IGA) will focus on encouraging the planned use and savings of generated income at a household level to help the affected families mitigate the impact of HIV/AIDS.

Continued Associated Activity Information

Activity ID: 5118
USG Agency: U.S. Agency for International Development
Prime Partner: World Relief Corporation
Mechanism: WR bilateral
Funding Source: GHAI
Planned Funds: $ 240,000.00

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

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.

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 (prior to 2007)

Cyangugu (prior to 2007)

Gisenyi (prior to 2007)

Kigali (Rurale) (prior to 2007)

Ruhengeri (prior to 2007)

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: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 8118
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007]
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.

Continued Associated Activity Information

Activity ID: 4767
USG Agency: U.S. Agency for International Development
Prime Partner: Family Health International
Mechanism: FHI Bridge

Funding Source: GHAI
Planned Funds: $ 384,000.00

Emphasis Areas

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

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	36	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	10,329	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)		☑

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Reducing violence and coercion

Food

Coverage Areas

Gicumbi

Muhanga

Nyamagabe

Karongi

Rubavu

Gasabo

Kicukiro

Nyarugenge

Table 3.3.06: 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: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 8139
Planned Funds: $ 0.00
Activity Narrative: Reprogramming 8/07: THis activity has been abandoned.

This activity relates to activities in HBHC (8188, 8716).

The overall goal of this activity is to build capacity to diagnose a multiplicity of OIs that occur among HIV-infected persons in Rwanda. OI diagnostic equipment will be purchased and laboratory space will be renovated in CHK, the largest public hospital in Rwanda.

OIs among PLWHA are caused by a variety of infectious agents necessitating disparate diagnostic modalities to enable selection of the correct therapeutic response. Unfortunately, the Rwandan health care system is broadly lacking in the kind of laboratory support required to identify responsible infectious agents, and must rely instead upon syndromic diagnosis of OIs, which can be completely inadequate. For example, an HIV-positive person who presents with a seizure might have any number of meningitis infections requiring different diagnostic and therapeutic approaches.

Planned activities under FY 2007 include purchasing bacterial culturing media and incubators, ELISA antigen detection kits, and tissue processing, sectioning and staining equipment. Funding will support two locally hired positions; a laboratory technician and a pathologist to work at CHK. Moreover, funding will provide additional training in the particular equipment upgrades.

This activity reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan by contributing to the expansion of palliative care provided to HIV/AIDS infected individuals. With new diagnostic knowledge pertaining to OIs and the necessary equipment needed for these diagnoses, the EP will work towards the goal of increasing human resource capacity for palliative care services.

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	0	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)		☑
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	0	☐

Table 3.3.06: Activities by Funding Mechanism

Mechanism: FANTA
Prime Partner: Academy for Educational Development
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 8141
Planned Funds: $ 0.00
Activity Narrative: This activity relates to activities in HBHC (7187, 7163, 7191, 8144, 8714, 8718, 7245, 7220, 7177), MTCT (7244, 8697), HVTB (7169), HKID (7148, 7155, 7156, 7186, 8148, 8150, 8152, 8727), HVCT (7242).

Malnutrition is a significant cause of infant morbidity and mortality in Rwanda. According to the 2005 RDHS-III, 45% of children under five have stunted growth associated with chronic malnutrition. HIV-exposed infants and HIV-positive children and adults are more at risk of malnutrition, due to greater energy requirements and frequent micronutrient deficiencies. Nutritional care for adult and children PLWHA is currently weak. Health facilities often delay referral of cases of moderate and severe malnutrition, do not consistently provide nutritional counseling to PLWHA, and require additional or refresher training in overall clinical evaluation of nutritional status of patients. To strengthen nutritional management at facilities, at the end of FY 2005 FANTA seconded a local nutritionist to provide TA to TRAC and the Nutrition Working Group for the development of nutritional guidelines and tools for medical practitioners to improve the nutritional management of PLWHA and exposed and infected infants and children. Guidelines and tools include nutritional assessment tools for nurses, job aids and a training curriculum for improved nutritional management for PLWHA and HIV-exposed and infected children. These will be tested and finalized by the end of FY 2006.

In FY 2007, FANTA will continue to support the scale-up of strengthened nutritional care services at all health facilities. This will include revision of training curriculum based on feedback from sites, and development of a training plan with TRAC and districts for decentralized training of districts and health facilities in nutrition counseling, clinical evaluation, and treatment for malnutrition. Training will emphasize management of moderate to severe malnutrition among HIV-positive adults and children, including timely referral to hospital-level care.

The FANTA advisor will lead the Food and Nutrition Working Group and will provide TA to the Care and Treatment Unit at TRAC to integrate relevant nutrition indicators into site-level reporting forms and to enter and analyze nutrition-related data for trends and program performance. The local advisor will be further supported by the BASICS IYCF advisor for TA and linkages to nutrition in the context of IYCF. In collaboration with BASICS, the FANTA advisor and TRAC will monitor and evaluate nutritional activities and, in collaboration with districts, conduct quarterly performance monitoring of health providers in nutritional management of PLWHA, HIV-exposed and infected infants and children, as well as management of children in therapeutic feeding centers. The FANTA advisor will also work closely with the PMTCT/VCT unit at TRAC and the MCH Unit of the MOH to ensure nutritional counseling and care is integrated into all PMTCT/MCH and CT activities, as well as with PNILT to integrate nutritional support for TB patients. In accordance with the new GOR directive to counsel and test children in nutritional centers, the FANTA advisor will work with the CT unit at TRAC to ensure that staff at all nutritional centers are trained in CT.

Funding under this activity will cover the costs of the advisor position as well as additional external TA costs from FANTA/AED HQ and one external nutrition-related workshop or conference. Costs for training activities; printing of curriculum, guidelines and tools; and costs of supervision visits will be included in the TRAC CoAg.

Emphasis Areas	% Of Effort
Food/Nutrition	10 - 50
Human Resources	51 - 100
Linkages with Other Sectors and Initiatives	10 - 50
Policy and Guidelines	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)		☑
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)		☑
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)		☑

Target Populations:

Community-based organizations
Doctors
Nurses
People living with HIV/AIDS
Policy makers
HIV positive pregnant women
Host country government workers
Other MOH staff (excluding NACP staff and health care workers described below)
Public health care workers
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas:

National

Table 3.3.06: Activities by Funding Mechanism

Mechanism: Transport Corridor Initiative
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 8142
Planned Funds: $ 100,000.00

Activity Narrative: This activity relates to activities under HVAB (7199), HVOP (7200), HVCT (7201), HKID (8727), and OHPS (8744).

The overall goal of the Regional Outreach Addressing AIDS through Development Strategies (ROADS) Project is to stem HIV transmission and mitigate the consequences of HIV/AIDS on vulnerable people along major East African transport corridors. This multi-sectoral project will target high-risk mobile populations including drivers and their assistants, CSWs, members of the uniformed services and stop-over site communities with regionally coordinated messages. It will also link these target populations with new or improved HIV/AIDS services and care tailored to meet their needs. Innovative elements of the ROADS SafeTStop model include essential HIV-related programming on alcohol, gender-based violence, food security and economic empowerment. The ROADS Project works in Kenya, Uganda, Djibouti, and the Southern Sudan and, in 2005, initiated activities in Rwanda, Burundi and the DRC.

Over the last year, the ROADS Project focused on three sites in Rwanda, one in Kigali and two at border sites (Gatuna on the Uganda border and Cyangugu on the DRC border). FHI launched the SafeTStop campaign in November 2005 with participation from the three major transport associations in Rwanda (truck drivers, mini-bus drivers and motorcycle taximen) as well as from the Association of Truckers' Wives, the CNLS and the Ministry of Labor. Since then, ROADS trained 132 peer educators from the associations who in turn reached over 3,400 individuals with ABC messages, information on STIs, and VCT referral. ROADS also completed an assessment on alcohol and HIV as part of a three-country study requested by the ECSA Ministers. Over the next few months, ROADS will finalize rapid assessments in all three sites to identify programming needs. ROADS will continue to train peer educators to convey HIV prevention messages including the risks associated with transgenerational sex and prevention for positives. The peer educators will be out-of-school youth, truck drivers, CSWs, and other community members. ROADS will also initiate mobile VCT services in partnership with PSI and other health facilities.

With FY 2007 funding, ROADS will continue to link and make referrals to existing OVC and PLWHA services in the communities. ROADS partners will also begin providing care and support services to vulnerable HIV-affected families in the three community sites. Working through local associations, women's groups and CBOs, ROADS will train 50 community members, truck drivers, pharmacists and counselors as peer educators to provide support to HIV-positive truck drivers and other HIV-positive individuals in the community. Approximately 1,500 PLWHA truck drivers and community members will be reached with counseling, referrals and information about positive living, nutrition, and ARV adherence. These PLWHA and their family members will also be offered a comprehensive menu of services including direct food assistance, health mutuelles membership, economic strengthening opportunities, psychosocial support and home-based care as needed.

The project will train 20 volunteers (teachers, community leaders, religious leaders, health workers) in adult learning to provide truck drivers, low-income women and out-of-school youth with skills and alternative activities in the evening. To enhance access to HIV care and support, the ROADS Project developed the LifeWorks Partnership, which creates jobs for marginalized, vulnerable people in East and Central Africa, including PLWHA, older orphans and low-income women. Through this partnership, ROADS attempts to support the long-term economic health of individuals, families and communities as a key HIV care and prevention strategy. To do this, ROADS has enlisted the private sector to: 1) identify small business opportunities for women and older orphans, including design and production of home and fashion accessories; 2) provide micro enterprise financing through development banks; 3) and give pro bono business expertise to help these new businesses grow. A key feature of LifeWorks is that nascent businesses not only provide jobs for the most at-risk people in a community but also that the companies themselves fight AIDS through their own corporate responsibility platforms.

ROADS addresses the key legislative issues of food, gender and stigma reduction. ROADS reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan by focusing prevention, care and treatment efforts on high-risk, mobile populations.

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, Quality Improvement and Supportive Supervision	10 - 50
Workplace Programs	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)		☑
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	1,500	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	50	☐

Target Populations:

Business community/private sector
Commercial sex workers
Community-based organizations
Discordant couples
Street youth
Truck drivers
Orphans and vulnerable children
Out-of-school youth
Partners/clients of CSW

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

North

Gicumbi

West

Rusizi

Kigali

Gasabo

Kicukiro

Table 3.3.06: Activities by Funding Mechanism

Mechanism: SCMS
Prime Partner: Partnership for Supply Chain Management
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 8716
Planned Funds: $ 1,620,000.00

Activity Narrative: This activity relates to HTXS (7213), HTXD (8170), HBHC (7187, 7177, 7165, 7160, 7163, 7191, 8144, 8718), HLAB (8189), OHPS (7218).

In FY 2006, the EP began its transition towards a consolidated approach for procurement of HIV-related commodities through the use of PFSCM and NRL as the primary procurement partners. In addition, the GOR is expanding the CPDS to include all HIV-related commodities, including OI drugs and diagnostics, test kits and CD4. During this transition year (FY 2006), PFSCM will support central-level quantification, procurement, storage and distribution systems in close collaboration with RPM+. RPM+ is leading the support to the CPDS, districts and sites.

In FY 2007, PFSCM will directly subcontract with CAMERWA for the procurement, storage and distribution of all HIV-related commodities, including laboratory. This consolidated approach to procurement will increase cost savings and improve efficiencies in procurement and distribution of commodities. In addition, PFSCM will take over the support to the CPDS to ensure smooth functioning of the CPDS system, quality data for quantification, and strong communication between sites, districts and CAMERWA. Partners will work in close collaboration through joint planning and workplan development, particularly for activities that support the LMIS and active distribution system.

This activity comprises three components: procurement of OI and preventive care drugs, TA, and procurement for HBC kits. For OI drug procurement, PFSCM will sub-contract with CAMERWA to procure, store and distribute OI drugs for 93,100 PLWHA at 175 USG-supported sites. Starting in FY 2006 and expanding in FY 2007, GFATM will cover membership to Rwanda's community-based health insurance scheme (Mutuelles) for a minimum of 100,000 PLWHA enrolled in care. USG funds through PFSCM will complement GFATM resources by covering the costs of drugs not included on the GFATM Mutuelles list, including preventive care drugs such as CTX, and more expensive OI drugs, such as Amphotericin B.

HIV and other diagnostic kits, reagents, supplies and equipment will be procured through PFSCM under HLAB.

PFSCM will also provide ongoing TA to CAMERWA and the CPDS for quantification, USG procurement regulations and for appropriate distribution of products to all sites. Product selection will also conform to GOR's minimum list of preventive care, OI and other palliative care medications, as well as to WHO standards for QA. PFSCM will support CAMERWA and the NRL to conduct quality assurance of OI medication arriving in country through Thin-Layer Chromotography (TLC) and use of mini-labs. As OI drugs will be integrated into the CPDS, PFSCM will provide TA and support to the relevant committees of the CPDS to develop a procurement and distribution plan for OI and palliative care drugs, to conduct quantification, monitor consumption patterns and stock levels, and to provide regular reports to donors.

In collaboration with RPM+, PFSCM will work closely with GFATM, MOH, CAMERWA, and districts to ensure the continuous availability and management of drugs covered by Mutuelles. This will be done through the use of a Mutuelles membership card and register, participation in the revision of Mutuelles policies and guidelines, and TA in collaboration with RPM+ to sites, district pharmacies and CAMERWA for monitoring, reporting and ordering essential medicines. PFSCM will review and revise the plan for M&E of HIV/AIDS pharmaceutical management, including any revision as necessary of pharmaceutical indicators related to consumption and use of OI drugs as well as ARVs and other HIV/AIDS-related commodities.

Finally, PFSCM will leverage donations for HBC kit contents and additional palliative care medications and supplies from CHAMP through CHAMP's cost-sharing agreement with DRI. PFSCM will procure drugs and supplies included in the nationally defined HBC kits on an as needed basis. PFSCM will also work with CHAMP, CAMERWA and the MOH to review and revise tools to support the storage, distribution, and tracking of HBC kits from CAMERWA to the community level.

This activity addresses the legislative area of wrap around through leveraging funds from the GFATM for membership coverage of PLWHA for the community-based health insurance

schemes. This will increase access to essential OI medicines for PLWHA. It also directly supports the Rwanda EP five-year strategy for ensuring sustainability by improving commodity forecasting, procurement procedures, storage and distribution, and information systems.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)		☑
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)		☑
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)		☑

Target Populations:

Country coordinating mechanisms
Doctors
Nurses
Pharmacists
International counterpart organizations
People living with HIV/AIDS
Policy makers
HIV positive pregnant women
Other MOH staff (excluding NACP staff and health care workers described below)
Laboratory workers
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Other

Coverage Areas:

National

Table 3.3.06: Activities by Funding Mechanism

Mechanism:	Refugees UNHCR
Prime Partner:	United Nations High Commissioner for Refugees
USG Agency:	Department of State / Population, Refugees, and Migration
Funding Source:	GHAI
Program Area:	Palliative Care: Basic Health Care and Support
Budget Code:	HBHC
Program Area Code:	06
Activity ID:	8718
Planned Funds:	$ 44,000.00

Activity Narrative: This activity relates to activities in MTCT (8696), HVAB (8700), HVOP (8711), HBHC (8716), HVTB (8670), HKID (8148, 8150, 8152), HVCT (8732), HTXS (7176, 8737, 8172), HLAB (8189).

Rwanda is host to almost 50,000 refugees in camps around the country. Refugee populations are considered to be at high risk of infectious disease, in particular HIV, as well as GBV and other forms of violence, and economic and psychological distress. While much is currently unknown about HIV prevalence rates in the camp populations in Rwanda, recent service statistics of newly implemented VCT and PMTCT programs in two camps record a prevalence rate around 5% among those tested, with at least 200 individuals currently known to be living with HIV. Since 2005, the EP has supported UNHCR implementing partners AHA and ARC to provide HIV prevention and care services in Kiziba, Gihembe and Nyabiheke refugee camps with linkages and referrals for treatment.

FY 2007 funding for this activity will support the provision and expansion of palliative care services to 480 PLWHA and the training of 120 health providers, laboratory technicians, and community volunteers in Kiziba, Gihembe, and Nyabiheke refugee camp health clinics and communities. The basic care package will include a full range of adult and pediatric preventive care services, clinical care, psychological, spiritual and social support services, including CTX prophylaxis for eligible adults and exposed infants in line with national guidelines, prevention counseling for positives, and strengthened nutritional services, including nutritional assessment according to anthropometric measures, nutrition counseling, and management of malnutrition through provision of micronutrients and multivitamin supplements and leveraging of food from GLIA and Title II partners for clinically-eligible malnourished PLWHA (particularly for pregnant and lactating women and exposed and infected infants).

UNHCR partners will ensure the provision of, or referrals for diagnosis and treatment of OIs and other HIV-related illnesses (including TB), routine clinical staging and systematic CD4 testing, medical records for all HIV-positive patients and infants, and referrals to community-based psychosocial and palliative care services. Infants born to HIV-positive mothers will be provided CTX, early infant diagnosis through PCR, and ongoing clinical monitoring and staging for ART.

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

PFSCM will procure and distribute through CAMERWA all palliative care and OI drugs, laboratory supplies and diagnostic kits. UNHCR partners will work with PFSCM, RPM+ and the districts to ensure appropriate storage, management and tracking of commodities, including renovation of pharmacy units at the health centers for adequate ventilation and security.

UNHCR partners will continue to support the continuum of care through the establishment of referral and tracking systems for comprehensive basic care and support services for PLWHA. Partners will strengthen linkages between palliative care and PMTCT, CT, OVC, TB and ART services, and will continue to work with the respective district hospitals to ensure an ongoing system of referral and care between the camps and other HIV care and support services, such as transport of blood specimen for CD4 and PCR testing, management of complicated OIs, and periodic monitoring of ART patients. UNHCR partners 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. UNHCR partners

will work with GLIA to ensure provision of, 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 and child-headed households affected by HIV/AIDS.

UNHCR will provide technical support and monitoring of IP activities and data collection, and ensure appropriate reporting through the hiring of an HIV/AIDS technical and program manager.

This activity addresses the key legislative areas of gender through reduction of GBV and support for women confronted with GBV as well as increasing women's access to income generating activities; wrap around through Title II food and GLIA-supported microfinance activities, and stigma and discrimination through increased community participation in the care and support of PLWHA.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Food/Nutrition	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	3	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	480	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	120	☐

Target Populations:

Community leaders
Community-based organizations
Nurses
HIV/AIDS-affected families
Refugees/internally displaced persons
People living with HIV/AIDS
Laboratory staff
HIV positive pregnant women
Caregivers (of OVC and PLWHAs)
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Increasing women's access to income and productive resources

Increasing women's legal rights

Stigma and discrimination

Wrap Arounds

Food

Microfinance/Microcredit

Coverage Areas

Byumba (prior to 2007)

Kibuye (prior to 2007)

Umutara (Mutara) (prior to 2007)

Gicumbi

Gatsibo

Karongi

Table 3.3.06: Activities by Funding Mechanism

Mechanism: Tulane bilateral
Prime Partner: Tulane University
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 9214
Planned Funds: $ 50,000.00
Activity Narrative: This activity relates to OHPS (7249) and HVSI (8175).

This activity is a public health evaluation, with methods described in further detail in an attached PHE backsheet. The overall goal of this evaluation is to improve palliative care services by determining what model of case management is best adapted to the Rwandan context. The USG has funded four distinct models of case management through Columbia, CRS, CARE, and IntraHealth Capacity in FY 2004, FY 2005 and FY 2006 to advance EP goals of creating a continuum of care. However, it is unclear which of these models will be both affordable and viable as an option for the national program. Within the Rwandan context, case management appears to be viewed as an initiative that is unsustainable in a resource-constrained setting, but no data exists to support this hypothesis. However, literature from other countries suggests that a case management model can both advance positive health outcomes for PLWHAs and be affordable. Consequently, this evaluation is necessary to advance data driven decisions for the USG Rwanda team and to advance the EP palliative care strategy on establishing a strong continuum of care from the point of diagnosis. The evaluation will assess the value added of a case management system in the care and treatment of PLWHAs using a prospective study at a defined number of sites with case management that will be matched with similar sites without case management. The evaluation will compare basic health outcomes and unmet needs between all sites and calculate per patient costs at sites where a case management system exists. In addition, as part of this evaluation, different models of case management will be costed out on a per patient basis. Overall, this activity will improve palliative care services and the direct output will be documentation on the effectiveness of case management in producing positive health outcomes and reducing unmet needs among HIV-positive persons.

This activity reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan by advancing the quality of HIV services and strengthening the continuum of care for PLWHAs.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Health Care Financing	10 - 50

Target Populations:

HIV/AIDS-affected families
Orphans and vulnerable children
People living with HIV/AIDS
USG in-country staff
Caregivers (of OVC and PLWHAs)
Host country government workers
Public health care workers
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Coverage Areas:

National

Table 3.3.06: 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: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 9637
Planned Funds: $ 0.00

Activity Narrative: Reprogramming 8/07: This activity has been abandoned.

This activity relates to activities in HBHC (8716, 8139).

The overall goal of this activity is to screen 3,000 HIV-positive women for cervical cancer and treat women found to have treatable lesions.

Cervical cancer, caused by the human papilloma virus (HPV), is the most common cancer among women throughout the developing world. HIV infection, especially in the later stages of immune dysfunction, has been shown to enhance the neoplastic effects of HPV, thereby increasing the incidence and progression of low- and high-grade cervical cytologic lesions. Prevention, detection and treatment of cervical cancer are therefore especially important for HIV-positive women.

In the US and Europe, screening for and treatment of cervical cancer is a basic standard of care for HIV-positive women. However, such care is generally absent for HIV-positive women in developing countries, principally for lack of capacity to collect and evaluate large numbers of pap smears. The incidence of cervical cancer in Rwanda is unknown; however, as in many other places in Sub-Saharan Africa, it is presumed to be many-fold higher than in the US or Europe, particularly among HIV-positive women.

Over the past 20 years, a growing body of literature has accrued regarding a new approach: Visual Inspection with Acetic acid (VIA or "see-and-treat") as an effective strategy for cervical cancer control in the developing world. Pap smears are eliminated from the diagnostic protocol and replaced with direct observation of the cervix (image-enhanced with dilute acetic acid) and immediate treatment of any visualized lesions. When suspicious lesions are found, simple, low-cost cryotherapy equipment is used to ablate the lesion while retaining full potential fertility. VIA is easier to use, can easily be taught to most medical personnel including nurses and midwives, and can be performed without complex and expensive equipment.

In FY 2007, Columbia will provide cervical screening by VIA and cryotherapy for 3,000 HIV-positive women over 35 years of age. They will be treated at CHK and at the National University Hospital of Butare. Women with lesions not amenable to treatment with cryotherapy will be provided with colposcopy, LEEP, and biopsy. Based on extrapolation from the prevalence of neoplastic changes previously found in VIA activities in Rwanda, 35-40% of the HIV-positive women are expected to have detectable lesions. In a subset of the HIV-positive women, we will also collect conventional pap smears, and pre-ablation biopsies will be performed on women with colposcopic findings, making it possible to assess the positive and negative predictive value of VIA in this population. Cytopathology and histopathology will be performed both locally and with a US partner so as to build local capacity through training of Rwandan diagnostic personnel (pathologists and cytotechnicians). Also included will be on-site training for Rwandan physicians, both generalists and gynecologists, to perform colposcopy and LEEP for the estimated 6% of women who require it.

This activity reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan by contributing to the expansion of palliative care among those currently under treatment. Such preventative services that are offered by this activity will have significant implications on improved overall health of PLWHAs and will increase the capacity for facilities to offer effective palliative care.

While this effort to treat women with cervical cancer will result in new data about the frequency of treatable cervical lesions in HIV-positive women and the feasibility of including such care within PEPFAR, the activity is not primarily proposed as a public health evaluation. There is ample evidence in the medical literature to clinically justify regular screening for Rwandan women with HIV. Nevertheless, in recognition of the fact that generalizable knowledge will be gained in the course of providing care to women who need it, a Technical Evaluation backsheet will be submitted for this activity as well as a detailed protocol for IRB review in accordance with standard procedures.

This activity supports EP plan for basic care and support and will inform national HIV program on the burden of cervical cancer among HIV positive women and treatment

effectiveness.

Emphasis Areas	% Of Effort
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	0	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	0	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	0	☐

Target Populations:

Pregnant women

Women (including women of reproductive age)

HIV positive pregnant women

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Coverage Areas:

National

Table 3.3.06: Activities by Funding Mechanism

Mechanism:	FHI New Bilateral
Prime Partner:	Family Health International
USG Agency:	U.S. Agency for International Development
Funding Source:	GHAI
Program Area:	Palliative Care: Basic Health Care and Support
Budget Code:	HBHC
Program Area Code:	06
Activity ID:	15225
Planned Funds:	$ 225,867.00

Activity Narrative: This activity relates to activities in HBHC (7187, 7220, 7245, 8716, 9637, 7163, 7165, 8141, 8716), MTCT (8698), HVAB (8129), HVOP (8137), HVTB (8147), HVCT (8168), HTXS (8172, 7213), HLAB (8189). In FY 2006, USAID clinical partners provided basic palliative care to 22,779 PLWHA at 100 sites. The package includes clinical staging and baseline CD4 count for all patients, follow-up CD4 every six months, management of OIs and other HIV-related illnesses, including OI diagnosis and treatment, and routine provision of CTX prophylaxis for eligible adults, children and exposed infants based on national guidelines, basic nutritional counseling and support, positive living and risk reduction counseling, pain and symptom management, and end-of-life care. In addition, USAID partners provide psychosocial counseling including counseling and referrals for HIV-positive female victims of domestic violence.

To ensure a comprehensive package of care across a continuum, USAID partners, through the partnership with CHAMP and other community services providers, refer patients enrolled in care to community-based palliative care services based on their individual need, including adherence counseling, spiritual support, stigma reducing activities, OVC support, IGA activities, and HBC services for end-of-life care. In FY 2007, USAID will issue an RFA which awarded a cooperative agreement to FHI to provide an expanded package of services at 43 sites.

FHI will expand services with an emphasis on quality services and continuum of care through operational partnerships, and sustainability of services through PBF. Under this expanded package, FHI will provide a full range of adult and pediatric preventive care, clinical care, psychological support, spiritual and legal support services across a continuum of care, including provision of CTX prophylaxis for PLWHA and exposed infants in line with national guidelines, strengthened nutritional services through training and provision of nutritional care, including counseling, nutritional assessments using anthropometric indicators, and management of malnutrition through provision of micronutrient and multivitamin supplements, and links to Title II food support for clinically eligible PLWHA and children in line national nutrition guidelines.

FHI will also support referrals for 23,000 PLWHA and their families for malaria prevention services, including for the provision of ITNs, in collaboration with CHAMP, GFATM and PMI; and referral of PLWHA and their families to CHAMP CBOs and other community-service providers for distribution of water purification kits and health education on hygiene. In addition, in collaboration with TRAC and CHAMP, FHI will ensure the provision of strengthened psychological and spiritual support services for PLWHA at clinic and community levels through expanded TRAC training in psychological support for all FHI-supported health facilities and community-based providers, including GBV counseling, positive living, and counseling on prevention for positives. FHI will provide referrals for routine CD4, the prevention, diagnosis and treatment of OIs, and ongoing follow-up care for all PMTCT, VCT, TB and ART clients through strengthened linkages and referral systems between these services at clinic level.

Through PFSCM, FHI will provide diagnostic kits, CD4 tests, and other exams for clinical monitoring, and will work with PFSCM for the appropriate storage, stock management, and reporting of all OI-related commodities. In order to ensure continuum of HIV care, FHI, in collaboration with CHAMP, will recruit case managers at each of the supported sites. These case managers with training in HIV patient follow-up will ensure the proper referral of patients through the different services within the health system and the community. FHI-supported sites will assess individual PLWHA needs, organize monthly clinic-wide case management meetings to minimize follow-up losses of patients, and provide direct oversight of community volunteers. In addition, these case managers will train 243 community volunteers and provide them with necessary tools to provide services to patients in the community. The community volunteers will be motivated through community PBF based on the number of patients they assist and quality of services provided.

FHI will work with CHAMP to develop effective referral systems between clinical care providers and psycho-social and livelihood support services, through the use of patient routing slips for referrals and counter referrals from community to facilities and vice versa. Depending on the needs of individuals and families, health facilities will refer PLWHA to community-based HBC services, adherence counseling, spiritual support through

church-based programs, stigma reducing activities, CHAMP-funded OVC support, IGA activities, particularly for PLWHA female- and child-headed households, legal support services, and community-based pain management and end-of-life care in line with national palliative care guidelines. Increasing pediatric patient enrollment is a major priority for all USG clinical partners in FY 2007. Case managers will ensure referrals to care services for pediatric patients identified through PMTCT programs, PLWHA associations, malnutrition centers, and OVC programs.

To do this, the case managers will have planning sessions with facilities and community-based service providers, and OVC services providers for more efficient use of patient referrals slips to ensure timely enrollment in care and treatment for children diagnosed with HIV/AIDS. In addition, adult patients enrolled in care will be encouraged to have their children tested and positive ones taken to HIV care and treatment sites. To expand quality pediatric care, Rwanda's few available pediatricians will train other clinical providers, using the model developed in FY 2006 and continuing in FY 2007. FHI will support health facilities to refer HIV-positive children to OVC programming for access to education, medical, social and legal services. FHI will also support sites to identify and support women who may be vulnerable when disclosing their status to their partner, and include in counseling the role of alcohol in contributing to high-risk behaviors. In the context of decentralization, DHTs now play a critical role in the oversight and management of clinical and community service delivery.

FHI will strengthen the capacity of five DHTs to coordinate an effective network of palliative care and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities. PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, FHI will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of palliative care and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool. This activity addresses the key legislative areas of gender, wrap around for food, microfinance and other activities, and stigma and discrimination through increased community participation in care and support of PLWHA.

Emphasis Areas	**% Of Effort**
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	51 - 100
Linkages with Other Sectors and Initiatives	10 - 50
Policy and Guidelines	10 - 50
Training	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	43	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	23,000	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	243	☐

Target Populations:

Country coordinating mechanisms
Faith-based organizations
Doctors
Nurses
Traditional birth attendants
HIV/AIDS-affected families
People living with HIV/AIDS
Prisoners
Other MOH staff (excluding NACP staff and health care workers described below)
Laboratory workers
HIV positive children (5 - 14 years)

Key Legislative Issues

Gender

Stigma and discrimination

Wrap Arounds

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Table 3.3.06: Activities by Funding Mechanism

Mechanism: EGPAF New Bilateral
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 15226
Planned Funds: $ 90,000.00

Activity Narrative: This activity relates to activities in HBHC (7187, 7220, 7245, 8716, 9637, 7163, 7165, 8141, 8716), MTCT (8698), HVAB (8129), HVOP (8137), HVTB (8147), HVCT (8168), HTXS (8172, 7213), HLAB (8189). In FY 2006, USAID clinical partners provided basic palliative care to 22,779 PLWHA at 100 sites. The package includes clinical staging and baseline CD4 count for all patients, follow-up CD4 every six months, management of OIs and other HIV-related illnesses, including OI diagnosis and treatment, and routine provision of CTX prophylaxis for eligible adults, children and exposed infants based on national guidelines, basic nutritional counseling and support, positive living and risk reduction counseling, pain and symptom management, and end-of-life care. In addition, USAID partners provide psychosocial counseling including counseling and referrals for HIV-positive female victims of domestic violence.

To ensure a comprehensive package of care across a continuum, USAID partners, through the partnership with CHAMP and other community services providers, refer patients enrolled in care to community-based palliative care services based on their individual need, including adherence counseling, spiritual support, stigma reducing activities, OVC support, IGA activities, and HBC services for end-of-life care. In FY 2007, USAID will issue an RFA which awarded a cooperative agreement to EGPAF to provide an expanded package of services at 26 sites. EGPAF will expand services with an emphasis on quality services and continuum of care through operational partnerships, and sustainability of services through PBF.

Under this expanded package, EGPAF will provide a full range of adult and pediatric preventive care, clinical care, psychological support, spiritual and legal support services across a continuum of care, including provision of CTX prophylaxis for PLWHA and exposed infants in line with national guidelines, strengthened nutritional services through training and provision of nutritional care, including counseling, nutritional assessments using anthropometric indicators, and management of malnutrition through provision of micronutrient and multivitamin supplements, and links to Title II food support for clinically eligible PLWHA and children in line national nutrition guidelines. EGPAF will also support referrals for 10,000 PLWHA and their families for malaria prevention services, including for the provision of ITNs, in collaboration with CHAMP, GFATM and PMI; and referral of PLWHA and their families to CHAMP CBOs and other community-service providers for distribution of water purification kits and health education on hygiene.

In addition, in collaboration with TRAC and CHAMP, EGPAF will ensure the provision of strengthened psychological and spiritual support services for PLWHA at clinic and community levels through expanded TRAC training in psychological support for all EGPAF-supported health facilities and community-based providers, including GBV counseling, positive living, and counseling on prevention for positives. EGPAF will provide referrals for routine CD4, the prevention, diagnosis and treatment of OIs, and ongoing follow-up care for all PMTCT, VCT, TB and ART clients through strengthened linkages and referral systems between these services at clinic level. Through PFSCM, EGPAF will provide diagnostic kits, CD4 tests, and other exams for clinical monitoring, and will work with PFSCM for the appropriate storage, stock management, and reporting of all OI-related commodities. In order to ensure continuum of HIV care, EGPAF, in collaboration with CHAMP, will recruit case managers at each of the supported sites.

These case managers with training in HIV patient follow-up will ensure the proper referral of patients through the different services within the health system and the community. EGPAF-supported sites will assess individual PLWHA needs, organize monthly clinic-wide case management meetings to minimize follow-up losses of patients, and provide direct oversight of community volunteers. In addition, these case managers will train 276 community volunteers and provide them with necessary tools to provide services to patients in the community. The community volunteers will be motivated through community PBF based on the number of patients they assist and quality of services provided. EGPAF will work with CHAMP to develop effective referral systems between clinical care providers and psycho-social and livelihood support services, through the use of patient routing slips for referrals and counter referrals from community to facilities and vice versa.

Depending on the needs of individuals and families, health facilities will refer PLWHA to community-based HBC services, adherence counseling, spiritual support through

church-based programs, stigma reducing activities, CHAMP-funded OVC support, IGA activities, particularly for PLWHA female- and child-headed households, legal support services, and community-based pain management and end-of-life care in line with national palliative care guidelines. Increasing pediatric patient enrollment is a major priority for all USG clinical partners in FY 2007. Case managers will ensure referrals to care services for pediatric patients identified through PMTCT programs, PLWHA associations, malnutrition centers, and OVC programs. To do this, the case managers will have planning sessions with facilities and community-based service providers, and OVC services providers for more efficient use of patient referrals slips to ensure timely enrollment in care and treatment for children diagnosed with HIV/AIDS. In addition, adult patients enrolled in care will be encouraged to have their children tested and positive ones taken to HIV care and treatment sites.

To expand quality pediatric care, Rwanda's few available pediatricians will train other clinical providers, using the model developed in FY 2006 and continuing in FY 2007. EGPAF will support health facilities to refer HIV-positive children to OVC programming for access to education, medical, social and legal services. EGPAF will also support sites to identify and support women who may be vulnerable when disclosing their status to their partner, and include in counseling the role of alcohol in contributing to high-risk behaviors. In the context of decentralization, DHTs now play a critical role in the oversight and management of clinical and community service delivery. EGPAF will strengthen the capacity of five DHTs to coordinate an effective network of palliative care and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities. PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services.

In coordination with the HIV PBF project, EGPAF will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of palliative care and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool. This activity addresses the key legislative areas of gender, wrap around for food, microfinance and other activities, and stigma and discrimination through increased community participation in care and support of PLWHA.

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

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	26	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	10,000	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	276	☐

Target Populations:

Community-based organizations
Faith-based organizations
Doctors
Nurses
Traditional birth attendants
HIV/AIDS-affected families
People living with HIV/AIDS
Prisoners
Volunteers
Other MOH staff (excluding NACP staff and health care workers described below)
Laboratory workers
HIV positive children (5 - 14 years)

Key Legislative Issues

Gender

Stigma and discrimination

Wrap Arounds

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Table 3.3.06: Activities by Funding Mechanism

Mechanism:	IntraHealth New Bilateral
Prime Partner:	IntraHealth International, Inc
USG Agency:	U.S. Agency for International Development
Funding Source:	GHAI
Program Area:	Palliative Care: Basic Health Care and Support
Budget Code:	HBHC
Program Area Code:	06
Activity ID:	15227
Planned Funds:	$ 109,534.00

Activity Narrative: This activity relates to activities in HBHC (7187, 7220, 7245, 8716, 9637, 7163, 7165, 8141, 8716), MTCT (8698), HVAB (8129), HVOP (8137), HVTB (8147), HVCT (8168), HTXS (8172, 7213), HLAB (8189). In FY 2006, USAID clinical partners provided basic palliative care to 22,779 PLWHA at 100 sites. The package includes clinical staging and baseline CD4 count for all patients, follow-up CD4 every six months, management of OIs and other HIV-related illnesses, including OI diagnosis and treatment, and routine provision of CTX prophylaxis for eligible adults, children and exposed infants based on national guidelines, basic nutritional counseling and support, positive living and risk reduction counseling, pain and symptom management, and end-of-life care. In addition, USAID partners provide psychosocial counseling including counseling and referrals for HIV-positive female victims of domestic violence.

To ensure a comprehensive package of care across a continuum, USAID partners, through the partnership with CHAMP and other community services providers, refer patients enrolled in care to community-based palliative care services based on their individual need, including adherence counseling, spiritual support, stigma reducing activities, OVC support, IGA activities, and HBC services for end-of-life care. In FY 2007, USAID awarded three coooperative agreement -one to IntraHealth - to provide an expanded package of services at 36 sites. IntraHealth will expand services with an emphasis on quality services and continuum of care through operational partnerships, and sustainability of services through PBF. Under this expanded package, IntraHealth will provide a full range of adult and pediatric preventive care, clinical care, psychological support, spiritual and legal support services across a continuum of care, including provision of CTX prophylaxis for PLWHA and exposed infants in line with national guidelines, strengthened nutritional services through training and provision of nutritional care, including counseling, nutritional assessments using anthropometric indicators, and management of malnutrition through provision of micronutrient and multivitamin supplements, and links to Title II food support for clinically eligible PLWHA and children in line national nutrition guidelines. IntraHealth will also support referrals for 11,890 PLWHA and their families for malaria prevention services, including for the provision of ITNs, in collaboration with CHAMP, GFATM and PMI; and referral of PLWHA and their families to CHAMP CBOs and other community-service providers for distribution of water purification kits and health education on hygiene. In addition, in collaboration with TRAC and CHAMP, IntraHealth will ensure the provision of strengthened psychological and spiritual support services for PLWHA at clinic and community levels through expanded TRAC training in psychological support for all IntraHealth-supported health facilities and community-based providers, including GBV counseling, positive living, and counseling on prevention for positives.

IntraHealth will provide referrals for routine CD4, the prevention, diagnosis and treatment of OIs, and ongoing follow-up care for all PMTCT, VCT, TB and ART clients through strengthened linkages and referral systems between these services at clinic level. Through PFSCM, IntraHealth will provide diagnostic kits, CD4 tests, and other exams for clinical monitoring, and will work with PFSCM for the appropriate storage, stock management, and reporting of all OI-related commodities. In order to ensure continuum of HIV care, IntraHealth, in collaboration with CHAMP, will recruit case managers at each of the supported sites. These case managers with training in HIV patient follow-up will ensure the proper referral of patients through the different services within the health system and the community. IntraHealth-supported sites will assess individual PLWHA needs, organize monthly clinic-wide case management meetings to minimize follow-up losses of patients, and provide direct oversight of community volunteers. In addition, these case managers will train 216 community volunteers and provide them with necessary tools to provide services to patients in the community.

The community volunteers will be motivated through community PBF based on the number of patients they assist and quality of services provided. IntraHealth will work with CHAMP to develop effective referral systems between clinical care providers and psycho-social and livelihood support services, through the use of patient routing slips for referrals and counter referrals from community to facilities and vice versa. Depending on the needs of individuals and families, health facilities will refer PLWHA to community-based HBC services, adherence counseling, spiritual support through church-based programs, stigma reducing activities, CHAMP-funded OVC support, IGA activities, particularly for PLWHA female- and child-headed households, legal support services, and community-based pain management and end-of-life care in line with national

palliative care guidelines. Increasing pediatric patient enrollment is a major priority for all USG clinical partners in FY 2007. Case managers will ensure referrals to care services for pediatric patients identified through PMTCT programs, PLWHA associations, malnutrition centers, and OVC programs.

To do this, the case managers will have planning sessions with facilities and community-based service providers, and OVC services providers for more efficient use of patient referrals slips to ensure timely enrollment in care and treatment for children diagnosed with HIV/AIDS. In addition, adult patients enrolled in care will be encouraged to have their children tested and positive ones taken to HIV care and treatment sites. To expand quality pediatric care, Rwanda's few available pediatricians will train other clinical providers, using the model developed in FY 2006 and continuing in FY 2007. IntraHealth will support health facilities to refer HIV-positive children to OVC programming for access to education, medical, social and legal services. IntraHealth will also support sites to identify and support women who may be vulnerable when disclosing their status to their partner, and include in counseling the role of alcohol in contributing to high-risk behaviors. In the context of decentralization, DHTs now play a critical role in the oversight and management of clinical and community service delivery.

IntraHealth will strengthen the capacity of four DHTs to coordinate an effective network of palliative care and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities. PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, IntraHealth will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of palliative care and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool.

This activity addresses the key legislative areas of gender, wrap around for food, microfinance and other activities, and stigma and discrimination through increased community participation in care and support of PLWHA.

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

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing HIV-related palliative care supported with performance-base financing		☑
Total number of service outlets providing HIV-related palliative care (excluding TB/HIV)	36	☐
Total number of individuals provided with HIV-related palliative care (excluding TB/HIV)	11,890	☐
Total number of individuals trained to provide HIV-related palliative care (excluding TB/HIV)	216	☐

Target Populations:

Community-based organizations
Faith-based organizations
Doctors
Nurses
Traditional birth attendants
HIV/AIDS-affected families
People living with HIV/AIDS
Prisoners
Other MOH staff (excluding NACP staff and health care workers described below)
Laboratory workers
HIV positive children (5 - 14 years)

Key Legislative Issues

Gender

Stigma and discrimination

Wrap Arounds

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Table 3.3.06: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Abt Associates
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 19254
Planned Funds: $ 400,000.00
Activity Narrative: n/a

Table 3.3.06: Activities by Funding Mechanism

Mechanism: N/A
Prime Partner: Land O'Lakes
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Palliative Care: Basic Health Care and Support
Budget Code: HBHC
Program Area Code: 06
Activity ID: 19255
Planned Funds: $ 500,000.00
Activity Narrative: n/a

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: $ 4,963,448.00

Program Area Context:

In 2004, WHO estimated the TB incidence in Rwanda to be 371/100,000 including 160/100,000 new smear-positive TB cases. This represents a 270% increase over the past 14 years - much of which has been fueled by the HIV epidemic. The DOTS strategy for TB control has been implemented in Rwanda since 1990 through the national TB program and Rwanda has 100% DOTS coverage in health facilities. The GOR has made TB/HIV a priority with support from EP, WHO and GFATM. In 2005 and 2006, a national policy on TB/HIV collaborative activities, implementation guidelines and standardized TB/HIV reporting were established. Key donors to PNILT include the USG, GFATM (Round 4), Damien Foundation, and WHO.

The most recent UNAIDS report on the HIV epidemic estimates that 3.1% of adult Rwandans are now living with HIV/AIDS. HIV infection is the single greatest risk factor for developing active TB disease with an annual risk of 5-10%. With EP support, PNILT implemented national TB/HIV reporting and surveillance. In 2005 and the first 2 quarters of 2006, 46-48% of TB patients were reported to also be HIV-positive. GOR estimates that there are 2000-3000 HIV-positive TB patients per year who are eligible for ART. USG efforts are consistent with the GOR and the WHO TB/HIV Framework which highlights the need for integrated programming, decreasing the burden of TB among PLWHA and increasing the availability of HIV care for TB patients. Reaching EP targets requires further expansion of the four core activities emphasized for TB/HIV programming: routine HIV testing of all TB patients; provision of care and treatment to all HIV-positive TB patients; screening all HIV-positive patients for active TB disease; linking all HIV-positive TB suspects to TB diagnosis and DOTS therapy.

EP assistance to TB/HIV control has included technical and financial support, assistance with national implementation guidelines, and training health care workers. In 2005 and 2006, the EP supported national coordination through a long-term TB/HIV technical advisor and program coordinators at PNILT and TRAC. With this assistance a national TB/HIV integration working group was established and continues to meet quarterly. The PNILT technical manual has been revised to include a chapter on TB/HIV, the TB register was revised to include HIV information and national reporting has been standardized and implemented at TB services sites. A baseline evaluation conducted in 2005 showed that approximately 48% of a sample of 438 TB patients registered for treatment at 23 geographically representative sites had a known HIV status, and that HIV-positive patients had a 6-fold increase in mortality compared to those that were HIV-negative. Ninety-six percent of TB patients reported acceptance of HIV-testing, if offered. The evaluation also showed that little information has been collected regarding HIV-positive TB patients' access to HIV care and treatment. These results have been used to modify national guidelines to promote TB/HIV activities. Early implementation of the national TB/HIV policy and guidelines has led to a reported national increase in HIV-testing of TB patients from 46% in 2004 to 77% by the second quarter of 2006. Moreover, in the second quarter of 2006, 43% of HIV-positive TB patients had documented access to cotrimoxazole prophylaxis and 30% were on ART.

In 2006, implementation of the national guidelines to screen all PLWHA for TB began at USG-supported sites. From January to June 2006, of 8,738 PLWHA enrolled in HIV care at 34 USG-supported health facilities, 2,830 (32%) were screened for TB. Of those screened, 174 (6%) were diagnosed with active TB and were started on TB treatment. A standardized paper-based ARV HIV register is being finalized and includes data on routine TB screening of PLWHA.

Despite significant progress, GOR, EP and WHO have identified numerous challenges that exist in integrating, coordinating and expanding services. These challenges include the need for sustained political commitment to support TB/HIV collaborative activities between programs at all levels, implementation of PIT, access to cotrimoxazole prophylaxis at all TB services sites, ensuring effective referral systems between programs for treatment, accurate recording and reporting of cases, effective supervision and review of program results. In FY 2007, the EP will continue to address these challenges by supporting

national-level coordination and program supervision through two national TB/HIV technical advisors and program coordinators at PNILT and TRAC. The EP will also expand a best practice model of integrating TB/HIV activities piloted in FY 2006 to 136 other USG-supported sites. A key element of the success of these efforts will be improving the diagnosis of TB among PLWHA by expanding intensified TB case finding at all HIV care and treatment sites, including implementing routine strategies for screening HIV-positive children for TB. In FY 2007, all PLWHA in care at USG-supported sites will be screened for TB and the 2,200 expected TB patients will be provided with cotrimoxazole and ART as appropriate. Conversely, all TB patients to be registered at USG supported sites will be offered HIV testing and those patients who test positive will be provided with a full package of HIV services including cotrimoxazole, palliative care and ART if needed.

The EP will also improve national TB diagnostic capacity by augmenting the pathology laboratory at CHK and the University of Rwanda National Pathology Laboratory. Activities will include recruitment and training laboratory staff and doctors on lymph node specimen preparation and diagnosis. Given the threat of MDR TB and new strains of XDR TB, the EP will also place an emphasis on implementing infection control guidelines at 27 hospitals in 22 districts to reduce and prevent TB transmission among PLWHA. The EP will continue to promote the integration of TB/HIV care into core programs, and continue efforts to improve the standard of care provided by EP partners, particularly those in HIV care and treatment, PMTCT, family-centered VCT and community programs. In addition, the EP will expand TB/HIV collaborative activities and services to 11 of Rwanda's 19 prisons.

The program will continue to support TB/HIV surveillance which yields valuable data for monitoring and program management. A web-based standard electronic TB register will be adapted for use in Rwanda based on the South African electronic TB register model. Program data will be used to benchmark quality at the district level and coordinated supportive supervisions will be used to reach quality and program targets.

The EP plan will continue collaboration with GFATM and will leverage USG resources going directly to WHO to scale-up TB/HIV activities. In addition, the EP will promote sustainability through performance-based financing and improve TB/HIV program quality through improved program data recording and use at USG and non-USG sites.

Program Area Target:

Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting	137
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	3,500
Number of HIV-infected clients given TB preventive therapy	0
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)	500

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: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 7162
Planned Funds: $ 797,173.00

Activity Narrative: Reprogramming 8/07: With these new funds AIDSRelief will recruit an international expert in TB.HIV to work with HIV and TB program for review and adaptation of guidelines, tools and job aids for integration TB.HIV at facility level. The expert will work with the two programs to conduct joint supervision at dsitrict level and support district health teams to conduct TB.HIV supervsiion at health center level. The expert will ensure that PEPFAR clinical partners provide appropriate support to health facilities in training, financial and human ressources to enable them to integrate TB and HIV activities. In addition AIDSRelief expert will coordinate with CDC laboratory advisor and USG HIV community services provider CHAMP project to integrate lab and clinical and community-based TB.HIV activities. In addition AIDSRelief will recuit local TB.HIV supervisors and provide them with transportation for national TB.HIV supervision. AIDSRelief will use part of these funds to provide training to TB services providers for lymphnode specimen preparation and routing to pathology laboratory as well as TA to laboratory to process those specimen. This activity will improve TB.HIV integration at facility, community and laboratory levels.

This activity relates to activities in HTXS (7158), HVCT (8164) and HBHC (7160).

In FY 2006 CRS started implementing national TB/HIV policy and guidelines at their eight supported sites. The program's achievements include an improvement in the percentage of TB patients screened for HIV from less than 50% to 70%. In addition, at CRS-supported sites, 60% of 6,535 patients enrolled in HIV care were screened for TB. All suspected TB cases among PLWHA are screened and referred for TB DOTS, cotrimoxazole prophylaxis, and ART, as appropriate.

In FY 2007 CRS will continue to support eight existing sites and add three new sites for the implementation of the TB/HIV component of the clinical package of HIV care. This activity has eight components.

This activity has eight components: the first component is to implement routine provider-initiated HIV testing to an estimated 300 TB patients at USG-supported sites. HIV testing will be conducted at sites providing TB services. The second component is to provide cotrimoxazole prophylaxis to all HIV-positive TB patients and ensure referral to HIV care and treatment services. The third component is the implementation of intensified TB case-finding among 10,200 PLWHA enrolled in care and treatment at USG-supported sites through routine TB screening using the national standardized questionnaire. The fourth component is to ensure timely TB diagnosis and treatment via DOTS to an estimated 400 PLWHA diagnosed with TB disease. The fifth component is the routine collection, recording, and reviewing of standard national TB/HIV program indicators at sites to inform and improve services. This data will also be routinely reported to the district and national levels through TRAC and PNILT. The sixth component of this activity is to support training of 50 doctors, nurses, social workers, and HIV and TB services providers on TB/HIV integration and standard operational protocols using the newly revised national training modules. The seventh component is to support sites to provide incentives for effective TB and HIV patients' case management and referrals between the two services by implementing clinical and community-based components of the national PBF system. The final component is support for 2 district hospitals to draft and implement a plan of TB infection control according to national guidelines developed in collaboration with WHO/OGAC project.

PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, partners will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Examples of quality indicators include correctly filling stock control cards in X-ray departments, the percentage of TB lab exams that are corroborated during quarterly controls, the number of X-rays of good quality with correct diagnosis and report in patient file, and the number of complete series of AFBs correctly done. Payment of indicators is linked to the quality of general health services through adjustments of payments based on the score obtained using the standardized national Quality Supervision tool and a performance incentive for the production of more than agreed upon quantities of each indicator.

This activity reflects the ideas presented in the Rwanda EP five-year strategy and the

Rwandan National Prevention Plan by advancing the integration of TB/HIV services through the operationalization of policies and increased coordination of prevention, care and treatment services

Continued Associated Activity Information

Activity ID: 4982
USG Agency: HHS/Health Resources Services Administration
Prime Partner: Catholic Relief Services
Mechanism: Catholic Relief Services Supplemental
Funding Source: GHAI
Planned Funds: $ 10,000.00

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	51 - 100
Human Resources	10 - 50
Quality Assurance, Quality Improvement 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 supported with perofrmance-based financing that are providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting		☑
Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting	11	☐
Number of HIV-infected clients given TB preventive therapy	0	☐
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	500	☐
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)	50	☐

Target Populations:

Community leaders
Faith-based organizations
Doctors
Nurses
Pharmacists
HIV/AIDS-affected families
Orphans and vulnerable children
People living with HIV/AIDS
Volunteers
HIV positive pregnant women
Caregivers (of OVC and PLWHAs)
Religious leaders
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Burera

Gicumbi

Gatsibo

Nyamasheke

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:	GHAI
Program Area:	Palliative Care: TB/HIV
Budget Code:	HVTB
Program Area Code:	07
Activity ID:	7169
Planned Funds:	$ 2,100,000.00

Activity Narrative: Reprogramming 8/07: With these additionnal funds Columbia University will hire additionnal staff with focus on TB.HIV surveillance in prisons. These staff in collaboration with CDC office in Rwanda and with the technical assistance from CDC TB department will conduct surveillance activities in prison and coordinate on-going public health evaluations in TB.HIV in Rwanda

TB is a leading cause of morbidity and death among PLWA because of atypical clinical presentations of TB in that population. Those clinical presentations are hard to diagnose without a strong lab component of the TB care system. PEPFAR Rwanda supported the national TB and HIV program in this area with provision of X-ray machines and training since 2006 but less progress has been made in strengthening and expanding TB lab capacity. PEPFAR Rwanda is proposing to use these new funds to upgrade the TB lab in NRL and Butare and establish a network for TB culture from all TB diagnosis centers to those two reference labs.

The upgrading will include infrastructure improvement by renovation, introduction of new techniques like liquid culture, PCR, rapid test and additional techniques for TB diagnosis in children. Transportation will be provided to the 2 labs for TB lab networking. Additionnal staff will be recruited and trained in these new techniques. These new funds will contibute to support the training and supervision of all TB providers in Ziehl Nielsen staining technique, and a better coordination of TB activities between PNILT, NRL/CHUK and TRAC. In addition monitoring & evaluation as well as quality assurance systems will be strengthened. The CHK pathology lab will be upgraded to cope with the increasing demand of TB related pathology lab. Finally these funds will support the drafting of a national strategic plan for TB lab and networking strengthening as well as a plan for the integration of TB and HIV activities.

TB infection control is becoming a pressing issue as more people living with HIV/AIDS with higher susceptibility to TB are attending health care facilities and mingle everyday with patients with suspected TB. PEPFAR Rwanda has initiated a process to review and update national infection control guidelines and provide training to hospital staff. The implementation of these new guidelines will require some investments in infrastructure rehabilitation. With these new funds PEPFAR Rwanda will renovate two districts hospitals to comply with the new guidelines. This activity will reduce the rate of nosocomial TB infections, improve the work conditions for hospital staff and offer a better care environment for people living with HIV/AIDS .

This activity relates to activities in HVTB (7162, 7266, 7241, 8146), HTXS (7164, 7246), and HBHC (7177).

In FY 2006 Columbia University supported PNILT and TRAC to ensure integration of TB/HIV programs at the national level. Key accomplishments included: development, revision and implementation of national policies, tools and guidelines; strengthening M&E for national TB/HIV activities; design TB/HIV training modules based on international guidelines; coordination of training of service providers to implement and integrate TB/HIV activities and support to two TB/HIV model centers to pilot and scale-up TB/HIV activities. Dedicated TB/HIV staff at both centers implemented new TB/HIV activities, recording and reporting tools to ensure quality care for patients with TB and HIV. Achievements at the two model centers included: increasing HIV testing for TB patients from 50% in 2005 to 92% by the second quarter of 2006; Cotrimoxazole provision to all patients with TB and HIV. By the end of FY 2006, national indicators for screening PLWHA for TB will be piloted and implemented at both centers. Patient care and program results are reviewed regularly by TB and HIV service providers at both centers.

In FY 2007, Columbia University will support TB/HIV collaborative activities at the central level through continuing support for the existing long-term TB/HIV technical advisor at PNILT. This advisor will continue to support the national TB/HIV working group, support implementation and oversight of TB/HIV activities. Other activities will include revision of guidelines, curricula and tools, including national infection control guidelines, guidelines for the diagnosis of smear-negative and extrapulmonary TB, and pediatric TB guidelines (including a national TB screening algorithm for HIV-infected children) in coordination with WHO/OGAC project.

The technical advisor will also transfer skills and competencies to locally recruited TB/HIV advisors at PNILT, TRAC and the model centers to sustain TB/HIV integration in Rwanda. Columbia University, in collaboration with other USG partners will continue to lead implementation of new TB/HIV activities at the two model centers. Activities will include monitoring the burden of the TB immune reconstitution syndrome, expanding TB contact tracing and counseling and HIV testing of family members of patients with TB disease and HIV.

As TB/HIV activities have expanded in Rwanda, detailed program information and review has become increasingly important at all levels. Columbia University will support PNILT to implement a standard electronic TB register to be phased in at selected sites in 2007 and expanded nation-wide in 2008. This register has already been developed and is currently used in South Africa, Botswana, and Tanzania and will be adapted to additional focus countries in upcoming months. EP sites will have the ability to link TB data to TRACNet via a patient's TRACNet ID number.

TB/HIV technical advisors will be supported to participate in international TB/HIV conferences to share the Rwanda experience in rolling-out TB/HIV interventions and also learn from others countries' experiences. Short-term TA will be provided to the country team to ensure program quality and share lessons learned from other countries.

These activities support country 5-year strategic planning under its component of Integration of HIV into the overall health system and EP plan to increase ART patient enrollment.

Continued Associated Activity Information

Activity ID: 2731
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Columbia University Mailman School of Public Health
Mechanism: Columbia UTAP
Funding Source: GHAI
Planned Funds: $ 616,000.00

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

Targets

Target	Target Value	Not Applicable
Number of service outlets supported with perofrmance-based financing that are providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting		☑
Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting		☑
Number of HIV-infected clients given TB preventive therapy		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	500	☐
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)		☑

Target Populations:

Doctors
Nurses
Pharmacists
Public health care workers
Laboratory workers
Other Health Care Worker
Private health care workers
Doctors
Laboratory workers
Nurses
Pharmacists
Other Health Care Workers

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas:

National

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: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 7180
Planned Funds: $ 37,807.00
Activity Narrative: This activity relates to activities in HVTB (7162, 7266, 7241), and HTXS (7164, 7246).

In FY 2005, Columbia supported the GOR for national TB/HIV integration with TA to the MOH on TB/HIV policy and guidelines design. In FY 2006, Columbia started implementing these policies and guidelines at 35 clinical sites. The program's achievements include an improvement in the percentage of TB patients screened for HIV from less than 50% to 83%. In addition, at Columbia-supported sites, 60% of 22,000 patients enrolled in HIV care were screened for TB. All suspected TB cases among PLWHA are screened and referred for TB DOTS, cotrimoxazole prophylaxis, and ART, as appropriate.

In FY2007, Columbia will continue to support 35 existing sites and add seven new clinical sites for the implementation of the TB/HIV component of the clinical package of HIV care. This activity has eight components: the first component is to implement routine provider-initiated HIV testing to an estimated 1,500 TB patients at USG-supported sites. HIV testing will be conducted at sites providing TB services. The second component is to provide cotrimoxazole prophylaxis to all HIV-positive TB patients and ensure referral to HIV care and treatment services. The third component is the implementation of intensified TB case-finding among 32,000 PLWHA enrolled in care and treatment at USG-supported sites through routine TB screening using the national standardized questionnaire. The fourth component is to ensure timely TB diagnosis and treatment via DOTS to an estimated 1,000 PLWHA diagnosed with TB disease. The fifth component is the routine collection, recording, and reviewing of standard national TB/HIV program indicators at sites to inform and improve services. This data will also be routinely reported to the district and national levels through TRAC and PNILT. The sixth component of this activity is to support training of 150 doctors, nurses, social workers, and HIV and TB services providers on TB/HIV integration and standard operational protocols using the newly revised national training modules. The seventh component is to support sites to provide incentives for effective TB and HIV patients' case management and referrals between the two services by implementing clinical and community-based components of the national PBF system. The final component is support for 5 district hospitals to draft and implement a plan of TB infection control according to national guidelines developed in collaboration with WHO/OGAC project.

PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, partners will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Examples of quality indicators include correctly filling stock control cards in X-ray departments, the percentage of TB lab exams that are corroborated during quarterly controls, the number of X-rays of good quality with correct diagnosis and report in patient file, and the number of complete series of AFBs correctly done. Payment of indicators is linked to the quality of general health services through adjustments of payments based on the score obtained using the standardized national Quality Supervision tool and a performance incentive for the production of more than agreed upon quantities of each indicator.

This activity reflects the ideas presented in the Rwanda EP five-year strategy and the Rwandan National Prevention Plan by advancing the integration of TB/HIV services through the operationalization of policies and increased coordination of prevention, care and treatment services

Continued Associated Activity Information

Activity ID: 4839
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Columbia University Mailman School of Public Health
Mechanism: Columbia MCAP Supplement
Funding Source: GHAI
Planned Funds: $ 176,494.00

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	51 - 100
Quality Assurance, Quality Improvement 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 treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting	42	☐
Number of HIV-infected clients given TB preventive therapy		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	1,000	☐
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)	150	☐

Target Populations:

Community leaders
Doctors
Nurses
Pharmacists
Prisoners
Volunteers
HIV positive pregnant women
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 7198
Planned Funds: $ 31,341.00
Activity Narrative: This extension will continue the activities of a current implementer to prevent treatment interruption. During the extension, implementer will make transition to follow-on awardee expected to be determined in late May.
[CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007]
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.

Continued Associated Activity Information

Activity ID: 5127
USG Agency: U.S. Agency for International Development
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
Mechanism: Call to Action/EGPAF

Funding Source: GHAI
Planned Funds: $ 96,000.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
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 service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting	20	☐
Number of HIV-infected clients given TB preventive therapy		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	157	☐
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)	25	☐

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Byumba (prior to 2007)

Kigali (Rurale) (prior to 2007)

Kigali-Ville (prior to 2007)

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: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 7207
Planned Funds: $ 4,500.00
Activity Narrative: This extension will continue the activities of a current implementer to prevent treatment interruption. During the extension, implementer will make transition to follow-on awardee expected to be determined in late May.
[CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007]
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.

Continued Associated Activity Information

Activity ID: 5128
USG Agency: U.S. Agency for International Development
Prime Partner: IntraHealth International, Inc
Mechanism: Capacity
Funding Source: GHAI
Planned Funds: $ 57,600.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
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 service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting	16	☐
Number of HIV-infected clients given TB preventive therapy		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	150	☐
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)		☑

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Byumba (prior to 2007)

Gitarama (prior to 2007)

Kibungo (prior to 2007)

Kibuye (prior to 2007)

Kigali (Rurale) (prior to 2007)

Umutara (Mutara) (prior to 2007)

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: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 7221
Planned Funds: $ 746,240.00

Activity Narrative: This activity relates activities in HVTB (7162, 7169, 8147, and 8664).

Performance-based financing is an innovative approach to financing of health services that enhances quality of services and leads to greater efficiency and sustainability. Financial incentives provided by performance-based funding motivate health facilities to improve performance through investments in training, equipment, personnel and payment systems that better link individual pay to individual performance. PBF financing is directly applied to TB and other HIV indicators at the facility level. As a result of successful pilots implemented by CordAID, GTZ and BTC, the MOH has endorsed national scale-up of performance-based financing for all health services. The USG, in partnership with the World Bank, BTC and other donors, is supporting national implementation of performance-based financing of health services.

In FY 2006, MSH/PBF supported the GOR in collaboration with key donors to develop a national strategy, policy, and implementation model of performance-based financing that applies to all health assistance. The initial strategy for EP-supported PBF activities was to transfer USG site support from a traditional inputs–based model to a purely output purchases model as sites achieved a certain level of technical competence. However, the implementation of COP06 activities brought a change in the USG team's thinking about this approach. Few, if any USG supported sites were found to be ready for complete graduation to an exclusively PBF model. While PBF clearly increases performance, technical assistance and basic input support is still needed, especially in the current context of rapid decentralization and accelerated national roll-out of the PBF model by the GOR. Therefore, an adjusted strategy has been developed that provides a combination of both input and output financing to all EP-supported sites. The combination of financing modalities will properly motivate health facilities for higher performance while providing necessary resources and tools to meet the established targets.

In FY 2007, MSH/PBF will continue to provide support to the MOH Performance Based Financing department and the national PBF TWG. In addition, MSH/PBF will provide TA to DHTs in all PEPFAR districts and to USG implementing partners to effectively shift some of their input financing to output-based financing for TB and other indicators in accordance with national policy. MSH/PBF will also provide output financing to health facilities in 8 districts (where other clinical partners will only provide input financing) through direct performance sub-contracts with health centers and district hospitals for TB and other indicators. Output financing involves the purchase of a certain quantity of indicators with a performance incentive for the production of more than agreed upon quantities of services. Full or partially reduced payment of TB and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool.

At the health center level, MSH/PBF will use a 'fixed price plus award fee' contract model to purchase a quantity of TB and other HIV indicators (such as the number of HIV+ clients who have been screened for TB) with a performance incentive. Performance on these indicators will be measured during monthly control activities jointly conducted by the MSH/PBF district coordinator and the district's Family Health Unit and quality of services will be evaluated through the existing national supervisory and quality assurance mechanisms. Examples of quality indicators for TB include correctly filling stock control cards in X-ray departments, the percentage of TB lab exams that are corroborated during quarterly controls, the number of X-rays of good quality with correct diagnosis and report in patient file, and the number of complete series of AFBs correctly done. The quantity and quality scores will be merged during the quarterly District PBF Steering Committee meetings and the final payments will be approved.

At the district hospital level, MSH/PBF will have sub-contracts with slightly different purpose and scope from that of health centers. In addition to the focus on increasing better quality service outputs, there is an emphasis on quality assurance, self-evaluation, and review by peers similar to an accreditation scheme. There will be payment for indicators from the National District Hospital PBF Scheme which reinforces the supervisory role hospitals play in district health networks.

At the District level, MSH/PBF will support the national model by 1) placing a district coordinator within the Family Health Unit to work with national family health steering

committee during data collection/entry and control of indicators, 2) facilitating the quantity control function by providing TA and paying associated costs, and 3) support secretarial functions for the Family Health Unit at the District level. Support to the District is critical for the proper functioning of the national PBF model since monthly HIV/AIDS invoice approved by the health center PBF management committee (COGE) and MSH are presented to the district steering committee for merging with quality index and final approval before payments are made.

Continued Associated Activity Information

Activity ID: 4001
USG Agency: U.S. Agency for International Development
Prime Partner: Management Sciences for Health
Mechanism: HIV/AIDS Performance Based Financing
Funding Source: GHAI
Planned Funds: $ 144,000.00

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, Quality Improvement and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets supported with perofrmance-based financing that are providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	127	☐
Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting	0	☐
Number of HIV-infected clients given TB preventive therapy	0	☐
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	0	☐
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)	0	☐

Target Populations:

Faith-based organizations
HIV/AIDS-affected families
International counterpart organizations
People living with HIV/AIDS
Volunteers
Other MOH staff (excluding NACP staff and health care workers described below)
Public health care workers
Implementing organizations (not listed above)
HIV positive children (5 - 14 years)

Key Legislative Issues

Gender

Coverage Areas

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Karongi

Rutsiro

Ngororero

Nyabihu

Nyamasheke

Rubavu

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 7266
Planned Funds: $ 69,000.00

Activity Narrative: Reprogramming 8/07: This activy has been reduced and CDC Rwanda will only coordinate and funds technical assistance from CDC Atlanta to conduct public health evaluations in TB.HIV and TB lab upgrading in coordination with Ministry of health and implementing partners

This activity relates to activities in HTXS (7169) and HVTB (8664).

In FY 2006, CDC in collaboration with WHO and Columbia, supported the MOH in TB/HIV collaborative activities by revising guidelines, tools and training materials at the central level. CDC worked closely with GOR and WHO to develop an integrated work plan for the two-year WHO/USG TB/HIV project and continues to support this project in an advisory role. CDC also provided TA for targeted evaluations conducted by PNILT and TRAC to inform national TB/HIV program policy and implementation of guidelines. A baseline evaluation of TB patients' acceptance of HIV-testing and access to HIV care and treatment was conducted and showed that of 207 TB patients interviewed at 23 geographically representative sites, 96% accepted or would be willing to accept an HIV test, if offered. Prior to implementation of the national TB/HIV policy and guidelines, HIV test results were only recorded for half of patients and there was no standard recording of other HIV-related data, suggesting that HIV-positive TB patients may not have access to cotrimoxazole prophylaxis or HIV care and treatment. Among TB patients with known HIV status, mortality for HIV-positive patients was six times greater during TB treatment than for HIV-negative TB patients. This evaluation, led by PNILT, provided important baseline data and recommendations for implementing TB/HIV activities and the national policy was revised to include providing cotrimoxazole to all HIV-positive TB patients. USG, through TA from CDC HQ and field staff, also provided TA for an evaluation by PNILT to identify how patients are diagnosed with smear-negative and extrapulmonary TB in Rwanda. Results of this evaluation are expected by the end of 2006 and will be used to inform and recommend changes to the current national guidelines to improve the timely diagnosis of TB among PLWHA. Rwanda has adopted a five-part screening questionnaire to screen adult PLWHA for TB.

Currently there are no national guidelines on screening HIV-positive children for TB. In FY 2006, CDC provided technical assistance to TRAC and PNILT to design and begin a public health evaluation to screen HIV-positive children for TB. Data will be used in conjunction with the experience from national pediatric experts and USG partners to develop an effective TB screening tool for all HIV-positive children.

In FY 2007 CDC will continue to provide short-term TA to USG partners, TRAC and PNILT to plan, implement and assess the impact of programmatic TB/HIV activities using national recording and reporting tools. CDC in collaboration with TRAC, PNILT and Columbia will establish a surveillance system for TB and HIV at the Kigali national prison and Gisenyi regional prison. All prisoners will be offered HIV counseling and testing and will be screened for TB. Prisoners found to be HIV-positive will be enrolled into care and treatment. Those found to have active TB will be treated through the national program under DOTS. In FY 2007 CDC will also provide TA and funds to TRAC and PNILT to supervise the scale-up of the TB/HIV surveillance and ensure care and appropriate treatment after discharge at an additional six prisons in Rwanda in coordination with the local DHTs. CDC will design with TRAC and PNILT a protocol for follow-up of prisoners after release.

CDC will provide short-term TA for implementation of the national infection control guidelines to be developed by PNILT through the WHO/USG-funded TB/HIV activity. Activities will focus on improving infection control at CHK, NRL, and sites caring for HIV-positive MDR TB patients. CDC will also support TA to PNILT to implement the electronic TB register in Rwanda and to link it to the TRACNet database.

In order to meet the PEPFAR priority of providing quality smear microscopy services and effective TB diagnostic services for PLWHA, CDC will support short-term TB laboratory TA to work with NRL and Columbia University to enhance the performance of the smear microscopy EQA system and the quality of culture and drug sensitivity testing services. Surveillance for extremely drug-resistant TB (XDR) will be conducted at CHK among TB patients that are failing TB treatment. Currently only two lab technicians are able to perform TB cultures and run first-line at NRL. CDC will provide short-term support to train

one additional lab technician in performing cultures and drug sensitivity testing at the supranational reference lab in Antwerp.

Extrapulmonary TB (ETB) is more strongly HIV-related than pulmonary TB (PTB), with combined ETB and PTB especially suggestive of underlying HIV-infection. Patients with HIV-related ETB often have disseminated disease and are at high risk of rapid clinical deterioration and death. Prompt diagnosis and treatment is essential because only approximately one half of HIV-positive patients that die from disseminated TB are diagnosed before death. In both 2004 and 2005, CHK reported a larger number of extrapulmonary TB cases than any other reference hospital or health district in Rwanda, with over 60% of all TB patients diagnosed with ETB. Diagnostic tests for ETB are severely limited in Rwanda. In FY 2007 CDC will provide support to the MOH to establish histology and pathology services at the CHK laboratory to improve the prompt diagnosis of ETB through TA, training and equipment. Simplified standardized clinical management guidelines for the most common and serious forms of ETB will be implemented. Immune reconstitution occurs rapidly in most HIV-positive adults who are started on ART and can lead to clinical signs and symptoms of active TB. There is little known about the burden of the immune reconstitution inflammatory syndrome (IRIS) in Rwanda. Rwanda has adopted guidelines to screen for TB prior to initiating ART to minimize IRIS morbidity and mortality. In close collaboration with USG partners, CDC will also provide TA to TRAC to establish TB IRIS surveillance.

In order to expand, monitor and improve TB/HIV services, one long-term TB/HIV technical advisor will be recruited and seconded to TRAC to oversee the implementation and expansion of integrated TB/HIV activities in HIV care and treatment programs. TA will include support for implementation of intensified TB case-finding among PLWHA, prioritizing implementation in care and treatment services and later expanding intensified TB case finding to PMTCT, VCT and palliative care services. The technical advisor will work closely with TRAC to fully implement, monitor and evaluate TB screening indicators to routinely assess program performance and provide training and supervision.

CDC support to TRAC, PNILT and USG partners in coordination with WHO will ensure quality and scale-up of TB HIV collaborative activities. This activity supports the Rwandan national policy for integration of TB and HIV services.

Continued Associated Activity Information

Activity ID: 2850
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: US Centers for Disease Control and Prevention
Mechanism: CDC Country Office GAP/TA
Funding Source: GHAI
Planned Funds: $ 45,000.00

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

Targets

Target	Target Value	Not Applicable
Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting		
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)		

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: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 8119
Planned Funds: $ 0.00

Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007] 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.
****PLUS-UP****
$260,000 - This activity supports the establishment of x-ray capacity at four district hospitals to increase timely, quality TB diagnosis and active TB disease case detection among PLWHA. This support will include procurement of x-ray machines and supplies, all necessary renovations, and technician and health care personnel training to interpret chest radiographs for radiological findings (often atypical) consistent with pulmonary TB disease among PLWHA, as an important diagnostic tool.
The HIV epidemic has been associated with a significant increase in the reported incidence of smear negative pulmonary TB in PLWHA when compared to those without HIV infection. PLWHA with smear-negative pulmonary TB have poorer treatment outcomes and higher mortality in resource-limited settings. Therefore, timely, quality diagnosis is imperative. Both international guidelines and Rwanda National TB program guidelines include chest radiography as an important component of the diagnostic algorithm of smear-negative pulmonary TB. There is international consensus to strongly encourage the use of chest radiography early in the diagnosis of smear negative pulmonary TB among PLWHA wherever possible, and to improve chest x-ray interpretation and reading capacity by clinical practitioners, including nurses, through specialized trainings and by encouraging peer review.
Increased chest radiography capacity at these sites is also expected to improve smear negative TB case detection among patients presenting with TB symptoms and provide additional numbers of patients to be tested for HIV and referred for HIV care and treatment services.

An additional 400 HIV-infected clients attending HIV care/treatment services will be appropriately screened for TB using x-ray. 36 HIV infected clients attending HIV care and treatment services will receive treatment for TB disease. An additional 20 personnel will be trained in a key elements of diagnosing TB among PLWHA and will provide timely treatment.

Continued Associated Activity Information

Activity ID: 4768
USG Agency: U.S. Agency for International Development
Prime Partner: Family Health International
Mechanism: FHI Bridge
Funding Source: GHAI
Planned Funds: $ 353,120.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
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 service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting	36	☐
Number of HIV-infected clients given TB preventive therapy		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	199	☐
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)	160	☐

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Byumba (prior to 2007)

Gikongoro (prior to 2007)

Gisenyi (prior to 2007)

Gitarama (prior to 2007)

Kibuye (prior to 2007)

Kigali (Rurale) (prior to 2007)

Kigali-Ville (prior to 2007)

Table 3.3.07: Activities by Funding Mechanism

Mechanism: HIV Support to RDF
Prime Partner: Drew University
USG Agency: Department of Defense
Funding Source: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 8146
Planned Funds: $ 24,896.00
Activity Narrative: This activity is related to other DOD funded activities under HBHC (7191), HTXS (7190), HVOP (8135), HLAB (7190), HVAB (7230).

In the RDF health network there are three military hospitals and five brigade clinics throughout the country. Drew University began working in two military hospitals and three brigade clinics in FY 2005 with EP support. The support modalities include TA and training on ARV and palliative care, M&E, and laboratory infrastructure. Drew collaborates with CHAMP for services in military communities such as OVC support, and receives drug procurement from PFSCM. In line with national policies, the hospitals incorporate performance-based financing as incentives for facilities.

In FY 2007, Drew University will work with the MOH and RDF to train health providers and improve the quality of TB integration in HIV treatment for HIV positive military personnel and civilians receiving care in the military. Drew University will screen 75% of TB patients for HIV. In addition, they will improve the infrastructure at six RDF hospitals and brigade clinics and train 40 RDF health providers to diagnose, treat and through an established information system, monitor and report TB progression trends. Drew University will ensure that the provision of preventive cotrimoxazole prophylaxis is integrated into a HIV care package.

Drew University will support facilities to strengthen referrals mechanisms within the same facility and between facilities to enable patients diagnosed with TB and HIV to adhere to TB treatment via DOTS, and have access to cotrimoxazole prophylaxis and baseline and follow-up CD4 and ART if eligible.

PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, Drew will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Examples of quality indicators include correctly filling stock control cards in X-ray departments, the percentage of TB lab exams that are corroborated during quarterly controls, the number of X-rays of good quality with correct diagnosis and report in patient file, and the number of complete series of AFBs correctly done. Payment of indicators is linked to the quality of general health services through adjustments of payments based on the score obtained using the standardized national Quality Supervision tool and a performance incentive for the production of more than agreed upon quantities of each indicator.

In addition, Drew University through regular supervision to supported sites will ensure that TB/HIV data are recorded and reported following national guidelines and that staff conduct quarterly M&E meetings with PLWA associations and community health workers to analyze data and use them for program quality improvement.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Quality Assurance, Quality Improvement 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 treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting	6	☐
Number of HIV-infected clients given TB preventive therapy	0	☐
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	200	☐
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)	40	☐

Target Populations:

Doctors
Nurses
Pharmacists
Military personnel
People living with HIV/AIDS
Men (including men of reproductive age)
Women (including women of reproductive age)

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 3.3.07: Activities by Funding Mechanism

Mechanism: SCMS
Prime Partner: Partnership for Supply Chain Management
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 8664
Planned Funds: $ 140,000.00
Activity Narrative: This activity relates to activities in HVTB (7266, 7169).

In FY 2007, PFSCM will be responsible for the procurement of all EP commodities through direct support to CAMERWA. PFSCM will provide TA and funding for procurement, storage and distribution of all medicines, equipment and laboratory supplies for TB and other EP program areas.

In FY 2007 CDC will provide support to the MOH to establish histology and pathology services at the CHK laboratory to improve the prompt diagnosis of extrapulmonary TB through TA, training and equipment. This laboratory will also serve as a referral center for the district of Muhima, which reported the second highest number of ETB cases in 2005.

PFSCM will procure necessary equipment and supplies to carry out the above activities, including one microtome, waterbath, tissue processor, IPOX, microscopes, consumables for TB diagnosis, fluorescence microscope, auramine stain, centrifuge, biosafety cabinets, and hood.

This activity contributes to the Rwanda EP five-year strategy goal of integrating TB and HIV services by strengthening TB diagnostic capacity at one of Rwanda's major reference hospitals.

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting		☑
Number of HIV-infected clients given TB preventive therapy		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease		☑
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)		☑

Target Populations:

Doctors
Laboratory workers

Coverage Areas

Kigali

Table 3.3.07: Activities by Funding Mechanism

Mechanism:	Refugees UNHCR
Prime Partner:	United Nations High Commissioner for Refugees
USG Agency:	Department of State / Population, Refugees, and Migration
Funding Source:	GHAI
Program Area:	Palliative Care: TB/HIV
Budget Code:	HVTB
Program Area Code:	07
Activity ID:	8670
Planned Funds:	$ 23,420.00

Activity Narrative: This activity relates to activities in MTCT (8696), HVAB (8700), HVOP (8711), HBHC (8718), HVCT (8732), and HTXS (8737).

Rwanda is host to almost 50,000 refugees in camps around the country. Refugee populations are considered to be at high risk of infectious disease, in particular HIV, as well as GBV and other forms of violence, and economic and psychological distress. While much is currently unknown about HIV prevalence rates in the camp populations in Rwanda, recent service statistics of newly implemented VCT and PMTCT programs in two camps record a prevalence rate around 5% among those tested, with at least 200 individuals currently known to be living with HIV. Since 2005, the EP has supported UNHCR implementing partners AHA and ARC to provide HIV prevention and care services in Kiziba, Gihembe and Nyabiheke refugee camps with linkages and referrals for treatment. In FY 2007, the EP will consolidate its support by funding UNHCR directly to expand the package of services for prevention, care, and treatment services for PLWHA. Funds will also be leveraged from the World Bank-funded GLIA and OPEC to complement EP-supported services.

The overall goal of TB/HIV collaborative activities is to decrease the morbidity and mortality of TB among PLWHA at 3 refugee camps. In FY 2007, the EP will support UNHCR as a new partner to implement the TB/HIV component of the clinical package of HIV care in 3 refugee camps. Of an estimated 30 TB patients anticipated to be registered for TB treatment in the 3 refugee camps, 27 will receive HIV counseling and testing. These collaborative TB/HIV activities include eight key items: 1) implementing routine provider-initiated HIV testing of TB patients at TB service sites; 2) providing cotrimoxazole prophylaxis to all HIV-positive TB patients and ensuring effective referral to HIV care and treatment services; 3) implementing intensified TB case-finding among 20 PLWHA enrolled in care and treatment through routine TB; 4) ensuring timely TB diagnosis work-up and treatment via DOTS for those PLWHA with TB disease; 5) routinely collecting, recording, reporting, and reviewing standard national TB/HIV program indicators at sites to inform and improve services, these data will also be routinely reported at the district level and national level through TRAC and PNILT; 6) training 3 HIV service providers on TB/HIV integration and standard operational protocols using the newly revised national training modules; 7) providing incentives for effective case management and referrals between services by implementing the community-based component the national PBF system; 8) UNHCR will conduct sensitization campaigns in all EP supported camps to raise awareness about the link between TB/HIV using PNILT materials.

This activity reflects the ideas presented in the Rwanda EP five-year strategy under its component of integration of HIV into the overall health system and the National Prevention Plan to prevent, diagnose and treat patients with both TB and HIV patients.

Emphasis Areas	% Of Effort
Information, Education and Communication	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	51 - 100
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting	3	☐
Number of HIV-infected clients given TB preventive therapy	0	☐
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	20	☐
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)	20	☐

Target Populations:

Refugees/internally displaced persons

Coverage Areas

Gatsibo

Nyagatare

Karongi

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: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 9733
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY 2006 -- NO NEW FUNDING IN FY 2007]

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.

Continued Associated Activity Information

Activity ID: 5129
USG Agency: U.S. Agency for International Development
Prime Partner: Community Habitat Finance International
Mechanism: CHAMP
Funding Source: GHAI
Planned Funds: $ 132,000.00

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 service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting		☑
Number of HIV-infected clients given TB preventive therapy		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	100	☐
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)	50	☐

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Bugesera

Gatsibo

Nyagatare

Rwamagana

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

Table 3.3.07: Activities by Funding Mechanism

Mechanism: RPM+
Prime Partner: Management Sciences for Health
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 12254
Planned Funds: $ 250,000.00
Activity Narrative: In FY06, the Emergency Plan supported a range of activities in TB pharmaceutical management in Rwanda. These include capacity building of district pharmacists with MSH RPM+, renovation of district hospital pharmacies with the district support block grant, and central level support with SCMS and CAMERWA. As the EP extends its geographic coverage in the country (22 out of 30 districts will receive direct EP support by the end of 2007), and in response to the GOR decision to reorient WB MAP support to other priority sectors, facilities demand for TB commodities will increasingly strain the existing passive drug distribution system.

To date, all health facilities offering TB/HIV services are required to place orders for and collect commodities from Kigali. In FY 2007, the EP will support the national medical stores medium term objective of establishing an semi-active commodity distribution system by providing technical and financial assistance to upgrade existing 2 district pharmacies into regional pharmacies, which will have additional warehousing space, cold chain etc to stock sufficient commodities for all sites offering TB/HIV services in their respective provinces.

MSH/RPM+, in collaboration with CAMERWA, MOH and SCMS, will strategically select the pharmacies to be upgraded. It is expected that these regional facilities will serve as warehouses and as regional medical stores for health facilities in their respective geographic areas, thereby reducing strain on the central level warehouse, and sharply cutting down on costs for re-stocking of drugs and other commodities. MSH/RPM+ will also support the adaptation of information systems for stock-management at regional pharmacy level. This information will improve the data for forecasting demand of TB drugs, ARV's and related commodities, and provide stronger data on site level consumption patterns. This activity supports the EP five-year strategy for national scale-up and sustainability, and the Rwandan Government administrative and TB/HIV integration plan by strengthening capacity of districts and sub-national institutions.

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

Coverage Areas

North

East

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: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 12595
Planned Funds: $ 0.00
Activity Narrative: Reprogramming 8/07: This activity has been abandoned

In COP07 PEPFAR Rwanda provides funds to TRAC for integration TB/HIV activities. However TRAC and PNILT are still using diffetrent formats of monitoring and evaluation for integration activities. PEPFAR Rwanda will support TRAC for additional staff and transportation for periodic joint TRAC and PNILT supervsion of TB/HIV activities at district level and data analysis dissemination and use. This activity will contribute to improved integration TB and HIV in Rwanda.

Table 3.3.07: Activities by Funding Mechanism

Mechanism: FHI New Bilateral
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 15228
Planned Funds: $ 232,707.00
Activity Narrative: This activity relates to activities in HVTB (7162, 7169, 7180, 7221, 8664, 7266), MTCT (8698), HVAB (8129), HVOP (8137), HBHC (8144), HVCT (8168), HTXS (8172). In FY 2006, USG partners started implementing National TB/HIV integration policy and guidelines at their supported sites. Partners refer all suspected TB cases among PLWHA for TB testing and expected new cases of active TB for TB DOTS, cotrimoxazole prophylaxis, and eligible patients for ART. In FY 2007, USAID awarded three cooperative agreements - one to FHI - to support sites where the TB/HIV component will be integrated into the clinical package of HIV care. This activity has eight components: the first component is to implement routine provider-initiated HIV testing to TB patients at FHI-supported sites.

HIV testing will be conducted at sites providing TB services. The second component is to provide cotrimoxazole prophylaxis to all HIV-positive TB patients and ensure referral to HIV care and treatment services. The third component is the implementation of intensified TB case-finding among PLWHA enrolled in care and treatment at USG-supported sites through routine TB screening using the national standardized questionnaire. The fourth component is to ensure timely TB diagnosis and treatment via DOTS to an estimated 711 PLWHA diagnosed with TB disease. The fifth component is the routine collection, recording, and reviewing of standard national TB/HIV program indicators at sites to inform and improve services. This data will also be routinely reported to the district and national levels through TRAC and PNILT. The sixth component of this activity is to support training of 50 doctors, nurses, social workers, and HIV and TB services providers on TB/HIV integration and standard operational protocols using the newly revised national training modules.

The seventh component is to support sites to provide incentives for effective TB and HIV patients' case management and referrals between the two services by implementing clinical and community-based components of the national PBF system. The final component is support for 5 district hospitals to draft and implement a plan of TB infection control according to national guidelines developed in collaboration with WHO/OGAC project. In addition, FHI will second three local hire technical advisors to TRAC to assist with TB/HIV program implementation at the central level (including supervision, training, etc.). These technical advisors will assure that the TB/HIV program is implemented correctly at all sites and that quality program data is collected. These advisors will build capacity at TRAC by transferring knowledge and skills to their GOR counterparts so these activities can eventually be carried out in the absence of external technical assistance.

PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, FHI will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Examples of quality indicators include correctly filling stock control cards in X-ray departments, the percentage of TB lab exams that are corroborated during quarterly controls, the number of X-rays of good quality with correct diagnosis and report in patient file, and the number of complete series of AFBs correctly done. Payment of indicators is linked to the quality of general health services through adjustments of payments based on the score obtained using the standardized national Quality Supervision tool and a performance incentive for the production of more than agreed upon quantities of each indicator. These activities support Rwandan national plan for TB/HIV and EP to prevent, diagnose and treat patients with both TB and HIV patients.

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

Targets

Target	Target Value	Not Applicable
Number of service outlets supported with perofrmance-based financing that are providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting	5	☐
Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting		☑
Number of HIV-infected clients given TB preventive therapy		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	711	☐
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)	50	☐

Target Populations:

Faith-based organizations
HIV/AIDS-affected families
People living with HIV/AIDS
Prisoners
Volunteers
HIV positive pregnant women
Other MOH staff (excluding NACP staff and health care workers described below)
Private health care workers
HIV positive children (5 - 14 years)

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Karongi

Ngororero

Nyabihu

Nyamasheke

Rubavu

Rutsiro

Table 3.3.07: Activities by Funding Mechanism

Mechanism: EGPAF New Bilateral
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 15229
Planned Funds: $ 73,140.00
Activity Narrative: This activity relates to activities in HVTB (7162, 7169, 7180, 7221, 8664, 7266), MTCT (8698), HVAB (8129), HVOP (8137), HBHC (8144), HVCT (8168), HTXS (8172). In FY 2006, USG partners started implementing National TB/HIV integration policy and guidelines at their supported sites. Partners refer all suspected TB cases among PLWHA for TB testing and expected new cases of active TB for TB DOTS, cotrimoxazole prophylaxis, and eligible patients for ART. In FY 2007, USAID made an award to EGPAF to support 38 sites where the TB/HIV component will be integrated into the clinical package of HIV care. This activity has eight components: the first component is to implement routine provider-initiated HIV testing to TB patients at EGPAF-supported sites. HIV testing will be conducted at sites providing TB services. The second component is to provide cotrimoxazole prophylaxis to all HIV-positive TB patients and ensure referral to HIV care and treatment services.

The third component is the implementation of intensified TB case-finding among PLWHA enrolled in care and treatment at USG-supported sites through routine TB screening using the national standardized questionnaire. The fourth component is to ensure timely TB diagnosis and treatment via DOTS to an estimated 285 PLWHA diagnosed with TB disease. The fifth component is the routine collection, recording, and reviewing of standard national TB/HIV program indicators at sites to inform and improve services. This data will also be routinely reported to the district and national levels through TRAC and PNILT. The sixth component of this activity is to support training of 70 doctors, nurses, social workers, and HIV and TB services providers on TB/HIV integration and standard operational protocols using the newly revised national training modules. The seventh component is to support sites to provide incentives for effective TB and HIV patients' case management and referrals between the two services by implementing clinical and community-based components of the national PBF system.

The final component is support for 5 district hospitals to draft and implement a plan of TB infection control according to national guidelines developed in collaboration with WHO/OGAC project. PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, EGPAF will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Examples of quality indicators include correctly filling stock control cards in X-ray departments, the percentage of TB lab exams that are corroborated during quarterly controls, the number of X-rays of good quality with correct diagnosis and report in patient file, and the number of complete series of AFBs correctly done.

Payment of indicators is linked to the quality of general health services through adjustments of payments based on the score obtained using the standardized national Quality Supervision tool and a performance incentive for the production of more than agreed upon quantities of each indicator. These activities support Rwandan national plan for TB/HIV and EP to prevent, diagnose and treat patients with both TB and HIV patients.

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

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets supported with perofrmance-based financing that are providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting		☑
Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting	38	☐
Number of HIV-infected clients given TB preventive therapy		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	285	☐
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)	70	☐

Target Populations:

Faith-based organizations
HIV/AIDS-affected families
People living with HIV/AIDS
Prisoners
Volunteers
HIV positive pregnant women
Other MOH staff (excluding NACP staff and health care workers described below)
Public health care workers
HIV positive children (5 - 14 years)

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Karongi

Ngororero

Nyabihu

Nyamasheke

Rubavu

Rusizi

Rutsiro

Table 3.3.07: Activities by Funding Mechanism

Mechanism: IntraHealth New Bilateral
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 15230
Planned Funds: $ 133,224.00
Activity Narrative: This activity relates to activities in HVTB (7162, 7169, 7180, 7221, 8664, 7266), MTCT (8698), HVAB (8129), HVOP (8137), HBHC (8144), HVCT (8168), HTXS (8172). In FY 2006, USG partners started implementing National TB/HIV integration policy and guidelines at their supported sites. Partners refer all suspected TB cases among PLWHA for TB testing and expected new cases of active TB for TB DOTS, cotrimoxazole prophylaxis, and eligible patients for ART. In FY 2007, USAID awarded three cooperative agreements - one to IntraHealth - to support sites where the TB/HIV component will be integrated into the clinical package of HIV care. This activity has eight components: the first component is to implement routine provider-initiated HIV testing to TB patients at IntraHealth-supported sites. HIV testing will be conducted at sites providing TB services. The second component is to provide cotrimoxazole prophylaxis to all HIV-positive TB patients and ensure referral to HIV care and treatment services.

The third component is the implementation of intensified TB case-finding among PLWHA enrolled in care and treatment at USG-supported sites through routine TB screening using the national standardized questionnaire. The fourth component is to ensure timely TB diagnosis and treatment via DOTS to an estimated 384 PLWHA diagnosed with TB disease. The fifth component is the routine collection, recording, and reviewing of standard national TB/HIV program indicators at sites to inform and improve services. This data will also be routinely reported to the district and national levels through TRAC and PNILT. The sixth component of this activity is to support training of 120 doctors, nurses, social workers, and HIV and TB services providers on TB/HIV integration and standard operational protocols using the newly revised national training modules. The seventh component is to support sites to provide incentives for effective TB and HIV patients' case management and referrals between the two services by implementing clinical and community-based components of the national PBF system.

The final component is support for 4 district hospitals to draft and implement a plan of TB infection control according to national guidelines developed in collaboration with WHO/OGAC project. PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, IntraHealth will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Examples of quality indicators include correctly filling stock control cards in X-ray departments, the percentage of TB lab exams that are corroborated during quarterly controls, the number of X-rays of good quality with correct diagnosis and report in patient file, and the number of complete series of AFBs correctly done.

Payment of indicators is linked to the quality of general health services through adjustments of payments based on the score obtained using the standardized national Quality Supervision tool and a performance incentive for the production of more than agreed upon quantities of each indicator. These activities support Rwandan national plan for TB/HIV and EP to prevent, diagnose and treat patients with both TB and HIV patients.

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

Targets

Target	Target Value	Not Applicable
Number of service outlets supported with perofrmance-based financing that are providing clinical prophylaxis and/or treatment for tuberculosis (TB) for HIV-infected individuals (diagnosed or presumed) in a palliative care setting		☑
Number of service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting	32	☐
Number of HIV-infected clients given TB preventive therapy		☑
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	384	☐
Number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)	120	☐

Target Populations:

Faith-based organizations
HIV/AIDS-affected families
People living with HIV/AIDS
Prisoners
Volunteers
Other MOH staff (excluding NACP staff and health care workers described below)
Public health care workers
HIV positive children (5 - 14 years)

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Karongi

Ngororero

Nyabihu

Nyamasheke

Rubavu

Rutsiro

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: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 19248
Planned Funds: $ 150,000.00
Activity Narrative: n/a

Table 3.3.07: Activities by Funding Mechanism

Mechanism: Twubakane
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Palliative Care: TB/HIV
Budget Code: HVTB
Program Area Code: 07
Activity ID: 19249
Planned Funds: $ 150,000.00
Activity Narrative: n/a

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: $ 9,587,814.00

Program Area Context:

With approximately 50 percent of individuals under the age of 15, Rwanda's population is young. Almost 30 percent of Rwandan children under the age of 18 are considered to be OVC according to the 2005 RDHS-III. This proportion is highest in the city of Kigali where 35% of children are defined as OVC. The 2006 Rwanda National Plan of Action for OVC estimates that there are 1,264,000 OVC in Rwanda. Of these OVC, 210,000 are estimated to be orphaned due to HIV/AIDS, and additional 27,000 are children living with HIV/AIDS. It is projected that the percentage of children orphaned as a result of HIV/AIDS will increase from seven percent to 52 percent by 2010. The EP focus on OVC infected with HIV/AIDS or from families affected by HIV/AIDS.

In Rwanda, the EP is the primary donor in OVC service provision. UNICEF, the other major international donor working with OVC, focuses only on central level TA and provides no direct services. There are limited private donations for OVC programs, but they are not dependable for steady program implementation. This creates a challenging environment for collaboration and referrals.

In FY 2006, USG assistance reached an estimated 27,000 OVC with a menu of services, including school fees, health insurance, food aid, psycho-social support and HIV prevention education. During the last year, CHAMP played the lead role in coordinating USG efforts to assist OVC and their families. CHAMP mapped USG community partners' activities in their 20 districts and began developing M&E tools to standardize how partners assess, monitor and report on the OVC they serve. In close collaboration with MIGEPROF, UNICEF, CNLS, MINISANTE, and other key stakeholders, CHAMP helped revise the National Plan of Action for OVC and participated in the development of a Round 6 OVC proposal for the GFATM.

In FY 2007, the EP aims to expand the coverage and quality of OVC services and build the capacity of national and local organizations serving OVC. The EP funding will support a full time position at MIGEPROF. USAID, CHAMP, and Track 1.0 partners will continue as active members of the OVC TWG which is currently preparing a GIS mapping of OVC and OVC implementers in Rwanda. CHAMP will assist the GOR with the development of district and sector level children's forums and orphan care committees to both ensure the participation of children and local leaders in OVC activities and to advance efficient coordination of services for OVC. ROADS, CHAMP, and the Track 1.0 partners will work closely with local women's groups, FBOs, and PLWHA associations to provide technical training in OVC care and support as well as institutional capacity building for these CBOs.

In FY 2007, local Rwanda partner organizations under CHAMP will greatly increase the number of OVC they support as the current international partners (World Relief and CARE) transfer their beneficiaries under the CHAMP umbrella to local partners. Using M&E tools developed in FY 2006, USG partners will assess and monitor all children receiving services in FY 2007. The GOR's menu of essential services for OVC closely mirrors the EP's core services: education, health, shelter, food, economic strengthening, psychosocial support, protection, and HIV prevention. Partners will either directly provide these services or refer them to other care and support programs. To expand OVC access to direct food aid and nutritional information, EP funding will provide support to three Title II partners. The EP OVC program will also wrap around PMI, microfinance, education, HIV prevention, and CT activities to ensure integration and linkages with other EP activities. All EP implementing partners will work to establish and strengthen referral networks and systems, particularly between ART, PMTCT, and CT to ensure that beneficiaries have access to the services available in their communities. In FY 2007, the GOR and USG clinical partners will also increase their efforts to identify and treat HIV positive OVC. Health facilities will begin testing malnourished children in their feeding centers who do not respond to supplementary feeding. As a result, USG anticipates increasing care and support to HIV positive children and their families in 2007.

The EP OVC partners will reach an estimated 45,000 OVC and train over 6,800 OVC caregivers by the end of September 2007. By the end of FY 2008, the EP expects to be serving over 60,000 OVC. CHAMP will

oversee the task of significantly increasing the number of beneficiaries by providing the needed technical and programmatic assistance to allow local partners and communities to take the lead in providing OVC services.

The EP OVC program addresses the key legislative issues of wrap around programming for food, education and microfinance. These activities support the EP five-year strategy to engage new partners, build sustainable local capacity, expand pediatric care, and link OVC care with other USG efforts.

Program Area Target:

Number of OVC served by OVC programs	49,575
Number of providers/caregivers trained in caring for OVC	6,815

Table 3.3.08: Activities by Funding Mechanism

Mechanism: Africare Track 1
Prime Partner: Africare
USG Agency: U.S. Agency for International Development
Funding Source: Central (GHAI)
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 7148
Planned Funds: $ 760,451.00
Activity Narrative: This activity relates to OVC (7186).

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 services for OVC, including education, health care, nutrition, psychosocial support, and vocational training. District officials, community leaders and OVC will be instrumental in the process of selecting beneficiaries and needed services.

This project will train community volunteers in psychosocial support, basic human rights for children, nutrition, trauma processing, HIV/AIDS prevention and monitoring the status of OVC and their families. These 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 (Africare is also a Title II implementing partner). The project will provide technical nutritional support and initiate backyard gardens. COPE will train caregivers in IGA support areas and assist them in undertaking selected income generation activities which have an identified commercial market. OVC will be enrolled in vocational training schools. COPE will provide relevant technical assistance and capacity building to associations serving OVC in the local communities.

Volunteers will create COPE clubs supported through CBOs, churches, schools and PLWHA associations in the communities served by the project. 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, 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 training in financial and program management to new partner FBOs and CBOs. 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 4,000 OVC.

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. It also supports two key legislative issues: stigma and discrimination; and, increasing women's access to income and productive resources.

Continued Associated Activity Information

Activity ID:	5262
USG Agency:	U.S. Agency for International Development
Prime Partner:	Africare
Mechanism:	N/A
Funding Source:	N/A
Planned Funds:	$ 0.00

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/caregivers 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.

Key Legislative Issues

Increasing women's access to income and productive resources

Stigma and discrimination

Coverage Areas

Rwamagana

Gasabo

Kicukiro

Table 3.3.08: Activities by Funding Mechanism

Mechanism: AVSI Track 1
Prime Partner: Associazione Volontari per il Servizio Internazionale
USG Agency: U.S. Agency for International Development
Funding Source: Central (GHAI)
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 7155
Planned Funds: $ 358,280.00

Activity Narrative: This activity relates to OVC (7186).

AVSI will provide quality, comprehensive care services to OVC and build the capacity of CBOs to provide care and support for OVC in their communities.

In FY 2006, AVSI is providing a comprehensive menu of services to 2,209 OVC in six districts. This menu of services includes education fees and materials, health insurance, after school programs, hygiene kits, psychosocial support, food assistance, and vocational training (as needed). In addition, training is being provided to 29 CBOs to build their organizational and management capacity, improve their ability to successfully implement IGAs, and provide support and care for OVC in their communities.

In FY 2007, AVSI will continue to provide a comprehensive menu of services to OVC, especially those affected by HIV. By working closely with community leaders and CBOs to identify beneficiaries they are able to ensure that the services provided are consistent with the real needs and expectations of the beneficiaries. AVSI social workers complete an in-depth assessment of each OVC to assess their current situation and provide a package of services tailored to their needs. The program ensures that every child who is supported is cared for by an adult, either in the family or by someone in the community. At the same time, AVSI works in collaboration with community development committees, MIGEPROF and GOR in order to build the capacity of CBOs to improve their organization and management and successfully implement IGAs by identifying their needs and supporting workshops to improve management skills, systems of accountability, and service delivery. 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. Because caregivers tend to be women and CHHs headed by girls are especially vulnerable, special attention will be given to including women in IGAs and vocational training for girls.

AVSI also works with communities to organize "under the tent" activities in each community. These activities include recreational activities for children, health education sessions for all community members (separated for youth and adults), traveling libraries, and song and dance activities. All activities are related to sharing information about HIV prevention, care and treatment and are designed to reduce the stigma and discrimination associated with HIV and AIDS in these communities.

In collaboration with CHAMP, AVSI will work to ensure that all OVC have access to appropriate HIV prevention messages and other HIV services as needed. In addition, general HIV prevention, care and treatment information will be shared with the CBOs receiving support under this activity through their regular meetings and capacity building activities. AVSI will work closely with CHAMP and other EP-funded OVC programs, and the GOR to standardize service delivery, reporting and data collection. AVSI will continue to organize quarterly meetings to oversee service delivery and ensure quality, transparency, efficiency and synergy of program activities with other implementing partners.

AVSI will use EP resources to leverage their other funding to expand ongoing efforts to provide education, health, economic and food assistance to OVC through a collaborative, multi-sectoral approach. Through a partnership with WFP, AVSI will provide food assistance to food insecure CHHs. AVSI will also work closely with CBOs to develop community gardens.

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. It also supports three key legislative issues: wrap arounds, especially for food and education; stigma and discrimination; and, increasing women's access to income and productive resources.

Continued Associated Activity Information

Activity ID: 5242
USG Agency: U.S. Agency for International Development
Prime Partner: Associazione Volontari per il Servizio Internazionale

Mechanism: N/A
Funding Source: N/A
Planned Funds: $ 0.00

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	2,231	☐
Number of providers/caregivers trained in caring for OVC	150	☐

Target Populations:

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

Key Legislative Issues

Increasing women's access to income and productive resources

Stigma and discrimination

Food

Education

Coverage Areas

Kamonyi

Muhanga

Nyanza

Ruhango

Gatsibo

Kigali

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: Central (GHAI)
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 7156
Planned Funds: $ 0.00
Activity Narrative: This activity is linked to following programs: HVAB (7157), HKID (8150, 7186).

Catholic Relief Services' "Support for OVC Affected by HIV/AIDS" project began in Rwanda in 2004. Since that time, the project has reached thousands of OVC in four target dioceses and in over 35 parishes. The project's main objectives are to ensure the provision of essential core services to OVC affected or infected by HIV/AIDS and to strengthening the family and community's ability to provide these services. CRS successfully integrates this OVC program into its Track 1.0 AB program and its Title II food assistance project. As the lead OVC partner within the CHAMP project, CRS uses the experience and lessons learned from implementing this Track 1 program to guide and improve other USG-supported OVC activities. CRS works closely with its primary partner Caritas, the GOR, and the CHAMP project to implement the below activities.

With FY 2006 funding, CRS is providing services to OVC in the following areas: education, health, agriculture/nutritional assistance, vocational training, and HIV/AIDS prevention. As of June 2006, CRS monitored and supported 55 secondary students with school fees and 4500 primary students with school materials. As well, CRS enrolled a total of 1227 OVC families (4841 individuals) in a community health-care insurance scheme known as Mutuelles de Santé. CRS conducted gardening and nutrition trainings, which included bio-intensive agriculture for 290 OVC and OVC caregivers. In addition, the program distributed 300 goats to OVC households in FY 2006. In the area of community strengthening, CRS relies on parish level committees to mobilize the community as well as to select and monitor the OVC. CRS conducted training sessions for Caritas staff on topics such as Nutrition, Child Rights, and Savings and Credit. CRS and Caritas hosted Community Mobilization and Sensitization meetings on HIV/AIDS focusing on abstinence and fidelity prevention methods in each of the parishes of the Butare Diocese reaching over 1,300 OVC.

To provide OVCs with a more comprehensive menu of services, in FY 2007 CRS will reduce the number of Track 1.0-supported beneficiaries from an estimated 5000 to 3266. CRS will maintain support to all current OVC beneficiaries under the age of 18 with EP funding through CHAMP, and no OVC will lose assistance. Community level committees will assess the individual needs of OVCs and provide them with a tailored menu of services. CRS plans to use an OVC Needs Assessment Tool currently under development by CHAMP to improve the overall provision of services and monitoring of beneficiaries. In FY 2007, CRS will use their newly developed OVC Committee Guide and the Volunteer Guide to train OVC Committee members and volunteers in mentoring, psycho-social support and child protection. CRS plans to train 340 volunteers and caregivers to support OVC. CRS will also increase efforts to appropriately link OVC with VCT services. The program will also create and train new Savings and Loan groups to improve the economic situation of OVC with a focus on girl-headed households. This program addresses key legislative issues concerning gender, women's access to income, food and stigma reduction. These activities support the National OVC Plan of Action and the Rwanda EP five-year strategy of strengthening the capacity of community and religious organizations to address the needs of vulnerable children.

Continued Associated Activity Information

Activity ID: 2830
USG Agency: U.S. Agency for International Development
Prime Partner: Catholic Relief Services

Mechanism: CRS Track 1
Funding Source: N/A
Planned Funds: $ 0.00

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

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	3,260	☐
Number of providers/caregivers trained in caring for OVC	340	☐

Target Populations:

Faith-based organizations
HIV/AIDS-affected families
Orphans and vulnerable children
Volunteers
Caregivers (of OVC and PLWHAs)
Religious leaders
HIV positive children (5 - 14 years)

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

Gisagara

Huye

Nyanza

Nyaruguru

Kayonza

Kirehe

Ngoma

Rwamagana

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: GHAI
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 7186
Planned Funds: $ 8,039,083.00

Activity Narrative: With additional funds, CHAMP will continue to work through their Rwanda partner organizations to both improve the quality of existing services and expand the number of OVC receiving services. Additional funds will supplement regular COP07 funding for expanding and improving the quality of services currently being offered, i.e. education, vocational training, health, food aid, protection, psychosocial support, shelter and basic needs. Since secondary school education in Rwanda is costly and start-up kits for vocational training graduates are expensive, CHAMP will use a portion of these funds to increase the number of current OVC who have access to the two services

In addition, CHAMP will use remaining funds to identify and serve 3,684 new OVC and ensure they have access to the full range of services, including health mutuelles, education, vocational training, food aid, protection, psychosocial support, shelter and basic needs. In identifying new OVC, CHAMP will address the needs of special populations such as children under five, adolescent girls, children living outside of family care, and out of school youth. CHAMP will also need to prioritize OVC in the same family due to the recent change in health insurance policy.

This activity relates to MTCT (7181), HVAB (7183), HVOP (7184), HVCT (7182), HBHC (7187), OHPS (7189), and HKID (8727, (7148, 7155, 7156).

Through financial support and technical and institutional capacity building for Rwandan partner organizations, CHAMP is working to ensure Rwandan communities have equitable access to high quality, sustainable continuum of HIV & AIDS services. CHAMP supports the provision of community services in all EP-supported districts, especially around EP-supported health facilities.

CHAMP works with three umbrella organizations - which collectively support over 1,000 associations representing women, PLWHA and the religious community - and six other Rwanda partner organizations. In FY 2007, CHAMP will continue to provide technical and financial assistance to these partner organizations and their members to provide comprehensive, quality services to OVC. CHAMP will also add new partners. In addition to building their technical capacity, CHAMP will work with the partners (and their member associations as appropriate) to build their capacity to manage programs, finances, and human resources with the ultimate goal of directly receiving donor funding in the future.

In FY 2006, CHAMP serves as the main coordinating mechanism for EP-supported OVC activities through three activities. First, CHAMP provides TA, training, and financial support to local partners to support and strengthen their capacity to directly provide care. Second, CHAMP supports the GOR programs and policies for OVC by seconding technical staff at the central level. Third, CHAMP incorporates Track 1.0 OVC programs in national planning and data collection through M&E training. CHAMP advances the network model by linking HIV/AIDS clinical and community partners, and by wrapping around non-HIV/AIDS services that are supported by other funding streams.

To ensure sustainable change, CHAMP will support and strengthen existing natural social linkages in the community for child protection, care and support.

To date, CHAMP has provided financial and technical support to nine subgrantees in 20 districts to reach over 17,000 OVC with a menu of services and trained 745 caregivers. In addition, CHAMP has been actively involved in the finalization of the GOR's OVC NPA, which implements the 2003 National Policy for Orphans and Other Vulnerable Children. The GOR's menu of essential services for OVC closely mirrors the EP's core services and includes education, health, shelter, food, economic strengthening, psychosocial support, protection and HIV prevention. The GOR developed the OVC NPA with the input of children through two National Children's Summits. The ongoing participation of children in these decisions will be supported by the district and sector level children's forums and orphan care committees.

In FY 2007, CHAMP will continue to support the OVC NPA through participation on the OVC TWG, participation in a national OVC mapping exercise in conjunction with MIGEPROF, and secondment of a technical advisor in MIGEPROF to oversee implementation of the OVC NPA. CHAMP will continue to work closely with its subgrantees and the EP Track 1.0 partners to assess the needs of individual OVC, and offer multiple

services and/or refer OVC to other services in the community based on their needs. This approach will be standardized among all EP OVC partners using forms and referral systems established in FY 2006. CHAMP will work to fill gaps and improve the quality of services currently being offered and expand services to ensure OVC have access to them, especially in the catchment areas around EP-supported health facilities. CHAMP will give special attention to child headed households and to OVC in communities surrounding military camps. CHAMP-supported partners will reach 35,400 OVC with a comprehensive menu of services.

CHAMP will train 5,000 OVC caregivers in psychosocial support, protection, HIV prevention and ways to link to other services such as education, healthcare, food and vocational training. CHAMP will ensure that caregivers trained in FY 2006 receive follow-up support and refresher training as needed.

CHAMP will continue to wrap around other USG-funded and CHAMP-supported OVC programs where appropriate. This includes Title II food support, the Ambassador's Girls Scholarship program, the Presidential Malaria Initiative, and other general health services for children supported by USG's child survival and health program, such as vitamin A distribution, immunization, and deworming.

This activity supports the key legislative issues of gender, stigma and discrimination, and wraps around food and education. This approach reflects the EP five-year strategy to integrate HIV prevention, care and treatment; expand pediatric HIV care; and mobilize community coordinated action.

Continued Associated Activity Information

Activity ID: 2810
USG Agency: U.S. Agency for International Development
Prime Partner: Community Habitat Finance International
Mechanism: CHAMP
Funding Source: GHAI
Planned Funds: $ 4,516,400.00

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	10 - 50
Food/Nutrition	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 OVC served by OVC programs	39,084	☐
Number of providers/caregivers trained in caring for OVC	5,000	☐

Target Populations:

Community leaders
Community-based organizations
Faith-based organizations
HIV/AIDS-affected families
Orphans and vulnerable children
Volunteers
Caregivers (of OVC and PLWHAs)
Religious leaders
HIV positive children (5 - 14 years)

Key Legislative Issues

Stigma and discrimination

Gender

Food

Education

Coverage Areas

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Bugesera

Gatsibo

Nyagatare

Rwamagana

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 7255
Planned Funds: $ 85,000.00
Activity Narrative: USAID/Rwanda has been providing local and international TA to GOR agencies and limited direct grants to local NGOs since FY 2004.

In FY 2007, the EP will expand this to further build local capacity. USAID anticipates continuing financial and technical support to Rwanda NGOs in sponsoring or attending conferences, workshops and technical meetings on HIV treatment. USAID will also support direct TA to other GOR agencies as needed, in particular CNLS and MIGEPROF.

Continued Associated Activity Information

Activity ID: 4969
USG Agency: U.S. Agency for International Development
Prime Partner: US Agency for International Development
Mechanism: USAID Rwanda Mission
Funding Source: GHAI
Planned Funds: $ 185,000.00

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/caregivers trained in caring for OVC		☑

Coverage Areas:

National

Table 3.3.08: Activities by Funding Mechanism

Mechanism: ACDI-VOCA Title II
Prime Partner: ACDI/VOCA
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 8148
Planned Funds: $ 20,000.00
Activity Narrative: This activity relates to HKID (8150, 8152).

ACDI/VOCA's partner, Africare, currently implements the Food Security and HIV/AIDS Initiative in Nyamagabe district in the Southern Province of Rwanda with Title II funding. The main objective of the project, which began in October 2005, is to improve the health and nutritional status of PLWHA and their family members and to reduce household and community vulnerability to HIV/AIDS and its effects. Over the last year, Africare trained 66 HBC volunteers to provide care and support to 668 PLWHA and their families from 31 different PLWHA Associations within Nyamagabe district. These services include HIV/AIDS prevention, healthy living, and nutritional information, psycho-social support, and supplementary feeding for malnourished PLWHA and OVC. Each HBC volunteer provides assistance to 10-15 households. As an incentive, Africare offers the HBC volunteers the opportunity to participate in IGA.

Title II direct food aid currently benefit thousands of HIV/AIDS affected households in Rwanda. USAID/Rwanda will support these important wrap-around programs by providing EP funding for two Africare staff positions - a nutritionist and a logistics manager. The EP funding will allow Africare to target its resources to support more beneficiaries while providing the staffing needed to manage the increased workloads. These positions will increase the overall integration of Title II and EP programming. The nutritionist will provide the following support: 1) train the HBC volunteers and Africare staff in IEC and Nutrition, 2) monitor and supervise the HBC volunteers, and 3) collaborate with other partners in the area. CHAMP, Twubakane, FHI and WFP support a number of activities in this district. The nutritionist will work closely with these partners to develop and maintain referral systems. This staff position will help ensure that the PLWHA and OVC referred to Africare's food aid program receive comprehensive services from the health facilities and community-based programs in the area. The logistics manager will be responsible for ensuring that all USG commodities are handled correctly and accounted for according to regulations until they reach the final beneficiaries. This position will supervise the warehouse staff, verify all warehouse reports for accuracy, report on delivery and warehouse losses, and dispose of any damaged food.

The EP support to the Title II program will allow the Africare program to increase their amount of direct food assistance. In FY 2007, the number of HBC volunteers will increase to 90 as the number of PLWHA households receiving food rations increases to over 900 every six-month period. Africare will move to a six-month food aid support package in FY 2007 in order to meet new GOR food aid protocols. The Title II funding will benefit a total of 1,800 HIV/AIDS affected households, or 9000 individuals, with food aid. There are no direct or indirect targets, however, for this activity as the beneficiaries will be directly counted by other partners providing PLWHA and OVC services. This increase in beneficiaries requires more management oversight and project monitoring, which the two EP-funded staff will provide.

This activity addresses the key legislative issue of food wrap around. This activity reflects the ideas presented in the Rwanda EP five-year strategy by integrating and linking PEPFAR programming with other USAID programming.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Food/Nutrition	51 - 100
Linkages with Other Sectors and Initiatives	10 - 50
Logistics	10 - 50

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	0	☐
Number of providers/caregivers trained in caring for OVC	0	☐

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 pregnant women
Caregivers (of OVC and PLWHAs)
Widows/widowers
Implementing organizations (not listed above)
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Wrap Arounds

Food

Coverage Areas

Nyamagabe

Table 3.3.08: Activities by Funding Mechanism

Mechanism: CRS Title II
Prime Partner: Catholic Relief Services
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 8150
Planned Funds: $ 50,000.00

Activity Narrative: This activity relates to HKID (8148, 8152).

Title II Food for Peace activities under CRS began in Rwanda in January 2001 with the objective of addressing food insecurity and responding to emergency drought situations. To date, CRS with its partner Caritas has increasingly targeted households affected by HIV/AIDS. Title II funding supports and enhances CRS' EP-funded activities for PLWHA and OVC. Title II direct food aid and nutritional information activities currently benefit thousands of HIV/AIDS affected households in Rwanda. USAID/Rwanda will support these important wrap-around programs by providing EP funding for four CRS staff positions – two Nutrition Officers and two Commodity Logistics Officers.

The primary objective of CRS' food security and HIV/AIDS initiative is to improve the health and nutritional status of PLWHA and OVC. CRS and its partner Caritas implement this Title II project in the districts of Gisagara and Huye in the Southern province and in the districts of Karongi and Ngororero in the Western province. Outside the city of Kigali, the Western and Southern provinces have the highest incidence of HIV infection, with 2.7% of adults in Southern Province and 3.2% of adults in Western Province testing positive (2005 RDHS-III). CRS identified the four selected districts based on their high levels of food insecurity. Additionally, in April 2006, an emergency food security assessment conducted by WFP identified Huye and Gisagara districts as two out of the five most severely food insecure districts in the country, with 18% of the population classified as severely food insecure. As such, these targeted districts are extremely food insecure. CRS' food aid program currently provides 4,400 beneficiaries with a multi-year food aid package. In FY 2007, CRS will move to a six-month food support package to follow the new national food aid guidelines.

In FY 2007, the EP funding will support two Nutrition Officers and two Commodity Logistics Officers to help expand and manage CRS' food aid and HIV/AIDS project. CRS and its partners work with PLWHA associations and OVC to provide a package of food security activities focused on supporting human capabilities of vulnerable food insecure households. The package will include: 1) time limited (six month) food distributions to targeted households; 2) education in nutrition and hygiene practices with an emphasis on the needs of PLWHA, OVCs and those on ART; 3) training in improved farming techniques through Farmer Field Schools; 4) provision of improved seed varieties through seed fairs; and 5) a savings mobilization program to build savings and enhance access to credit.

The two Nutrition Officers will oversee the above activities involving nutritional education – training and supervising the volunteers and Caritas staff and collaborating with the other partners in the four districts. These two staff positions will help ensure that the PLWHA and OVC referred to CRS' food aid program receive comprehensive services from the health facilities and community-based programs in the area. The Nutrition Officers will also increase the overall integration of CRS' Title II and PEPFAR programming. In addition to Title II activities, CRS and Caritas support OVC and AB Track 1 prevention activities in Gisagara and Huye. CRS and Caritas also implement multiple HIV/AIDS related programs in Karongi and Ngororero districts with Title II and CHAMP funding. The two Commodity Logistics Officers will be responsible for ensuring that all USG commodities are handled correctly and accounted for according to regulations until they reach the final beneficiaries. These positions will supervise the warehouse staff, verify all warehouse reports for accuracy, report on delivery and warehouse losses, and dispose of any damaged food.

This funding will allow CRS to target its Title II resources to support more beneficiaries and more volunteers while at the same time providing the staffing needed to manage the increase in program activity. CRS plans to reach a total of 8,800 HIV-affected households, or 44,000 individuals with food aid. There are no direct or indirect targets for this activity as the beneficiaries will be directly counted by other partners providing PLWHA and OVC services.

This activity addresses the key legislative issue of food wrap around. This activity reflects the ideas presented in the Rwanda EP five-year strategy by integrating and linking PEPFAR programming with other USAID programming.

Emphasis Areas

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Food/Nutrition	51 - 100
Linkages with Other Sectors and Initiatives	10 - 50
Logistics	10 - 50

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	0	☐
Number of providers/caregivers trained in caring for OVC	0	☐

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
HIV positive pregnant women
Caregivers (of OVC and PLWHAs)
Widows/widowers
Implementing organizations (not listed above)
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Wrap Arounds

Food

Coverage Areas

Gisagara

Huye

Karongi

Ngororero

Table 3.3.08: Activities by Funding Mechanism

Mechanism:	WV Title II
Prime Partner:	World Vision International
USG Agency:	U.S. Agency for International Development
Funding Source:	GHAI
Program Area:	Orphans and Vulnerable Children
Budget Code:	HKID
Program Area Code:	08
Activity ID:	8152
Planned Funds:	$ 50,000.00
Activity Narrative:	This activity relates to HKID (8148, 8150).

World Vision and its partner, ADRA, began Title II Food for Peace development activities in Rwanda in October 2004 with the objective of addressing food insecurity, especially among households affected by HIV/AIDS. Title II direct food aid and nutritional information activities currently benefit thousands of HIV/AIDS affected households in Rwanda. USAID/Rwanda will support these wrap-around programs by providing EP funding for two Nutrition Officers and two Logistics Managers for both World Vision and ADRA.

Over the last year, World Vision and ADRA targeted 1,500 households with food aid. The health and nutrition component of this project includes improving the health and nutrition for women, children and vulnerable groups including PLWHA and OVC. World Vision operates in the following 11 districts: Bugesera and Gatsibo (Eastern province); Gicumbi, Gakenke, Musanze, and Rulindo (Northern province); Nyamagabe and Nyaruguru (Southern province); and Gasabo, Kicukiro, and Nyarugenge (Kigali province). In the existing Title II program, World Vision and ADRA provide food aid, education, support, and health services to PLWHA and their families. These partners employ the Hearth Model for training mothers, foster parents, and health workers. Malnourished children and PLWHA receive supplemental feeding and vitamins for nutritional recuperation. World Vision is also working to enhance agricultural production and marketing, environmental protection, and infrastructure through business training and rehabilitation of feeder-roads and culverts. These activities target PLWHA, and include HIV/AIDS prevention activities that promote healthy behaviors.

In FY 2007, the EP will support two Nutrition Officers and two Logistics Managers to help expand and manage World Vision's and ADRA's food aid and HIV/AIDS activities. The two Nutrition Officers will oversee the above activities involving nutritional education – training and supervising the volunteers and collaborating with the other partners in the 11 districts. These two positions will serve as liaisons between the Title II food aid programs and PEPFAR ensuring that PLWHA and OVC participating in World Vision and ADRA's food aid programs receive comprehensive services from the health facilities and community-based programs in the area. The two Commodity Logistics Officers will be responsible for ensuring that all USG commodities are handled correctly and accounted for according to regulations until they reach the final beneficiaries. These positions will supervise the warehouse staff, verify all warehouse reports for accuracy, report on delivery and warehouse losses, and dispose of any damaged food.

This EP funding will allow World Vision and ADRA to target their Title II resources to support more beneficiaries and more volunteers while at the same time providing the staffing needed to manage the increase in program activity. In FY 2007, these partners will provide food aid to an estimated 5000 HIV/AIDS infected and affected households, or 28,000 individuals. There are no direct or indirect targets however for this activity as the beneficiaries will be directly counted by other partners providing PLWHA and OVC services.

This activity addresses the key legislative issue of food wrap around. This activity reflects the ideas presented in the Rwanda EP five-year strategy by integrating and linking PEPFAR programming with other USAID programming.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Food/Nutrition	51 - 100
Linkages with Other Sectors and Initiatives	10 - 50
Logistics	10 - 50

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	0	☐
Number of providers/caregivers trained in caring for OVC	0	☐

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
HIV positive pregnant women
Caregivers (of OVC and PLWHAs)
Widows/widowers
Implementing organizations (not listed above)
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Food

Coverage Areas

Gakenke

Gicumbi

Musanze

Rulindo

Nyamagabe

Nyaruguru

Bugesera

Gatsibo

Gasabo

Kicukiro

Nyarugenge

Table 3.3.08: Activities by Funding Mechanism

Mechanism:	Transport Corridor Initiative
Prime Partner:	Family Health International
USG Agency:	U.S. Agency for International Development
Funding Source:	GHAI
Program Area:	Orphans and Vulnerable Children
Budget Code:	HKID
Program Area Code:	08
Activity ID:	8727
Planned Funds:	$ 75,000.00

Activity Narrative: This activity relates to ROADS activities under HVAB (7199), HVOP (7200), HVCT (7201), HBHC (8142), and OHPS (8744).

The overall goal of the ROADS Project is to stem HIV transmission and mitigate the consequences of HIV/AIDS on vulnerable populations along major East African transport corridors. This multi-sectoral project will target high-risk mobile populations--drivers and their assistants, CSWs, members of the uniformed services and stop-over site communities--with regionally coordinated SafeTStop messages. It will also link these target populations with new or improved HIV/AIDS services and care tailored to meet their needs. Innovative elements of the SafeTStop model include essential HIV-related programming on alcohol, gender-based violence, food security and economic empowerment. The ROADS Project works in Kenya, Uganda, Djibouti, Southern Sudan, Rwanda, Burundi and the DRC.

Over the last year, the ROADS Project focused on three sites in Rwanda: Kigali-ville, Gatuna on the Uganda border and Cyangugu on the DRC border. FHI launched the SafeTStop campaign in November 2005 with participation from the three major transport associations in Rwanda (Truck drivers, Mini-bus drivers and Motorcycle Taximen) as well as from the Association of Truckers' Wives, the CNLS and the Ministry of Labor. ROADS has trained 132 peer educators from the associations who in turn reached more than 3,400 individuals with ABC messages, information on STIs, and VCT referral. In FY 2006, ROADS completed an assessment on alcohol and HIV as part of a three-country study requested by the ECSA Ministers. ROADS will finalize rapid assessments in all three SafeTStop sites to identify programming needs. ROADS will continue to train peer educators to convey HIV prevention messages including the risks associated with cross-generational sex and prevention for positives. The peer educators will be out-of-school youth, truck drivers, commercial sex workers, and other community members. ROADS will work in partnership with PSI and health facilities to provide mobile VCT services.

In FY 2007, ROADS will continue to link and make referrals to existing OVC and PLWHA services in the communities. However, ROADS will also begin directly providing care and support services to vulnerable HIV-affected families in the three communities. Working through local associations, women's groups and CBOs, ROADS will monitor and provide 1,000 HIV/AIDS OVC access to school fees, health mutuelles, nutritional support, psychosocial support, economic strengthening opportunities, shelter and protection according to their individual needs. Each of these beneficiaries will also receive age-appropriate AB information about HIV/AIDS prevention.

The project will also train about 20 volunteers (teachers, community leaders, religious leaders, health workers) to work with truck drivers, low-income women and out-of-school youth with. To enhance access to HIV care and support, the ROADS Project has developed the LifeWorks Partnership, which creates jobs for marginalized, vulnerable people in East and Central Africa, including PLWHA, older orphans and low-income women. Through this partnership, ROADS attempts to secure the long-term economic health of individuals, families and communities, as a key HIV care and prevention strategy. To do this, ROADS has enlisted the private sector to: 1) identify small business opportunities for women and older orphans, including design and production of home and fashion accessories; 2) provide source financing through development banks; 3) and give pro bono business expertise to help these new businesses grow. A key feature of LifeWorks is that nascent businesses not only provide jobs for the most at-risk people in a community, but that the companies themselves fight AIDS through their own corporate responsibility platforms. This partnership will be initiated in Rwanda for above target population.

These activities address the key legislative issues of gender, stigma reduction, and wraps around food. The ROADS project reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan by focusing prevention, care and treatment efforts on high-risk, vulnerable populations.

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

Targets

Target	Target Value	Not Applicable
Number of OVC served by OVC programs	1,000	☐
Number of providers/caregivers trained in caring for OVC	25	☐

Target Populations:

Business community/private sector
Commercial sex workers
Community-based organizations
Discordant couples
Street youth
Truck drivers
Orphans and vulnerable children
Out-of-school youth
Partners/clients of CSW

Key Legislative Issues

Stigma and discrimination

Gender

Food

Coverage Areas

North

Gicumbi

West

Rusizi

Kigali

Gasabo

Kicukiro

Table 3.3.08: Activities by Funding Mechanism

Mechanism: CRS USAID Supplemental
Prime Partner: Catholic Relief Services
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Orphans and Vulnerable Children
Budget Code: HKID
Program Area Code: 08
Activity ID: 16343
Planned Funds: $ 150,000.00
Activity Narrative: As part of the FY07 plus-up, additional funds to the CRS Track 1 mechanism will enable CRS to improve the quality of services currently being provided by program. With current funding, CRS is supporting 3,260 OVC with a variety of services including school fees, school materials, health insurance, gardening and nutrition training, psychosocial support, and limited income generating activities. CRS is currently able to support only 55 OVC with support for secondary education and just 100 OVC with vocational training, given the high costs for these services in Rwanda. This additional funding will allow CRS to provide more OVC with access to secondary school education, vocational training and post-training starter-up kits. CRS will also prioritize supporting other OVC in the same family for a more "family centered" approach, providing insecticide-treated mosquito bed nets for the prevention of malaria, and increase access to the existing goat distribution program (GDP).

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: $ 4,195,937.00

Program Area Context:

As Rwanda is successfully advancing toward its goal of providing ART for all persons who need it, the efficient deployment of CT resources becomes ever more important to achieve both identification of HIV-positive individuals and to refine effective testing-based HIV prevention programs. CT activities in FY 2007 will support existing CT sites while expanding services to reach most at risk populations. By the end of FY 2006, the EP will have provided counseling and testing services to over 150,000 individuals in 24 districts in Rwanda. In FY 2007, the EP will add 15 CT facilities for a total of 176 EP-supported sites, train 1,051 counselors, establish 2 new CT mobile units, and provide CT to 175,190 persons. This accounts for nearly 50% of Rwanda's national CT target for 2007.

To strengthen facility-based CT in Rwanda, all USG clinical partners will receive CT funding in 2007. CT will continue to be offered in sites where patients can also receive basic care such as PMTCT, CD4 staging, OI prophylaxis and treatment, nutrition counseling and referral to community services and higher level clinical care. In order to improve the efficiency of rapid CT services, GOR has adopted a change in the specimen collection protocol from venous blood draw to finger-stick collection. In order to reach more clients, EP partners have adopted advanced testing strategies such as increased testing of male partners of PMTCT clients through community sensitization, facilitated couples testing through weekend CT services, improved pediatric case-finding through testing during immunization days and special family/child testing days during vacation days. In FY 2007, EP clinical partners will provide CT through a strategic mix of targeted PIT, family-centered CT, and client-initiated CT services that ensure confidentiality, minimize stigma and discrimination, and reach those individuals most likely to be infected. Through these activities, refugee and military populations will also be reached at three UNHCR-supported camps and six Drew-supported hospitals and brigade clinics, respectively.

In FY 2007, CHAMP community activities will support the promotion of CT among OVC and PLWHA and their families served by CHAMP-supported partners. This targeted promotion of CT services will identify those most likely to be infected and ensure they are referred to appropriate sites to receive care and treatment. These activities will contribute to increasing the number of people served by clinical partners.

In order to reach high prevalence populations, EP partners efforts will continue to focus on several groups considered to be most at-risk. CSWs and their clients, refugees, prisoners, and itinerant workers (tea and coffee plantation workers, fishermen, and truck drivers) are all planned recipients of MVCT. Four complementary activities with different points of emphasis are planned for MVCT. A mobile team fielded by CDC will focus on the generation of actionable, strategic information about most-at-risk-persons (MARPs), while two mobile teams fielded by a TBD partner will emphasize MVCT service delivery through testing for 10,000 MARPs. Through the Transport Corridor Initiative, FHI provides a third use of MVCT by ensuring CT services at 3 SafeTStops for drivers, commercial sex workers, and other mobile groups. Finally, PSI will continue to provide MVCT services to the military as well as military spouses and families. These four implementing partners will coordinate activities to avoid duplication and maximize MVCT coverage to at-risk populations.

Family and couples CT has been endorsed by the GOR and promoted by USG since 2004; however, implementation of these activities has been slow. In FY 2007, EP will help Rwanda to build upon its network of facilities already offering CT by hiring and supporting 200 new "contact counselors" whose primary responsibilities will be to counsel newly-identified HIV-positive individuals, conduct contact tracing to families and sexual partners, and offer HIV testing to these contacts. These counselors will be supported by USG clinical partners and CDC will work with TRAC to establish policies and procedures for family and couples testing, and will play a focal role in the coordination of related M&E. Contact counselors will emphasize offering counseling and testing to the families (sexual partners and children) of PMTCT clients found to be HIV-positive. Contact counselors will also identify discordant couples who will receive intensive prevention counseling. As Rwanda moves towards a disease registry-based system, individuals

identified through family and couples CT will be entered into a database that utilizes the national identification number as the basis of a case report. Moreover, this system will permit the compilation of a sub-registry of HIV-discordant couples to allow expanded activities in prevention for seropositives (see SI overview).

The GOR has now endorsed PIT as a pillar of CT strategy for the foreseeable future and is in the process of establishing guidance for its implementation. Remaining obstacles include defining details of implementation such as opt-in versus opt-out consent requirements, and the appropriate content and duration of pretest counseling in the context of care. In FY 2007, the USG will continue to support TRAC for the development of policies that promote PIT as routine procedure.

Rapid testing for all CT is conducted in accordance with GOR national algorithms which have been developed with USG technical support. In FY 2007, supply chain management for test kits will be further strengthened with the implementation of SCMS as the umbrella commodities management system. PFSCM will provide test kits for all USG-supported CT activities in FY 2007.

Program Area Target:

Number of service outlets providing counseling and testing according to national and international standards	176
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	175,190
Number of individuals trained in counseling and testing according to national and international standards	1,051

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: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 7147
Planned Funds: $ 0.00

Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 - NO NEW FUNDING IN FY2007][

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.

Continued Associated Activity Information

Activity ID: 4874
USG Agency: U.S. Agency for International Development
Prime Partner: African Humanitarian Action
Mechanism: Refugees AHA
Funding Source: GHAI
Planned Funds: $ 22,000.00

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
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national and international standards	1	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	5,000	☐
Number of individuals trained in counseling and testing according to national and international standards	25	☐

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 (prior to 2007)

Table 3.3.09: Activities by Funding Mechanism

Mechanism: AIHA Twinning Ctr
Prime Partner: American International Health Alliance
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 7149
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 - NO NEW FUNDING UNDER FY2007]

This activity is related to CDC Direct CT activity # 2845. In collaboration with AIHA, Liverpool VCT will conduct an initial assessment of local Rwandan NGOs and assess their capacity to provide VCT services. Liverpool VCT will then develop and tailor specific strategies for Rwandan NGOs to develop their programmatic, financial and technical capacity with the goal of providing high quality VCT services by 2008. Liverpool currently provides similar services in Kenya where it has a proven track record. To advance local capacity, Liverpool will also promote South to South exchanges and provide technical assistance in order to develop the capacity of Rwandan NGOs. Liverpool will specifically provide Rwandan NGOs with assistance in developing advanced VCT services including mobile VCT services as well as enhance current clinic based services.

Continued Associated Activity Information

Activity ID: 6602
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: American International Health Alliance
Mechanism: AIHA Twinning Ctr
Funding Source: GHAI
Planned Funds: $ 82,913.00

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national and international standards supported with performance-based financing		☑
Number of service outlets providing counseling and testing according to national and international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results (including TB)		☑
Number of individuals trained in counseling and testing according to national and international standards		☑

Key Legislative Issues

Twinning

Table 3.3.09: Activities by Funding Mechanism

Mechanism: Refugees - Rwanda
Prime Partner: American Refugee Committee
USG Agency: Department of State / Population, Refugees, and Migration
Funding Source: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 7153
Planned Funds: $ 0.00

Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 - NO NEW FUNDING IN FY2007]

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.

Continued Associated Activity Information

Activity ID:	4867
USG Agency:	Department of State / Population, Refugees, and Migration
Prime Partner:	American Refugee Committee
Mechanism:	Refugees - Rwanda
Funding Source:	GHAI
Planned Funds:	$ 30,000.00

Targets

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

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 (prior to 2007)

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: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 7170
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 - NO NEW FUNDING IN FY2007]

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 confidentially 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.

Continued Associated Activity Information

Activity ID: 2732
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Columbia University Mailman School of Public Health
Mechanism: Columbia UTAP
Funding Source: GHAI
Planned Funds: $ 200,000.00

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 and international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results (including TB)		☑
Number of individuals trained in counseling and testing according to national and international standards		☑

Coverage Areas

Gisenyi (prior to 2007)

Kibuye (prior to 2007)

Kigali-Ville (prior to 2007)

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: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 7178
Planned Funds: $ 75,614.00

Activity Narrative: This activity is related to activities in HVOP (8133), HBHC (7177), HTXS (7164, 7174) and HVCT (8167, 8730).

In FY 2006, Columbia is supporting care and treatment services in 35 sites and reaching approximately 7,000 clients with PIT. Per GOR norms, VCT will be offered in sites where patients can receive needed basic care such as PMTCT, CD4 staging, OI prophylaxis and treatment, and referral to community services and higher level clinical care. In order to improve the efficiency of CT services, partners are moving to rapid testing and advanced strategies for testing. In order to reach more clients, partners have increased male partner testing of PMTCT clients through community sensitization, facilitated couples testing through weekend CT services, improved pediatric case-finding through testing during immunization days and special family/child testing days during vacation days.

In FY 2007, Columbia will reach 30,240 individuals through a strategic mix of targeted PIT, family-centered CT, and client-initiated CT services that ensure confidentiality, minimize stigma and discrimination, and reach those individuals most likely to be infected. This activity will support CT services at 35 existing and 7 new ART sites. At all Columbia-supported health facilities, PIT services will target adult and pediatric inpatients presenting with TB and other HIV-related OIs and symptoms, malnourished children and HIV-exposed infants, and STI patients. PIT will be implemented with a revised counseling component whereby pre-test counseling is more focused with emphasis placed on post-test counseling. Moreover, case managers and community workers will be trained as counselors in order to provide continuous support beyond the consultation to encourage testing acceptance, family and/or partner tracing, and support for those who received their test results. A total of 200 doctors, nurses and social workers at Columbia sites will be trained in PIT.

In collaboration with CHAMP, case managers will work with PLWHA associations, religious institutions, community DOTS programs, and OVC and HBC programs to identify those infected, in particular HIV-exposed infants, family members of PLWHA, and OVC. CT providers will continue to provide traditional CT (client-initiated) for those who wish to know their status, in particular for pre- and post-nuptial couples, ANC male partners, and youth. Counseling messages will emphasize prevention, including abstinence and fidelity, alcohol reduction, GBV sensitization, disclosure of test results, and follow-up care.

In order to counsel and test those individuals most likely to be HIV-positive, 63 new "contact counselors" will be recruited to conduct contact tracing of all patients who test positive for HIV at Columbia sites. Contact counselors will be responsible for accompanying HIV-positive clients to their community, encouraging their spouse and family members to be tested, providing HIV testing, and identifying discordant couples who are in need of intensive prevention counseling. As Rwanda moves towards a disease registry-based system, individuals receiving services through these family and couple CT efforts will be entered into a database that utilizes the national identification number as the basis of a case report. Moreover, this system will permit the compilation of a sub-registry of HIV-discordant couples to allow expanded activities in prevention for seropositives. CDC will work with TRAC to establish policies and procedures for family and couples testing, and will play a focal role in the coordination of related M&E.

To strengthen the continuum of care for PLWHA and their families, partners will establish a formalized referral system to link community care and clinical services. The case manager, in collaboration with CHAMP, will ensure that HIV-positive patients are provided patient education, positive living counseling and referral for community-based services, such as IGA, through PLWHA associations, OVC, and HBC programs. At the health facility level, partners will ensure a system for supportive supervision of nursing and counseling staff, including training of select staff in supervision for CT, use of quality control checklists, and data quality control.

Columbia will monitor site performance and provide patient referral tools developed by TRAC for timely enrollment of HIV-positive patients diagnosed in any service at the site. Columbia will support sites to track PIT and contact tracing data for use at site level for program improvement and reporting. Through regular supervision at sites, patient satisfaction surveys, and HIV testing records review, Columbia will ensure that basic ethical practices and confidentiality related to HIV counseling and testing are practiced at

all sites.

PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, Columbia will shift some of its support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of CT and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool.

PFSCM will procure HIV test kits and supplies for all sites. Columbia will work with PFSCM and district pharmacies to ensure that all sites have adequate and secure storage facilities as well as inventory monitoring and tracking systems for the test kits.

This activity supports the EP five-year strategy for sustainability, national scale-up of counseling and testing, and provision of integrated treatment, care, and prevention services.

Continued Associated Activity Information

Activity ID: 2800
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Columbia University Mailman School of Public Health
Mechanism: Columbia MCAP Supplement
Funding Source: GHAI
Planned Funds: $ 474,000.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Quality Assurance, Quality Improvement 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 counseling and testing according to national and international standards	42	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	30,240	☐
Number of individuals trained in counseling and testing according to national and international standards	200	☐

Target Populations:

Family planning clients
Doctors
Nurses
Pharmacists
HIV/AIDS-affected families
Infants
Other Health Care Worker

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 7182
Planned Funds: $ 100,000.00
Activity Narrative: This activity is related to activities in MTCT (7181), HVAB (7183), HVOP (7184), HBHC (7187), HKID (7186), OHPS (7189), and HVCT (7178, 8164, 8168, 8169).

The Community HIV/AIDS Mobilization Program (CHAMP), through financial support and technical and institutional capacity building for Rwandan partner organizations, is working to ensure that Rwandan communities have equitable access to a high quality, sustainable continuum of HIV/AIDS care services. CHAMP supports the provision of community services in all EP-supported districts, particularly around EP-supported health facilities.

In FY 2006, CHAMP is training trainers from various community and faith-based organizations to promote CT services among OVC, PLWHA, their families and caregivers through home visits and group talks. By the end of FY 2006, over 3,000 individuals will have received messages on the importance of counseling and testing for HIV prevention, care, and treatment.

In FY 2007, CHAMP will continue to support the promotion of CT among OVC and PLWHA and their families who are being served by CHAMP-supported partners. This targeted promotion of CT services will identify those most likely to be infected and ensure they are referred to appropriate sites to receive care and treatment. CHAMP will not have any direct targets in this area, but will contribute to increasing the number of people served by clinical partners and mobile CT activities.

This activity supports the Rwanda EP five-year strategy to scale-up quality CT services and addresses the key legislative issue of stigma and discrimination.

Continued Associated Activity Information

Activity ID: 2806
USG Agency: U.S. Agency for International Development
Prime Partner: Community Habitat Finance International
Mechanism: CHAMP
Funding Source: GHAI
Planned Funds: $ 192,000.00

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 service outlets providing counseling and testing according to national and international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results (including TB)		☑
Number of individuals trained in counseling and testing according to national and international standards		☑

Target Populations:

Community leaders
Community-based organizations
Faith-based organizations
HIV/AIDS-affected families
Orphans and vulnerable children
People living with HIV/AIDS
Caregivers (of OVC and PLWHAs)
Religious leaders

Key Legislative Issues

Stigma and discrimination

Coverage Areas

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Bugesera

Gatsibo

Nyagatare

Rwamagana

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 7195
Planned Funds: $ 109,695.00
Activity Narrative: This extension will continue the activities of a current implementer to prevent treatment interruption. During the extension, implementer will make transition to follow-on awardee expected to be determined in late May.
[CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007]
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

Continued Associated Activity Information

Activity ID: 2756
USG Agency: U.S. Agency for International Development
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
Mechanism: Call to Action/EGPAF
Funding Source: GHAI

Planned Funds: $ 336,000.00

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

Targets

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

Target Populations:

Adults
Doctors
Nurses
HIV/AIDS-affected families
Laboratory workers
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Addressing male norms and behaviors

Stigma and discrimination

Microfinance/Microcredit

Coverage Areas

Gicumbi

Nyagatare

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 7201
Planned Funds: $ 125,000.00
Activity Narrative: This activity relates to activities in HVAB (7199), HVOP (7200), HKID (8727), HBHC (8142), OHPS (8744), and HVCT (8167).

The overall goal of the Regional Outreach Addressing AIDS through Development Strategies (ROADS) Project is to stem HIV transmission and mitigate the consequences of HIV/AIDS on vulnerable people along major East African transport corridors. This multi-sectoral project will target high-risk mobile populations including drivers and their assistants, CSWs, members of the uniformed services and stop-over site communities with regionally coordinated messages. It will also link these target populations with new or improved HIV/AIDS services and care tailored to meet their needs. Innovative elements of the ROADS SafeTStop model include essential HIV-related programming on alcohol, gender-based violence, food security and economic empowerment. The ROADS Project works in Kenya, Uganda, Djibouti, and the Southern Sudan and, in 2005, initiated activities in Rwanda, Burundi and the DRC.

Over the last year, the ROADS Project focused on three sites in Rwanda, one in Kigali and two at border sites (Gatuna on the Uganda border and Cyangugu on the DRC border). FHI launched the SafeTStop campaign in November 2005 with participation from the three major transport associations in Rwanda (truck drivers, mini-bus drivers and motorcycle taximen) as well as from the Association of Truckers' Wives, the CNLS and the Ministry of Labor. Since then, ROADS trained 132 peer educators from the associations who in turn reached over 3,400 individuals with ABC messages, information on STIs, and VCT referral. ROADS also completed an assessment on alcohol and HIV as part of a three-country study requested by the ECSA Ministers. Over the next few months, ROADS will finalize rapid assessments in all three sites to identify programming needs. ROADS will continue to train peer educators to convey HIV prevention messages including the risks associated with transgenerational sex and prevention for positives. The peer educators will be out-of-school youth, truck drivers, CSWs, and other community members. ROADS is initiating mobile CT services in partnership with PSI and other health facilities.

In FY 2007, ROADS will continue the above HIV prevention and CT promotion activities, training six new CT counselors and providing CT to 4,450 new individuals in the three communities. ROADS will collaborate with PSI to conduct both the training and mobile testing. PLWHA will receive information about healthy living and prevention for positives. The project will continue to link and make referrals for PLWHA and their families to existing HIV/AIDS community care services. New under FY 2007 funding, ROADS partners will begin providing care and support services to vulnerable HIV-affected families in three community sites. This activity addresses the key legislative issues of gender and stigma reduction.

PFSCM will procure HIV test kits and supplies for all sites. ROADS will work with PFSCM and district pharmacies to ensure inventory monitoring and tracking systems for the test kits.

The ROADS project reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan by focusing prevention, care and treatment efforts on high-risk, mobile populations.

Continued Associated Activity Information

Activity ID: 4778
USG Agency: U.S. Agency for International Development
Prime Partner: Family Health International
Mechanism: Transport Corridor Initiative
Funding Source: GHAI
Planned Funds: $ 86,400.00

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
Workplace Programs	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national and international standards supported with performance-based financing		☑
Number of service outlets providing counseling and testing according to national and international standards	3	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	4,450	☐
Number of individuals trained in counseling and testing according to national and international standards	6	☐

Target Populations:

Business community/private sector
Commercial sex workers
Community-based organizations
Discordant couples
Street youth
Truck drivers
Orphans and vulnerable children
Volunteers
Out-of-school youth
Partners/clients of CSW
Public health care workers
Private health care workers

Key Legislative Issues

Stigma and discrimination

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

Coverage Areas

Gicumbi

Rusizi

Gasabo

Kicukiro

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: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 7203
Planned Funds: $ 34,717.00
Activity Narrative: This extension will continue the activities of a current implementer to prevent treatment interruption. During the extension, implementer will make transition to follow-on awardee expected to be determined in late May.
[CONTINUING ACTIVITY FROM FY2006 -- NO NEW FUNDING IN FY2007]
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

Continued Associated Activity Information

Activity ID:	2775
USG Agency:	U.S. Agency for International Development
Prime Partner:	IntraHealth International, Inc
Mechanism:	Capacity
Funding Source:	GHAI
Planned Funds:	$ 444,400.00

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	10 - 50
Human Resources	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 service outlets providing counseling and testing according to national and international standards	16	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	49,000	☐
Number of individuals trained in counseling and testing according to national and international standards	200	☐

Key Legislative Issues

Reducing violence and coercion

Addressing male norms and behaviors

Stigma and discrimination

Microfinance/Microcredit

Coverage Areas

Gicumbi

Muhanga

Nyamagabe

Nyagatare

Karongi

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 7216
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 - NO NEW FUNDING IN FY2007]

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.
****PLUS-UPS****
$650,000 – This activity includes $200,000 for procurement of approximately 130,000 HIV test kits and confirmatory testing for USG partners and $450,000 for approximately 250,000 HIV test kits and confirmatory testing at Global Fund sites.

Additional HIV test kits are needed by USG partners due to anticipated increased uptake based upon provider initiated testing.

The Global Fund under Round 1 awarded a grant to fund approximately 120 VCTI sites in Rwanda. These 120 sites, which are located throughout the country, are a critical complement to USG ART services. In addition, these VCTI sites are essential to achieving overall country targets. Round 1 grants will expire in June 2006. The Global Fund will reprogram some of its Round 5 funds in order to ensure that these sites do not stop functioning. However, the Rwanda Global Fund program does not have enough funds to continue providing services to all 120 sites during this year. In order to ensure continuity of services, the USG Rwanda program has agreed to a joint procurement of HIV test kits.

The Global Fund and GOR will be responsible for personnel and clinical infrastructural operations at GF sites. With the provision of HIV test kits, the Global Fund should be able to reach country targets and continue to provide essential services without an adverse impact on the Rwanda program.

Continued Associated Activity Information

Activity ID: 5155
USG Agency: U.S. Agency for International Development
Prime Partner: Management Sciences for Health
Mechanism: RPM+
Funding Source: GHAI
Planned Funds: $ 116,760.00

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

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national and international standards supported with performance-based financing		☑
Number of service outlets providing counseling and testing according to national and international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results (including TB)		☑
Number of individuals trained in counseling and testing according to national and international standards		☑

Target Populations:

National AIDS control program staff

Pharmacists

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:	GHAI
Program Area:	Counseling and Testing
Budget Code:	HVCT
Program Area Code:	09
Activity ID:	7217
Planned Funds:	$ 373,120.00

Activity Narrative: This activity is related to activities in HVCT (7178, 7182, 8164, 8168), MTCT (7219), HBHC (7220), HVTB (7221), HTXS (7222), HVSI (8743).

Performance-based financing is an innovative approach to financing of health services that enhances quality of services and leads to greater efficiency and sustainability. Financial incentives provided by performance-based funding motivate health facilities to improve performance through investments in training, equipment, personnel and payment systems that better link individual pay to individual performance. PBF financing is directly applied to VCT and other HIV indicators at the facility level. As a result of successful pilots implemented by CordAID, GTZ and BTC, the MOH has endorsed national scale-up of performance-based financing for all health services. The USG, in partnership with the World Bank, BTC and other donors, is supporting national implementation of performance-based financing of health services.

In FY 2006, MSH/PBF supported the GOR in collaboration with key donors to develop a national strategy, policy, and implementation model of performance-based financing that applies to all health assistance. The initial strategy for EP-supported PBF activities was to transfer USG site support from a traditional inputs–based model to a purely output purchases model as sites achieved a certain level of technical competence. However, the implementation of COP06 activities brought a change in the USG team's thinking about this approach. Few, if any USG supported sites were found to be ready for complete graduation to an exclusively PBF model. While PBF clearly increases performance, technical assistance and basic input support is still needed, especially in the current context of rapid decentralization and accelerated national roll-out of the PBF model by the GOR. Therefore, an adjusted strategy has been developed that provides a combination of both input and output financing to all EP-supported sites. The combination of financing modalities will properly motivate health facilities for higher performance while providing necessary resources and tools to meet the established targets.

In FY 2007, MSH/PBF will continue to provide support to the MOH Performance Based Financing department and the national PBF TWG. In addition, MSH/PBF will provide TA to DHTs in all PEPFAR districts and to USG implementing partners to effectively shift some of their input financing to output-based financing for CT and other indicators in accordance with national policy. MSH/PBF will also provide output financing to health facilities in 6 districts (where other clinical partners will only provide input financing) through direct performance sub-contracts with health centers and district hospitals for CT and other indicators. Output financing involves the purchase of a certain quantity of indicators with a performance incentive for the production of more than agreed upon quantities of services. Full or partially reduced payment of CT and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool.

At the health center level, MSH/PBF will use a 'fixed price plus award fee' contract model to purchase a quantity of CT and other HIV indicators with a performance incentive. Examples of CT indicators include the number of persons tested for HIV and number of couples and partners tested for HIV. Performance on these indicators will be measured during monthly control activities jointly conducted by the MSH/PBF district coordinator and the district's Family Health Unit and quality of services will be evaluated through the existing national supervisory and quality assurance mechanisms. The quantity and quality scores will be merged during the quarterly District PBF Steering Committee meetings and the final payments will be approved.

At the district hospital level, MSH/PBF will have sub-contracts with slightly different purpose and scope from that of health centers. In addition to the focus on increasing better quality service outputs, there is an emphasis on quality assurance, self-evaluation, and review by peers similar to an accreditation scheme. There will be payment for indicators from the National District Hospital PBF Scheme which reinforces the supervisory role hospitals play in district health networks.

At the district level, MSH/PBF will support the national model by 1) placing a district coordinator within the Family Health Unit to work with national family health steering committee during data collection/entry and control of indicators, 2) facilitating the quantity control function by providing TA and paying associated costs, and 3) support secretarial

functions for the Family Health Unit at the district level. Support to the district is critical for the proper functioning of the national PBF model since monthly HIV/AIDS invoices are approved by the health center PBF management committee and MSH and are presented to the district steering committee for merging with a quality index and final approval before payments are made.

Performance-Based Financing of CT and other HIV services is a critical step to achieving the goal of sustainable, well-managed, high quality, and cost-effective VCT service delivery in a comprehensive HIV/AIDS treatment network. This financing modality supports the Rwanda EP five-year strategy for increasing institutional capacity for a district managed network model of HIV clinical treatment and care services.

Continued Associated Activity Information

Activity ID: 2812
USG Agency: U.S. Agency for International Development
Prime Partner: Management Sciences for Health
Mechanism: HIV/AIDS Performance Based Financing
Funding Source: GHAI
Planned Funds: $ 400,000.00

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, Quality Improvement and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national and international standards supported with performance-based financing	161	☐
Number of service outlets providing counseling and testing according to national and international standards	0	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	0	☐
Number of individuals trained in counseling and testing according to national and international standards	0	☐

Target Populations:

Adults
Community-based organizations
Country coordinating mechanisms
Faith-based organizations
Family planning clients
HIV/AIDS-affected families
Infants
International counterpart organizations
Non-governmental organizations/private voluntary organizations
Pregnant women
Volunteers
Other MOH staff (excluding NACP staff and health care workers described below)
Public health care workers
Implementing organizations (not listed above)

Coverage Areas

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Karongi

Rutsiro

Ngororero

Nyabihu

Nyamasheke

Rubavu

Gasabo

Kicukiro

Nyarugenge

Table 3.3.09: Activities by Funding Mechanism

Mechanism: PSI Healthy Schools
Prime Partner: Population Services International
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 7227
Planned Funds: $ 100,000.00
Activity Narrative: In FY 2007, PSI will field a mobile VCT team to provide HIV testing and counseling to high risk groups. This funding will cover salaries of counselors, laboratory supplies, transportation costs, and partial salaries for VCT Coodinator and Director of HIV Programs at PSI. The GOR's overall strategy continues to be prioritizing support for facility-based CT and expansion of new sites. However, GOR endorses selective use of mobile CT to reach mobile populations such as the uniformed services, CSWs and their clients, prisoners, men who have sex with men, truck drivers, and itinerant workers (fishermen, tea plantation workers, etc) - high-risk populations that are likely to have higher than average seroprevalence rates. PSI will work with the GOR and other key partners to field an MVCT team to provide high quality, client-initiated CT services that ensure confidentiality, minimize stigma and discrimination, and reach those individuals most likely to be infected.Counseling messages will emphasize prevention, including abstinence and reduction of partners, alcohol reduction, GBV sensitization, disclosure of test results, and follow-up care.

PSI's mobile team will coordinate schedules, target populations, and locations of testing with other EP partners conducting MVCT. In order to ensure proper referral to care, PSI will identify ARV sites in proximity of each MVCT testing location and provide this information and actively refer each HIV-positive client, and a follow-up system will be used to determine what percentage of clients actually accessed care. This will be implemented in accordance with GOR standards and guidelines. PSI will work with PFSCM and district pharmacies to ensure inventory monitoring and tracking systems for the test kits. This MVCT activity reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan by scaling-up CT services, increasing the availability of CT services outside of health facilities, and providing prevention messages to high-risk groups.

Continued Associated Activity Information

Activity ID: 2796
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Population Services International
Mechanism: HIV/AIDS School Based Program-Procurement
Funding Source: GHAI
Planned Funds: $ 100,000.00

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 and international standards		☑
Number of individuals who received counseling and testing for HIV and received their test results (including TB)		☑
Number of individuals trained in counseling and testing according to national and international standards		☑

Coverage Areas

Gitarama (prior to 2007)

Kigali-Ville (prior to 2007)

Table 3.3.09: Activities by Funding Mechanism

Mechanism:	PSI-DOD
Prime Partner:	Population Services International
USG Agency:	Department of Defense
Funding Source:	GHAI
Program Area:	Counseling and Testing
Budget Code:	HVCT
Program Area Code:	09
Activity ID:	7231
Planned Funds:	$ 450,000.00

Activity Narrative: This activity is related to activities in HVOP (7229), HVAB (7183, 7230), and HVCT (8167).

Under this activity, PSI/Rwanda and the Directorate of Military Services (DMS) will work together to promote HIV prevention among members of the RDF. While many soldiers practice sexual abstinence and fidelity, their living situation, mobility, and age make them vulnerable to HIV transmission. For married soldiers, the distance from their families and spouses can make it difficult to maintain stable relationships. A 2004 KAP survey conducted by PSI/Rwanda indicated that 60% of soldiers were young and single and 90% were aged between 20 and 34. The GOR estimates that the Rwandan military is made up of 25,000–30,000 soldiers, 80% of whom are deployed in hard-to-reach areas with minimal access to CT and HIV treatment services.

In FY 2006, this program is reaching at least 10,000 members of the RDF with mobile CT services to under served, hard-to-reach soldiers by providing military-specific CT services through a mobile outreach unit. An integrated mobile CT unit and a mobile video unit travel to each of the RDF's 12 brigades. Advance visits employ the mobile video unit to sensitize and prepare the soldiers for testing days and the CT team returns shortly thereafter to conduct counseling and testing. The CT team returns to the brigade as many times as necessary to satisfy the demand for testing and confirm test results.

In FY 2007, these activities will reach 7,500 members of the RDF and their spouses, family members, and/or sexual partners. Partners will be reached through their husbands and through the existing structures of the military such as women's associations. Counseling messages will emphasize prevention, including abstinence and fidelity, alcohol reduction, GBV sensitization, disclosure of test results, and follow-up care.

In close collaboration with DMS, PSI will 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, providing a link between community services and clinical services. CHAMP 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 stigma and discrimination, and to promote behavior change and safe sexual practices.

PSI/Rwanda, in collaboration with Drew University and DMS, will establish a database for HIV case management in the RDF. PSI will assist the DMS in data entry and analysis of CT and HIV prevalence. 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.

Capacity building of the DMS and health units at the brigade level is a key focus area in FY 2007. This will strengthen the competencies and skills of DMS technical staff at the central and brigade level to implement, coordinate, and monitor mobile CT program and HIV prevention activities. This strategy will facilitate and strengthen decentralization of HIV/AIDS service delivery within the military system. Measures to build capacity will include formal trainings and ongoing technical assistance for the brigade level staff 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. Another strategy to build local capacity will be to hire and train local CT counselors to provide the mobile services and ensure linkage with HIV/AIDS service delivery sites. PSI will continue to supervise and control the quality of service delivery. PSI will work closely with Drew University to strengthen the capacity at the brigade level in those areas.

PFSCM will procure HIV test kits and supplies for this activity. PSI will work with PFSCM and district pharmacies to ensure adequate inventory monitoring and tracking systems for the test kits.

This activity supports the EP five-year strategy through sustainability, providing focused prevention activities in the military and scaling-up CT services.

Continued Associated Activity Information

Activity ID: 4006
USG Agency: Department of Defense
Prime Partner: Population Services International
Mechanism: PSI-DOD
Funding Source: GHAI
Planned Funds: $ 255,000.00

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
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national and international standards	1	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	7,500	☐
Number of individuals trained in counseling and testing according to national and international standards	30	☐

Target Populations:

Military personnel

Women (including women of reproductive age)

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:

National

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: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 7234
Planned Funds: $ 0.00

Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 - NO NEW FUNDING IN FY2007]

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.

Continued Associated Activity Information

Activity ID: 4880
USG Agency: U.S. Agency for International Development
Prime Partner: Population Services International
Mechanism: PSI Bilateral
Funding Source: GHAI
Planned Funds: $ 288,000.00

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 and international standards	2	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	4,620	☐
Number of individuals trained in counseling and testing according to national and international standards	10	☐

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: TRAC Cooperative Agreement
Prime Partner: Treatment and Research AIDS Center
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 7242
Planned Funds: $ 120,000.00
Activity Narrative: This activity is related to activities in MTCT (2744), HBHC (7245), HVTB (7241), HTXD (2746), and HVSI (7238).

In FY 2006, TRAC is revising aspects of the national CT norms and guidelines which represent incremental changes that are reflective of the current policy environment. These new components include using lay counselors to conduct CT, routine CT for all malnourished children, and targeted PIT for hospitalized and TB inpatients. TRAC is also conducting TOT sessions on CT service provision, using the most recent norms and guidelines. TRAC conducts supervision visits of decentralized trainings three times a year and assures service quality through the training of district-level supervisors who conduct supervision activities at the site level.

In FY 2007, in collaboration with the EP Prevention TWG and other partners, TRAC will continue to revise national CT norms, guidelines, and tools (e.g. client forms, reporting forms, educational and supervision tools) and will disseminate them to all health facilities providing CT services. Ongoing revisions are necessary in order to address new approaches to CT and PIT as they become acceptable components of the national CT program. To this point, aspects of policy revision that have yet to be incorporated into the national guidelines include the finger-prick method of specimen collection, expanded and more flexible testing algorithms, abbreviated pre-test counseling in the context of PIT, and automatic family/partner tracing of all HIV-positive clients.

TRAC will also conduct three TOT sessions to train 90 people on CT service provision, including CT, PIT, and nutrition counseling. These training sessions will cover all aspects of the expanded national CT protocol. The participants in these trainings (trainers from each of Rwanda's 30 health districts) will subsequently train CT service providers in all CT sites. TRAC will conduct supervision of these decentralized trainings each trimester. In addition, TRAC will conduct two training sessions for district-level supervisors, who will make regular visits for CT sites to assure the quality of services.

As CT in Rwanda has expanded to include mobile testing and PIT, the GOR has recognized the need for a standardized referral system that will ensure adequate referral and follow-up of all HIV-positive clients. In FY 2007, TRAC will establish a harmonized referral system for CT services to be used in all counseling and testing approaches (fixed site, outreach, and mobile) throughout the country. Guidelines, forms, and tools for implementation of this system will be developed and disseminated.

The budget for this activity also includes long-term TA to the PMTCT/VCT unit at TRAC. The CT master trainer and CT program officer will lead the aforementioned CT policy revision process, coordinate and supervise TRAC's trainings, ensure collaboration with partners, and co-chair the CT/PMTCT technical working group.

This activity reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan through scaling-up of CT services and capacity building of Rwandan institutions that design and lead the fight against HIV/AIDS at the central level.

Continued Associated Activity Information

Activity ID: 2741
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Treatment and Research AIDS Center

Mechanism: TRAC Cooperative Agreement
Funding Source: GHAI
Planned Funds: $ 120,000.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Local Organization Capacity Development	10 - 50
Policy and Guidelines	51 - 100
Quality Assurance, Quality Improvement 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 and international standards	0	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)		☑
Number of individuals trained in counseling and testing according to national and international standards	90	☐

Target Populations:

National AIDS control program staff
Policy makers
Doctors
Nurses
Other Health Care Workers

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:	GHAI
Program Area:	Counseling and Testing
Budget Code:	HVCT
Program Area Code:	09
Activity ID:	7261
Planned Funds:	$ 440,000.00

Activity Narrative: This activity is related to activities in HVCT (7242, 8169, 8167, 7178, 8164, 8168).

In FY 2006, CDC is training and deploying one Mobile VCT team to implement a testing campaign in secondary schools in Kigali and Gitarama as part of the Healthy Schools Initiative in coordination with PSI's school-based prevention activities and demand-creation for CT. Eleven thousand secondary students are being reached with testing services through MVCT.

The GOR's overall strategy continues to be prioritizing support for facility-based CT and expansion of new sites. However, GOR endorses selective use of mobile CT to reach mobile populations such as the uniformed services, CSWs and their clients, prisoners, men who have sex with men, truck drivers, and itinerant workers (fishermen, tea plantation workers, etc) - high-risk populations that are likely to have higher than average seroprevalence rates. Students are considered to be a non-mobile population with adequate access to facility-based CT, so in 2007 this mobile unit will be used with the explicit goal of outreach from facility-based CT and collecting strategic information on high-risk subgroups.

The USG will work with the GOR and other key partners to field an MVCT team to provide high quality, client-initiated CT services that ensure confidentiality, minimize stigma and discrimination, and reach those individuals most likely to be infected. Innovative approaches will be used to reach these populations, such as evening testing hours and testing in strategic locations in order to best access the clients. Counseling messages will emphasize prevention, including abstinence and reduction of partners, alcohol reduction, GBV sensitization, disclosure of test results, and follow-up care.

CDC's mobile team will coordinate schedules, target populations, and locations of testing with other EP partners conducting MVCT. CDC will bring its technical expertise to these coordinated MVCT activities, utilizing in-country and short-term international TA to support M&E, laboratory protocols, and strategic information collection.

In order to ensure proper referral to care, the MVCT team will identify ARV sites in proximity of each MVCT testing location and provide this information and actively refer each HIV-positive client, and a follow-up system will be used to determine what percentage of clients actually accessed care. This will be implemented in accordance with GOR standards and guidelines.

This activity also includes support for a Program Officer for Counseling and Testing in the CDC office. This long-term technical position will provide regular oversight of the MVCT staff and activities, including supervision and M&E. Also supported under this activity are the MVCT team members: Coordinator, Counselor-Trainer, Community Mobilizer, Laboratory Technician, two full-time counselors, and six part-time counselors. This team, already in place and supported by 2006 EP funding, will plan, coordinate, execute, and assist with evaluation of the activities. The Counselor-Trainer, in coordination with TRAC's PMTCT/CT unit, will conduct CT trainings for all newly hired counselors. Refresher trainings will also be provided as needed throughout the year.

Funding for this activity also includes policy development and M&E for implementation of family and couples CT which will be implemented by USG clinical partners. CDC, in collaboration with TRAC and USG clinical partners, will formulate and adapt procedures for CT that address sensitive issues surrounding contact tracing and partner notification. "Contact counselors" supported by clinical partners will actively provide supportive counseling and testing to family members and other sexual contacts for increased referrals for testing and treatment. Additionally, this activity will encompass the collection of programmatic data useful for longitudinal follow-up of families and sexual dyads.

PFSCM will procure HIV test kits and supplies for all sites. CDC will work with PFSCM and district pharmacies to ensure inventory monitoring and tracking systems for the test kits.

This MVCT activity reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan by scaling-up CT services, increasing the availability of CT services outside of health facilities, and providing prevention messages to high-risk groups.

Continued Associated Activity Information

Activity ID: 2845
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: US Centers for Disease Control and Prevention
Mechanism: CDC Country Office GAP/TA
Funding Source: GHAI
Planned Funds: $ 220,000.00

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

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national and international standards	1	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	1,000	☐
Number of individuals trained in counseling and testing according to national and international standards	10	☐

Target Populations:

Commercial sex workers
Men who have sex with men
Truck drivers
Migrants/migrant workers
Partners/clients of CSW

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Kigali

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: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 8120
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY2006 - NO NEW FUNDING IN FY2007]

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.

Continued Associated Activity Information

Activity ID: 4769
USG Agency: U.S. Agency for International Development
Prime Partner: Family Health International
Mechanism: FHI Bridge

Funding Source: GHAI
Planned Funds: $ 1,250,000.00

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

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national and international standards	32	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	94,746	☐
Number of individuals trained in counseling and testing according to national and international standards	32	☐

Key Legislative Issues

Addressing male norms and behaviors

Reducing violence and coercion

Stigma and discrimination

Microfinance/Microcredit

Coverage Areas

Byumba (prior to 2007)

Gikongoro (prior to 2007)

Gisenyi (prior to 2007)

Gitarama (prior to 2007)

Kigali (Rurale) (prior to 2007)

Kigali-Ville (prior to 2007)

Table 3.3.09: Activities by Funding Mechanism

Mechanism: Catholic Relief Services Supplemental
Prime Partner: Catholic Relief Services
USG Agency: HHS/Health Resources Services Administration
Funding Source: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 8164
Planned Funds: $ 71,900.00

Activity Narrative: This activity is related to activities in MTCT (8185), HBHC (7177), HVCT (7261, 8167), and HTXS (7158, 7161).

In FY 2006, this USG implementing partner is supporting care and treatment services in eight sites. CRS does not have specific funding in 2006 for VCT.

In FY 2007, CRS will reach 10,000 individuals through a strategic mix of targeted PIT, family-centered CT, and client-initiated CT services that ensure confidentiality, minimize stigma and discrimination, and reach those individuals most likely to be infected. This activity will support CT services at eight existing and five new ART sites. At all CRS-supported health facilities, PIT services will target adult and pediatric inpatients presenting with TB and other HIV-related OIs and symptoms, malnourished children and HIV-exposed infants, and STI patients. PIT will be implemented with a revised counseling component whereby pre-test counseling is more focused with emphasis placed on post-test counseling. Moreover, case managers and community workers will be trained as counselors in order to provide continuous support beyond the consultation to encourage testing acceptance, family and/or partner tracing, and support for those who received their test results. A total of 100 doctors, nurses and social workers at CRS sites will be trained in PIT.

In collaboration with CHAMP, case managers will work with PLWHA associations, religious institutions, community DOTS programs, and OVC and HBC programs to identify those infected, in particular HIV-exposed infants, family members of PLWHA, and OVC. CT providers will continue to provide traditional CT (client-initiated) for those who wish to know their status, in particular for pre- and post-nuptial couples, ANC male partners, and youth. Counseling messages will emphasize prevention, including abstinence and fidelity, alcohol reduction, GBV sensitization, disclosure of test results, and follow-up care.

In order to counsel and test those individuals most likely to be HIV-positive, 20 new "contact counselors" will be recruited to conduct contact tracing of all patients who test positive for HIV at CRS sites. Contact counselors will be responsible for accompanying HIV-positive clients to their community, encouraging their spouse and family members to be tested, providing HIV testing, and identifying discordant couples who are in need of intensive prevention counseling. As Rwanda moves towards a disease registry-based system, individuals receiving services through these family and couple CT efforts will be entered into a database that utilizes the national identification number as the basis of a case report. Moreover, this system will permit the compilation of a sub-registry of HIV-discordant couples to allow expanded activities in prevention for seropositives. CDC will work with TRAC to establish policies and procedures for family and couples testing, and will play a focal role in the coordination of related M&E.

To strengthen the continuum of care for PLWHA and their families, partners will establish a formalized referral system to link community care and clinical services. The case manager, in collaboration with CHAMP, will ensure that HIV-positive patients are provided patient education, positive living counseling and referral for community-based services, such as IGA, through PLWHA associations, OVC, and HBC programs. At the health facility level, partners will ensure a system for supportive supervision of nursing and counseling staff, including training of select staff in supervision for CT, use of quality control checklists, and data quality control.

CRS will monitor site performance and provide patient referral tools developed by TRAC for timely enrollment of HIV-positive patients diagnosed in any service at the site. CRS will support sites to track PIT and contact tracing data for use at site level for program improvement and reporting. Through regular supervision at sites, patient satisfaction surveys, and HIV testing records review, CRS will ensure that basic ethical practices and confidentiality related to HIV counseling and testing are practiced at all sites.

PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, CRS will shift some of its support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of CT and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national

Quality Supervision tool.

PFSCM will procure HIV test kits and supplies for all sites. CRS will work with PFSCM and district pharmacies to ensure that all sites have adequate and secure storage facilities as well as inventory monitoring and tracking systems for the test kits.

This activity supports the EP five-year strategy for sustainability, national scale-up of counseling and testing, and provision of integrated treatment, care, and prevention services.

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	10 - 50
Quality Assurance, Quality Improvement 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 counseling and testing according to national and international standards	13	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	10,000	☐
Number of individuals trained in counseling and testing according to national and international standards	100	☐

Target Populations:

Faith-based organizations
Family planning clients
Doctors
Nurses
Pharmacists
Most at risk populations
HIV/AIDS-affected families
Infants
Orphans and vulnerable children
Caregivers (of OVC and PLWHAs)
Partners/clients of CSW
Laboratory workers
Other Health Care Worker

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Burera

Gicumbi

Gatsibo

Nyamasheke

Table 3.3.09: Activities by Funding Mechanism

Mechanism: HIV Support to RDF
Prime Partner: Drew University
USG Agency: Department of Defense
Funding Source: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 8165
Planned Funds: $ 36,641.00

Activity Narrative: This activity relates to activities in HBHC (7191), HTXS (7190), HVOP (8135), HLAB (7190), HVAB (7230), and HVCT (8167).

In the RDF health network there are three military hospitals and five brigade clinics throughout the country. Drew University began working in two military hospitals and three brigade clinics in FY 2005 with EP support. The support modalities include TA and training on ARV and palliative care, M&E, and laboratory infrastructure. Drew collaborates with CHAMP for services in military communities such as OVC support, and receives drug procurement from PFSCM. In line with national policies, the hospitals incorporate performance-based financing as incentives for facilities.

In FY 2007, Drew University will integrate CT services at the brigade level which will enable the RDF to conduct PIT and routine HIV testing of 8,000 individuals at three military hospitals and three brigade clinics. CT services will ensure confidentiality, minimize stigma and discrimination, and reach those individuals most likely to be infected. A total of 30 doctors, nurses and social workers at Drew sites will be trained in PIT and CT.

In addition, Drew University-supported facility-based CT sites will collaborate with PSI's mobile CT unit to conduct home CT services to soldiers at the battalion and company levels, as well as for their spouses and family members tracked through the established information systems. This exercise will facilitate the identification of discordant couples and enhance HIV care, particularly prevention for positives.

In order to counsel and test those individuals most likely to be HIV-positive, nine new "contact counselors" will be recruited to conduct contact tracing of all patients who test positive for HIV at Drew sites. Contact counselors will be responsible for accompanying HIV-positive clients to their community, encouraging their spouse and family members to be tested, providing HIV testing, and identifying discordant couples who are in need of intensive prevention counseling. As Rwanda moves towards a disease registry-based system, individuals receiving services through these family and couples CT efforts will be entered into a database that utilizes the national identification number as the basis of a case report. Moreover, this system will permit the compilation of a sub-registry of HIV-discordant couples to allow expanded activities in prevention for seropositives. This contact tracing activity will also be supported by CDC who will help establish policies and procedures and coordinate related M&E activities.

To strengthen the linkage between services, Drew University and PSI will use a database to record all CT-related data, and PDAs will be used to record demographic data of HIV-positive clients during post-test counseling, including setting appointments for the client to HIV staging and evaluation at a referral site. On-site training and supervision in HIV counseling and testing will be provided to RDF providers and Drew University will second technical staff to new CT sites in RDF, if needed.

PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, Drew will shift some of its support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of CT and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool.

PFSCM will procure HIV test kits and supplies for all sites. Drew will work with PFSCM and district pharmacies to ensure that all sites have adequate and secure storage facilities as well as inventory monitoring and tracking systems for the test kits.

This activity supports the EP five-year plan by scaling up CT services and providing integrated treatment, care, and prevention services to high risk groups.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Information, Education and Communication	51 - 100
Quality Assurance, Quality Improvement 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 and international standards	6	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	8,000	☐
Number of individuals trained in counseling and testing according to national and international standards	30	☐

Target Populations:

Military personnel

Children and youth (non-OVC)

Women (including women of reproductive age)

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 3.3.09: Activities by Funding Mechanism

Mechanism: SCMS
Prime Partner: Partnership for Supply Chain Management
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 8167
Planned Funds: $ 1,025,000.00
Activity Narrative: This activity relates to activities in HVCT (7178, 7231, 7261, 8164, 8165, 8166, 8168, 8169, 8732), HTXD (8170), HTXS (7213), OHPS (7212).

In FY 2006, the EP began its transition towards a consolidated approach for procurement of HIV-related commodities through the use of PFSCM and NRL as the primary procurement partners. In addition, the GOR is expanding the CPDS to include all HIV-related commodities, including OI drugs and diagnostics, test kits and CD4. During this transition year (FY 2006), PFSCM will support central-level quantification, procurement, storage and distribution systems in close collaboration with RPM+. RPM+ is leading the support to the CPDS, districts and sites.

In FY 2007, PFSCM will directly subcontract with CAMERWA for the procurement, storage and distribution of all HIV-related commodities, including laboratory. This consolidated approach to procurement will increase cost savings and improve efficiencies in procurement and distribution of commodities. In addition, PFSCM will take over the support to the CPDS to ensure smooth functioning of the CPDS system, quality data for quantification, and strong communication between sites, districts and CAMERWA. Partners will work in close collaboration through joint planning and workplan development, particularly for activities that support the LMIS and active distribution system.

In FY 2007, PFSCM will directly fund CAMERWA for the procurement, storage, and distribution of rapid test kits and supplies (gloves, lancets, filter paper) for 176 EP-supported health facilities, to target all CT and PMTCT clients. In addition, PFSCM will procure additional test kits for GFATM sites, continuing EP's ongoing support to GFATM, begun in FY 2005.

Test kits will be procured in line with the national testing protocol, which includes Determine, First Response, Unigold, Capillus, OraQuick and others that may be incorporated into the national algorithm. PFSCM will coordinate and regularly communicate with USG partners to ensure they have adequate information for the quantification and distribution of test kits, as well as to discuss issues related to test kit procurement, distribution and management. As CPDS increasingly expands to include other commodities, PFSCM will work closely with CPDS to ensure appropriate integration of kits into the system, including development of a procurement plan that integrates test kits, support for national quantification in collaboration with NRL and other members of the Quantification Committee and integrated distribution to sites.

PFSCM will work closely with RPM+ to ensure appropriate integration of test kit information into LMIS at all USG-supported sites and district pharmacies, and to ensure appropriate stock management of test kits. As the country continues to strengthen its CT strategy and implementation, PFSCM will work with CAMERWA and RPM+ to analyze and report on district pharmacy and health facility stock levels on a regular basis to monitor for trends, potential stock outs, and make any revisions to procurement plans and projections.

Emphasis Areas	**% Of Effort**
Commodity Procurement	51 - 100
Logistics	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

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

Target Populations:

Country coordinating mechanisms
Pharmacists
International counterpart organizations
National AIDS control program staff
Non-governmental organizations/private voluntary organizations
Policy makers
USG in-country staff
Other MOH staff (excluding NACP staff and health care workers described below)
Implementing organizations (not listed above)

Coverage Areas:

National

Table 3.3.09: Activities by Funding Mechanism

Mechanism:	Refugees UNHCR
Prime Partner:	United Nations High Commissioner for Refugees
USG Agency:	Department of State / Population, Refugees, and Migration
Funding Source:	GHAI
Program Area:	Counseling and Testing
Budget Code:	HVCT
Program Area Code:	09
Activity ID:	8732
Planned Funds:	$ 40,000.00

Activity Narrative: This activity is related to activities in MTCT (8696), HVAB (8700), HVOP (8711), HBHC (8718), HVTB (8670), HKID (8148, 8150, 8152), HVCT (8732, 8167), and HTXS (8737).

Rwanda is host to almost 50,000 refugees in four camps around the country. Refugee populations are considered to be at high risk for HIV as well as GBV and other forms of violence, economic, and psychological distress. While little is currently known about HIV prevalence rates in the camp populations in Rwanda, recent service statistics of newly implemented VCT and PMTCT programs in two camps show a prevalence of 5% among CT clients with at least 200 refugees currently known to be living with HIV.

Since 2005, the EP has supported UNHCR implementing partners AHA and ARC to provide HIV prevention and care services in Kiziba, Gihembe and Nyabiheke refugee camps with linkages and referrals for treatment. In FY 2006, ARC received funds to support AB prevention activities in two camps. In FY 2007, USG will consolidate its support by funding UNHCR directly to expand the package of services for the prevention, care, and treatment of PLWHA. Funds will also be leveraged from the World Bank-funded GLIA and OPEC to complement EP-supported services.

Currently, HIV testing rates remain fairly low in the refugee camps, with less than 15% of the reproductive age population having been tested for HIV in the two larger camps. The third camp, Nyabiheke, has just started testing activities and there are not yet enough data to indicate the percent uptake for testing. FY 2007 funds will increase CT at these three refugee camps to reach a total of 4,000 refugees with CT services.

UNHCR partners will reach more refugees with CT by strengthening PIT for TB and STI patients, malnourished and non-thriving infants, and patients presenting with HIV-related illnesses. In line with a revised strategy for a family-centered approach to CT, UNHCR partners will train staff in approaches for reaching family members of HIV-positives including improved counseling techniques to increase disclosure and encourage partners and family members to get tested, and contact tracing through a care coordinator at the refugee facility. Ongoing community-based campaigns will utilize refugee groups, refugee community leaders, and PLWHA to communicate HIV/AIDS stigma reduction messages and promote CT.

Health providers in refugee camps will receive training or refresher training in PIT, as well as in counseling for youth, male partners, and other targeted populations in refugee camp settings. Counseling will emphasize partner reduction, stigma, and alcohol reduction to sensitize clients to issues related to GBV, as well as confront social norms that contribute to these issues. CT providers will be trained or given refresher trainings in GBV and trauma counseling for women, particularly for both HIV-positive and negative women and widows who may be victims of violence. To ensure quality CT service delivery, UNHCR partners will provide supportive supervision of CT staff through QA, monitoring provider performance, and data quality reviews and will continue to support and strengthen the capacity of refugee health care providers to monitor and evaluate CT services.

UNHCR partners will also strengthen routine referrals 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 district hospitals, UNHCR partners will develop referral plans for services not offered on site including diagnosis and management of complicated OIs, severe malnutrition, and laboratory tests. Partners will also continue to strengthen referrals for PLWHA and their family members for community-based services, including IGA, OVC, PLWHA associations, legal services, food wrap-around through Title II partners and WFP, community based programs for distribution of bed nets in collaboration with PMI and the GFATM, and hygiene and safe water initiatives.

PFSCM will procure HIV test kits and supplies for all camps. UNHCR partners will work with PFSCM and district pharmacies to ensure that all camps have adequate and secure storage facilities as well as inventory monitoring and tracking systems for the test kits. UNHCR will provide technical support and monitoring of partner activities and data collection, and ensure appropriate reporting through the hiring of a technical and program

manager.

This activity supports the EP five-year strategy by scaling up counseling and testing services and providing integrated treatment, care, and prevention services to high risk groups.

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
Quality Assurance, Quality Improvement 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 and international standards	3	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	4,000	☐
Number of individuals trained in counseling and testing according to national and international standards	50	☐

Target Populations:

Commercial sex workers
Community leaders
Community-based organizations
Family planning clients
Nurses
HIV/AIDS-affected families
Refugees/internally displaced persons
Orphans and vulnerable children
Volunteers
Men (including men of reproductive age)
Women (including women of reproductive age)
Caregivers (of OVC and PLWHAs)
Out-of-school youth
Religious leaders
Laboratory 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

Stigma and discrimination

Wrap Arounds

Food

Other

Coverage Areas

Byumba (prior to 2007)

Kibuye (prior to 2007)

Umutara (Mutara) (prior to 2007)

Gicumbi

Gatsibo

Karongi

Table 3.3.09: Activities by Funding Mechanism

Mechanism: FHI New Bilateral
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 15441
Planned Funds: $ 312,944.00

Activity Narrative: This activity relates to activities in MTCT (8698), HVAB (8129), HVOP (8137), HBHC (8144), HVTB (8147), HVCT (8167, 7217, 7182), and HTXS (8172). In FY 2006, USAID partners are supporting VCT services in 100 sites to reach approximately 100,000 clients. In accordance with GOR norms, CT will be offered in sites where patients can receive needed basic care such as PMTCT, CD4 staging, OI prophylaxis and treatment, and referral to community services and higher level clinical care. In order to improve the efficiency of CT services, partners are moving to rapid testing and advanced strategies for testing. In order to reach more clients, partners have increased male partner testing of PMTCT clients through community sensitization, facilitated couples testing through weekend CT services, improved pediatric case-finding through testing during immunization days and special family/child testing days during vacation days.

In FY 2007, FHI will reach 40,000 individuals through a strategic mix of targeted PIT, family-centered CT, and client-initiated CT services that ensure confidentiality, minimize stigma and discrimination, and reach those individuals most likely to be infected. This activity will support CT services at 43 sites. At all FHI-supported health facilities, PIT services will target adult and pediatric inpatients presenting with TB and other HIV-related OIs and symptoms, malnourished children and HIV-exposed infants, and STI patients. PIT will be implemented with a revised counseling component whereby pre-test counseling is more focused with emphasis placed on post-test counseling. Moreover, case managers and community workers will be trained as counselors in order to provide continuous support beyond the consultation to encourage testing acceptance, family and/or partner tracing, and support for those who received their test results.

A total of 193 doctors, nurses and social workers at FHI-supported sites will be trained in PIT. In order to implement PIT, all health care providers and case managers will receive CT training and all community workers will receive counseling training. In collaboration with CHAMP, case managers will work with PLWHA associations, religious institutions, community DOTS programs, and OVC and HBC programs to identify those infected, in particular HIV-exposed infants, family members of PLWHA, and OVC. CT providers will continue to provide client-initiated CT for those who wish to know their status, in particular for pre- and post-nuptial couples, ANC male partners, and youth. Counseling messages will emphasize prevention, including abstinence and fidelity, alcohol reduction, GBV sensitization, disclosure of test results, and follow-up care. To strengthen the continuum of care for PLWHA and their families, FHI will establish a formalized referral system to link community care and clinical services.

The case manager, in collaboration with CHAMP, will ensure that HIV-positive patients are provided patient education, positive living counseling and referral for community-based services, such as IGA, through PLWHA associations, OVC, and HBC programs. At the health facility level, 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. PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, FHI will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of palliative care and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool. PFSCM will procure HIV test kits and supplies for all sites.

FHI will work with PFSCM and district pharmacies to ensure that all sites have adequate and secure storage facilities as well as inventory monitoring and tracking systems for the test kits. This activity supports the EP five-year strategy for sustainability, national scale-up of counseling and testing, and provision of integrated treatment, care, and prevention services.

Emphasis Areas

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	51 - 100
Information, Education and Communication	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national and international standards supported with performance-based financing		☑
Number of service outlets providing counseling and testing according to national and international standards	43	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	40,000	☐
Number of individuals trained in counseling and testing according to national and international standards	193	☐

Target Populations:

Adults
Faith-based organizations
Family planning clients
HIV/AIDS-affected families
Infants
National AIDS control program staff
Prisoners
Volunteers
Other MOH staff (excluding NACP staff and health care workers described below)
Public health care workers

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Karongi

Table 3.3.09: Activities by Funding Mechanism

Mechanism: EGPAF New Bilateral
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Counseling and Testing
Budget Code: HVCT
Program Area Code: 09
Activity ID: 15442
Planned Funds: $ 30,811.00

Activity Narrative: This activity relates to activities in MTCT (8698), HVAB (8129), HVOP (8137), HBHC (8144), HVTB (8147), HVCT (8167, 7217, 7182), and HTXS (8172). In FY 2006, USAID partners are supporting VCT services in 100 sites to reach approximately 100,000 clients. In accordance with GOR norms, CT will be offered in sites where patients can receive needed basic care such as PMTCT, CD4 staging, OI prophylaxis and treatment, and referral to community services and higher level clinical care. In order to improve the efficiency of CT services, partners are moving to rapid testing and advanced strategies for testing. In order to reach more clients, partners have increased male partner testing of PMTCT clients through community sensitization, facilitated couples testing through weekend CT services, improved pediatric case-finding through testing during immunization days and special family/child testing days during vacation days.

In FY 2007, EGPAF will reach 35,000 individuals through a strategic mix of targeted PIT, family-centered CT, and client-initiated CT services that ensure confidentiality, minimize stigma and discrimination, and reach those individuals most likely to be infected. This activity will support CT services at 26 sites. At all EGPAF-supported health facilities, PIT services will target adult and pediatric inpatients presenting with TB and other HIV-related OIs and symptoms, malnourished children and HIV-exposed infants, and STI patients. PIT will be implemented with a revised counseling component whereby pre-test counseling is more focused with emphasis placed on post-test counseling. Moreover, case managers and community workers will be trained as counselors in order to provide continuous support beyond the consultation to encourage testing acceptance, family and/or partner tracing, and support for those who received their test results.

A total of 116 doctors, nurses and social workers at EGPAF-supported sites will be trained in PIT. In order to implement PIT, all health care providers and case managers will receive CT training and all community workers will receive counseling training. In collaboration with CHAMP, case managers will work with PLWHA associations, religious institutions, community DOTS programs, and OVC and HBC programs to identify those infected, in particular HIV-exposed infants, family members of PLWHA, and OVC. CT providers will continue to provide client-initiated CT for those who wish to know their status, in particular for pre- and post-nuptial couples, ANC male partners, and youth. Counseling messages will emphasize prevention, including abstinence and fidelity, alcohol reduction, GBV sensitization, disclosure of test results, and follow-up care. To strengthen the continuum of care for PLWHA and their families, EGPAF will establish a formalized referral system to link community care and clinical services.

The case manager, in collaboration with CHAMP, will ensure that HIV-positive patients are provided patient education, positive living counseling and referral for community-based services, such as IGA, through PLWHA associations, OVC, and HBC programs. At the health facility level, 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. PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, EGPAF will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of palliative care and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool.

PFSCM will procure HIV test kits and supplies for all sites. EGPAF will work with PFSCM and district pharmacies to ensure that all sites have adequate and secure storage facilities as well as inventory monitoring and tracking systems for the test kits. This activity supports the EP five-year strategy for sustainability, national scale-up of counseling and testing, and provision of integrated treatment, care, and prevention services

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	51 - 100
Information, Education and Communication	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national and international standards supported with performance-based financing		☑
Number of service outlets providing counseling and testing according to national and international standards	26	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	35,000	☐
Number of individuals trained in counseling and testing according to national and international standards	116	☐

Target Populations:

Adults
Faith-based organizations
Family planning clients
HIV/AIDS-affected families
Infants
National AIDS control program staff
Prisoners
Volunteers
Other MOH staff (excluding NACP staff and health care workers described below)
Public health care workers

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Karongi

Table 3.3.09: Activities by Funding Mechanism

Mechanism:	IntraHealth New Bilateral
Prime Partner:	IntraHealth International, Inc
USG Agency:	U.S. Agency for International Development
Funding Source:	GHAI
Program Area:	Counseling and Testing
Budget Code:	HVCT
Program Area Code:	09
Activity ID:	15443
Planned Funds:	$ 150,495.00

Activity Narrative: This activity relates to activities in MTCT (8698), HVAB (8129), HVOP (8137), HBHC (8144), HVTB (8147), HVCT (8167, 7217, 7182), and HTXS (8172). In FY 2006, USAID partners are supporting VCT services in 100 sites to reach approximately 100,000 clients. In accordance with GOR norms, CT will be offered in sites where patients can receive needed basic care such as PMTCT, CD4 staging, OI prophylaxis and treatment, and referral to community services and higher level clinical care. In order to improve the efficiency of CT services, partners are moving to rapid testing and advanced strategies for testing. In order to reach more clients, partners have increased male partner testing of PMTCT clients through community sensitization, facilitated couples testing through weekend CT services, improved pediatric case-finding through testing during immunization days and special family/child testing days during vacation days.

In FY 2007, IntraHealth will reach 25,000 individuals through a strategic mix of targeted PIT, family-centered CT, and client-initiated CT services that ensure confidentiality, minimize stigma and discrimination, and reach those individuals most likely to be infected. This activity will support CT services at 36 sites. At all IntraHealth-supported health facilities, PIT services will target adult and pediatric inpatients presenting with TB and other HIV-related OIs and symptoms, malnourished children and HIV-exposed infants, and STI patients. PIT will be implemented with a revised counseling component whereby pre-test counseling is more focused with emphasis placed on post-test counseling. Moreover, case managers and community workers will be trained as counselors in order to provide continuous support beyond the consultation to encourage testing acceptance, family and/or partner tracing, and support for those who received their test results.

A total of 216 doctors, nurses and social workers at IntraHealth-supported sites will be trained in PIT. In order to implement PIT, all health care providers and case managers will receive CT training and all community workers will receive counseling training. In collaboration with CHAMP, case managers will work with PLWHA associations, religious institutions, community DOTS programs, and OVC and HBC programs to identify those infected, in particular HIV-exposed infants, family members of PLWHA, and OVC. CT providers will continue to provide client-initiated CT for those who wish to know their status, in particular for pre- and post-nuptial couples, ANC male partners, and youth. Counseling messages will emphasize prevention, including abstinence and fidelity, alcohol reduction, GBV sensitization, disclosure of test results, and follow-up care. To strengthen the continuum of care for PLWHA and their families, IntraHealth will establish a formalized referral system to link community care and clinical services.

The case manager, in collaboration with CHAMP, will ensure that HIV-positive patients are provided patient education, positive living counseling and referral for community-based services, such as IGA, through PLWHA associations, OVC, and HBC programs. At the health facility level, 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. PBF is a major component of the Rwanda EP strategy for ensuring long-term sustainability and maximizing performance and quality of services. In coordination with the HIV PBF project, IntraHealth will shift some of their support from input to output financing based on sites' performance in improving key national HIV performance and quality indicators. Full or partially reduced payment of palliative care and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool.

PFSCM will procure HIV test kits and supplies for all sites. IntraHealth will work with PFSCM and district pharmacies to ensure that all sites have adequate and secure storage facilities as well as inventory monitoring and tracking systems for the test kits. This activity supports the EP five-year strategy for sustainability, national scale-up of counseling and testing, and provision of integrated treatment, care, and prevention services.

Emphasis Areas

Emphasis Areas	% Of Effort
Community Mobilization/Participation	10 - 50
Development of Network/Linkages/Referral Systems	51 - 100
Information, Education and Communication	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing counseling and testing according to national and international standards supported with performance-based financing		☑
Number of service outlets providing counseling and testing according to national and international standards	36	☐
Number of individuals who received counseling and testing for HIV and received their test results (including TB)	25,000	☐
Number of individuals trained in counseling and testing according to national and international standards	216	☐

Target Populations:

Adults
Faith-based organizations
Family planning clients
HIV/AIDS-affected families
Infants
National AIDS control program staff
Prisoners
Volunteers
Other MOH staff (excluding NACP staff and health care workers described below)
Public health care workers

Key Legislative Issues

Gender

Stigma and discrimination

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Karongi

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: $ 13,750,000.00

Program Area Context:

In January 2005, Rwanda became the first Emergency Plan Focus Country to conduct a national coordinated procurement of ARVs for all donor-supported ART programs to increase efficiencies and reduce costs. Under this coordinated procurement and distribution system (CPDS), donors, including GFATM, MAP, and others, purchase portions of Rwanda's national ARV needs based on a national quantification and according to their individual procurement restrictions and patient targets. The selection of ARVs is based on efficacy, tolerance, and costs and is approved by the MOH.

National quantification and procurements are conducted on a bi-annual basis by the Quantification Committee (QFC). The team is comprised of quantification experts from TRAC, CAMERWA, Clinton Foundation, RPM+, and PFSCM. The QFC uses site-level data, expected stock on hand, expected pipeline, expiration dates of existing stock, and stock movements related to rational use and prescribing clinician behaviors to estimate national drug needs. The results of the quantification are presented to the Resource Management Committee (RMC) which is comprised of donor agencies and implementing partners, and which approves the quantification and allocation of donor support. CAMERWA conducts a competitive tendering process, and evaluates suppliers for pricing, lead time, adequacy of packaging for patient needs, past performance, stability of the product, and refrigeration requirements.

This coordinated procurement and access to Clinton Foundation pricing have significantly lowered ARV drug costs to an average monthly cost of 20.1 USD per adult patient, and 34 USD per pediatric patient. Cost per patient is expected to further decrease due to access to PFSCM pricing, increased availability of FDA-tentatively approved generics, and Rwanda's inclusion in the UNITAID/CHAI pediatric donation. CAMERWA has expanded its product formulary to include FDA-approved or tentatively-approved generics. As there is no drug registration system in country, all new products require a visa and importation license, certification of quality assurance, and an official waiver from the MOH.

Since the establishment of the CPDS, RPM+ and the Clinton Foundation have provided significant support for national quantification, product selection, warehousing, distribution, and LMIS. In FY 2006, all funds for ARV and OI drug procurement were reprogrammed to PFSCM, which also provided intensive TA to CAMERWA to ensure appropriate financial systems and standard operating procedures are in place to receive direct USG funds, and improve QA through the use of thin-layer chromatography (TLC). PFSCM is strengthening CAMERWA warehousing and inventory management systems. RPM+, in coordination with PFSCM, is continuing its support for the implementation of the active distribution system, monitoring provider behaviors, and training and supporting district pharmacies and sites.

In line with the recent decentralization of health services, CAMERWA is shifting from passive to active distribution of all health commodities. Under this new system, sites will be supplied by district pharmacies instead of from Kigali. There is concern among GOR, donors, and CAMERWA that the district pharmacies lack the capacity to manage a decentralized distribution system. In preparation for the new system, RPM+ has been providing TA to CAMERWA and eight district pharmacies through training, renovations, QA/supervision, and development of SOPs and tools for inventory management, reporting, and distribution. In FY 2006, PFSCM is supporting CAMERWA to deploy a LMIS.

At the end of FY 2007, there will be an estimated 58,000 people on ARVs, of which 36,621 will be directly supported by USG, including 3,620 pediatric patients. PFSCM will contract directly with CAMERWA for the procurement of ARVs and other HIV commodities in line with USG procurement regulations, as well as for the storage and distribution of these commodities to the districts. For FY 2007, USG has four main objectives for support of the supply chain management system: provide direct support to CAMERWA for the procurement, storage and distribution of all USG-funded products; strengthen the capacity of the CPDS, district pharmacies and health facilities to manage HIV commodities; improve rational use of ARVs and other medicines; and, strengthen the National Drug Authority. In order to achieve these objectives,

USG will dedicate staff to oversee these activities and ensure coordination among partners and donors.

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: GHAI
Program Area: HIV/AIDS Treatment/ARV Drugs
Budget Code: HTXD
Program Area Code: 10
Activity ID: 7214
Planned Funds: $ 0.00

Activity Narrative: [CONTINUED ACTIVITY IN FY 2006 - NO NEW FUNDING IN FY 2007.]

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+

Continued Associated Activity Information

Activity ID: 2762
USG Agency: U.S. Agency for International Development
Prime Partner: Management Sciences for Health
Mechanism: RPM+

Funding Source: GHAI
Planned Funds: $ 1,632,668.00

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: SCMS
Prime Partner: Partnership for Supply Chain Management
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: HIV/AIDS Treatment/ARV Drugs
Budget Code: HTXD
Program Area Code: 10
Activity ID: 8170
Planned Funds: $ 13,750,000.00
Activity Narrative: This activity relates to HBHC (8716), HVTB (8664), HVCT (8167), HLAB (8189), HTXS (7161, 7174, 7213, 7246, 8172, 8735, 8737), and OHPS (7212).

In FY 2006, USG began its transition towards a consolidated procurement system for HIV-related commodities through PFSCM and NRL. PFSCM will support CAMERWA to further strengthen warehousing, procurement, management and distribution. RPM+ will support the CPDS, district pharmacies and the PTF. In FY 2007, USG will procure all commodities, including laboratory supplies, through PFSCM in order to increase cost savings and improve efficiencies. In addition, PFSCM will extend its support to the CPDS to ensure proper functioning of the CPDS system, availability of quality data for quantification, and improved information sharing between sites, district pharmacies and CAMERWA. PFSCM, RPM+, DELIVER and PMI will coordinate their activities in support of the LMIS and active distribution system.

In FY 2007, funds for this activity will support three components. Under the first component, PFSCM will directly sub-contract with CAMERWA for the procurement, storage, and distribution of USG-financed ARVs procured through the CPDS for 136 EP-supported ART sites and 36,621 patients, including 3,662 pediatric patients. Through CAMERWA, PFSCM will also procure ARVs for the revised PMTCT bi-therapy regimen for 4,056 HIV-positive pregnant women.

Under the second component, PFSCM will continue to provide TA to CAMERWA for procurement, warehousing, storage, active distribution. Implementation of the LMIS between districts and CAMERWA will be supported in collaboration with RPM+, DELIVER and PMI. PFSCM will fund one position at CAMERWA to assist in timely monitoring, analysis and reporting on stock levels to the CPDS and to PFSCM.

PFSCM will be the lead TA agency to the CPDS. This will include continued funding of one position in CPDS responsible for coordinating between and reporting to the GOR, donors and implementing partners, and conducting data analysis of pipelines and stock movements. PFSCM will provide technical support and supervision to the QFC and increasingly shift responsibility for quantification to the QFC (quantification exercises are currently led by USG partners). In addition, PFSCM will provide technical support to the Resource Management Committee (RMC) and the Implementation Committee to ensure optimal use of funds. PFSCM will continue to participate in quarterly data quality control visits with TRAC, RPM+ and the districts.

Finally, PFSCM will collaborate with RPM+ to strengthen QA systems. It is critical that all drugs reaching patients are safe, effective and meet quality standards. PFSCM will work with RPM+, the NDA, CAMERWA and the CPDS to ensure prudent supplier and product selection and certification, and other components of the WHO Certification Scheme. PFSCM will support the establishment of Thin-Layer Chromatography (TLC) and mini-labs in collaboration with the NDA, University of Butare and the NRL to test the quality of ARVs.

Continued Associated Activity Information

Activity ID: 2762
USG Agency: U.S. Agency for International Development
Prime Partner: Management Sciences for Health
Mechanism: RPM+
Funding Source: GHAI

Planned Funds: $ 1,632,668.00

Emphasis Areas	% Of Effort
Commodity Procurement	51 - 100
Local Organization Capacity Development	10 - 50
Logistics	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Target Populations:

Country coordinating mechanisms
Pharmacists
International counterpart organizations
National AIDS control program staff
People living with HIV/AIDS
USG in-country staff
Laboratory staff
HIV positive pregnant women
Other MOH staff (excluding NACP staff and health care workers described below)
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Coverage Areas:

National

Table 3.3.10: 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: GHAI
Program Area: HIV/AIDS Treatment/ARV Drugs
Budget Code: HTXD
Program Area Code: 10
Activity ID: 8735
Planned Funds: $ 0.00
Activity Narrative: Reprogramming 8/07: This activity has been abandoned.

This activity relates to HTXS (7213), HTXD (8170), OHPS (7212, 9638) and HVSI (7248).

The overall goal of this activity is to provide a simple, small-scale program of passive surveillance for adverse events among Rwandan patients who receive EP-distributed pharmaceuticals.

The EP relies heavily upon pharmaceutical interventions to ameliorate disease and interrupt viral transmission. However, these drugs often have secondary adverse effects that negate their primary therapeutic benefits. While the antiretroviral and anti-infective drugs employed by the EP are well characterized, many could have adverse effects that remain unrecognized in special clinical circumstances.

In FY 2007, FDA will provide TA in collaboration with PMI and RPM+ to the NDA, TRAC and APHAR to establish a small-scale program of passive surveillance for adverse events. Through short term TA, FDA will train caregivers in select hospitals in the use of simplified reporting forms, as well as a GOR-based analyst in their appropriate interpretation. In addition, FDA will provide periodic QA and supervision to those health care providers to ensure appropriate completion of the reports, quality of data, and reporting to the NDA. While this innovation is very small in both scale and budget, it represents a significant innovation as it would be the first categorical drug safety program instituted in Rwanda.

This activity reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan by providing quality assurance of treatment commodities, and strengthening the quality of ARV services.

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: $ 22,893,463.00

Program Area Context:

As of June 30, 2006, 25,931 patients have been put on ARV treatment, including 2,124 children, at 116 sites across Rwanda. Approximately 1% of patients are on second line regimens and 15% of pregnant women are on HAART as per the new national PMTCT protocol. The national plan expects to achieve near universal access by providing ART services to 57,820 patients, including 7,612 pediatric patients by the end of 2007 – surpassing the EP target of 50,000 on ART by the end of FY 2009.

Along with GFATM and World Bank MAP, the EP has been one of the major programs supporting the National Treatment Plan since 2004. With the GOR decision to shift World Bank support away from HIV/AIDS services, EP represents an even larger share of the support to the national program by taking on MAP sites within EP districts and offering services in 22 of the 30 districts in Rwanda. In addition, EP supports ART decentralization from district hospital to health centers through 1) central level support to TRAC, NRL and MOH to develop and revise policies, adapt guidelines, update training curricula, and supervise decentralized services; 2) technical and financial support to the DHTs to strengthen linkages, referral systems, and communications; and 3) support to health center ART sites where nurses provide patient care with district hospital physician oversight.

In FY 2005 and FY 2006, FHI successfully piloted an expanded role of nurses in the provision of ARV care. District hospital physicians support nurses to manage ARV cases through regular visits, mentoring, remote support via telephone for urgent questions and use of simplified protocols. This decentralized model of care will be implemented more broadly by all EP partners in FY 2007. In addition, USG will strengthen nursing training through pre-and in-service training in HIV/AIDS care and treatment.

In FY 2007, the EP will continue supporting all levels of the decentralized ART network, starting from central level institutions and extending to the community as the most peripheral point of service. The EP will scale-up ART support by putting 36,621 eligible patients, including 3,662 children, on ART at 135 EP-supported sites of which 34 are new in FY 2007. The EP will support ART services in all 11 prisons within EP districts and two refugee camps. To expand quality pediatric care, Rwanda's few available pediatricians will mentor other clinical providers, using the Columbia UTAP model developed in FY 2006. Starting in FY 2006 and expanding in FY 2007, USG will improve rational use of ARVs through the creation of DTCs at hospitals and the establishment of a national level DTC. In line with GOR policy, the EP will expand performance-based financing, piloted by MSH in FY 2006, to all EP-supported sites. Implementing partners will gradually shift from input financing to output financing with the purchase of improved performance for specific HIV indicators at the hospital, health center and community.

At the central level, the EP will continue supporting TRAC to revise national guidelines, tools, curricula, and training of trainers, with an emphasis on pediatric care and informed by the latest research. To further improve the quality of services, TRAC-led supervisions will include donors and implementing partners, and regular feedback will be provided to sites. The EP will also continue supporting the planning and decentralization unit of the MOH to support district health teams in their new decision-making roles in strategic planning and budgeting.

At the district level, EP partners will provide a package of support to 28 DHTs in 22 districts to strengthen their capacity to coordinate an effective network of ARV and other HIV/AIDS medical services. This network focuses on maximizing access and improving quality of care at the most decentralized level. Implementing partners will provide a basic package of financial and technical support to DHTs to strengthen linkages, referral systems, transport, communications and financing systems necessary to support an effective ART and other HIV/AIDS care network. DHTs are responsible for assuring access of patients to quality HIV/AIDS care, coordination of lab services, organization of specific care components, and good management of resources.

At site level, EP partners will provide a standardized package of ARV services through support and development of a coordinated network of HIV/AIDS services linking ART with PMTCT and other services. Following a tiered approach to service delivery (network model) USG partners will provide comprehensive ART services at larger facilities and a basic package of ART services at satellite health centers. Nurses will serve as the primary HIV service provider at these more distal sites of the health care system and have physician back-up at district level facilities. Services provided at the health center level will include: identification of HIV infected persons who may be eligible for ART, follow-up of patients on ART and referral of complex cases. Additionally, EP partners will continue to focus on ensuring the expansion and monitoring of pediatric HIV-related outpatient services, including CTX prophylaxis, early infant diagnosis, infant feeding education and ARV treatment to eligible infants and children. Moreover, partners will streamline the model of pediatric enrollment through early diagnosis by using specialized pediatricians to train general practitioners and reinforcing linkages to other consultation services such as nutrition, vaccinations, and well-child visits. Additionally, partners will promote a service environment sensitive to issues that may limit women's access to HIV/AIDS related services, including treatment. The EP will improve geographic access by expanding the number of full ART sites and increasing the services provided in satellite ART sites where physicians have less frequent rotations but patients on ART could access a full range of routine ART management services near their homes.

At the community level, partners will ensure continuum of care and adherence by using peer support groups, community mobilization, home visits, community-based registers, referral slips, patient cards and other monitoring tools to facilitate transfer of information between facilities and communities for better follow-up and referrals. HIV case managers at sites will train and supervise community volunteers including CHWs, PLWHA association members, and other caretakers, in collaboration with CHAMP. In addition to basic palliative care, these community volunteers will provide adherence counseling, patient education, and referrals for drug side effect awareness and management. Moreover, case managers will ensure referrals of pediatric patients identified from PMTCT programs, TB services, PLWHA associations, and malnutrition centers as increasing pediatric patient enrollment is a priority for all EP clinical partners in FY 2007. Since the GOR has mandated that community workers must serve on a voluntary basis, USG partners will motivate community volunteers through performance-based incentive schemes.

In line with Rwanda EP 5-year strategy and sustainability goals, all EP implementing partners will provide the same package of support at district, health facility and community level to ensure all patients receive the same standard of quality care. At the central level, the EP will capitalize on different partners' comparative advantages to provide targeted support to the national program. Consolidating lessons learned from the different programs piloted in the past, the EP has harmonized its support across all clinical implementing partners, with minor variations for those serving special populations such as refugees and the military. By so doing, the EP increases efficiencies and assures equity in the provision of services.

Program Area Target:

Number of service outlets providing antiretroviral therapy	136
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	38,035
Number of individuals receiving antiretroviral therapy by the end of the reporting period	36,946
Number of individuals newly initiating antiretroviral therapy during the reporting period	13,810
Total number of health workers trained to deliver ART services, according to national and/or international standards	2,024

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: Central (GHAI)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 7158
Planned Funds: $ 621,139.00
Activity Narrative: This activity relates to HTXS (7161), HBHC (7160), HVTB (7162), HVAB (8187), OHPS (7218).

In FY 2006, CRS is providing a comprehensive package of ART services at eight sites serving 2,000 patients, including 200 children. The package includes treatment with ARV drugs, routine CD4 follow up, viral load testing for an estimated 400 eligible patients with decreased or stable CD4 after nine months of HAART, management of ARV drug side effects, and patient referrals to community-based care.

In FY 2007, CRS will expand quality clinical services, continue support to the DHTs, increase sustainability through performance-based financing, and strengthen SI at all levels.

With procurement support from PFSCM, CRS will provide ARV drugs, CD4 tests, and viral load tests to all supported sites. In order to ensure continuum of care, HIV case managers at sites will train and supervise community volunteers including CHWs, PLWHA association members, and other caretakers, in collaboration with CHAMP. Increasing pediatric patient enrollment is a major priority for all USG clinical partners in FY 2007. Case managers will ensure referrals of pediatric patients identified from PMTCT programs, PLWHA associations, and malnutrition centers. In addition, adult patients enrolled in care will be encouraged to have their children tested. To expand quality pediatric care, Rwanda's few available pediatricians will mentor other clinical providers, using the Columbia UTAP model developed in FY 2006.

In the context of decentralization, DHTs now play a critical role in the oversight and management of clinical and community service delivery. CRS will strengthen the capacity of eight DHTs to coordinate an effective network of ARV and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities.

The Rwanda EP will continue a gradual shift in funding from input financing to performance-based financing. Through a strategic mix of input through the district support package and directly to health facilities, and output performance-based financing through the purchase of improved performance for specific HIV indicators, districts will receive the appropriate support to increase autonomy and sustainability.

In addition, CRS will strengthen district and facility level capacity for data collection, reporting and use with focus on ARV drugs management, HIV case management, and improved quality implementation and program evaluation. Sites will generate routine summary reports of patient-level data and will interpret that data to inform their programmatic operations. CRS will also organize periodic M&E workshops for all supported sites to discuss the collection and use of data at the site-level.

This activity supports the EP five-year strategy for national scale-up and sustainability and the Rwandan Government ART decentralization plan and addresses the key legislative issues of gender, stigma and discrimination.

Continued Associated Activity Information

Activity ID: 2783
USG Agency: HHS/Health Resources Services Administration
Prime Partner: Catholic Relief Services
Mechanism: AIDS Relief
Funding Source: N/A
Planned Funds: $ 0.00

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

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing antiretroviral therapy supported with performance-based financing		☑
Number of service outlets providing antiretroviral therapy	8	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	1,800	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	1,746	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards	20	☐

Target Populations:

Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
HIV/AIDS-affected families
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
HIV positive pregnant women
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas

Burera

Gicumbi

Gatsibo

Nyamasheke

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: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 7161
Planned Funds: $ 670,011.00
Activity Narrative: This activity relates to activities HTXS (7158, 7164, 7174, 7176, 7185, 7213, 7222, 7246, 7262, 8172), MTCT (8185), HVAB (8187), HBHC (7163), HVTB (7162), HVCT (8164), HTXD (8170) and HLAB (7224, 8189).

In FY 2006, CRS is providing a comprehensive package of ART services at eight sites serving 2,000 patients, including 200 children. The package includes treatment with ARV drugs, routine CD4 follow up, viral load testing for an estimated 400 eligible patients with decreased or stable CD4 after nine months of HAART, management of ARV drug side effects, and patient referrals to community-based care.

In FY 2007, CRS will expand quality clinical services to an additional three sites, continue support to the DHTs, increase sustainability through performance-based financing, and strengthen SI at all levels. This activity will reach 1,800 new patients, including 180 children, enrolled at a total of 11 sites.

With procurement support from PFSCM, CRS will provide ARV drugs, CD4 tests, and viral load tests to all supported sites. In order to ensure continuum of care, HIV case managers at sites will train and supervise community volunteers including CHWs, PLWHA association members, and other caretakers, in collaboration with CHAMP. Increasing pediatric patient enrollment is a major priority for all USG clinical partners in FY 2007. Case managers will ensure referrals of pediatric patients identified from PMTCT programs, PLWHA associations, and malnutrition centers. In addition, adult patients enrolled in care will be encouraged to have their children tested. To expand quality pediatric care, Rwanda's few available pediatricians will mentor other clinical providers, using the Columbia UTAP model developed in FY 2006.

In the context of decentralization, DHTs now play a critical role in the oversight and management of clinical and community service delivery. CRS will strengthen the capacity of two DHTs to coordinate an effective network of ARV and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities.

The Rwanda EP will continue a gradual shift in funding from input financing to performance-based financing. Through a strategic mix of input through the district support package and directly to health facilities, and output performance-based financing through the purchase of improved performance for specific HIV indicators, districts will receive the appropriate support to increase autonomy and sustainability.

In addition, CRS will strengthen district and facility level capacity for data collection, reporting and use with focus on ARV drugs management, HIV case management, and improved quality implementation and program evaluation. Sites will generate routine summary reports of patient-level data and will interpret that data to inform their programmatic operations. CRS will also organize periodic M&E workshops for all supported sites to discuss the collection and use of data at the site-level.

This activity supports the EP five-year strategy for national scale-up and sustainability and the Rwandan Government ART decentralization plan and addresses the key legislative issues of gender, stigma and discrimination.

Continued Associated Activity Information

Activity ID: 4849
USG Agency: HHS/Health Resources Services Administration
Prime Partner: Catholic Relief Services
Mechanism: Catholic Relief Services Supplemental
Funding Source: GHAI
Planned Funds: $ 471,975.00

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

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy supported with performance-based financing	0	☐
Number of service outlets providing antiretroviral therapy	11	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	1,800	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	1,692	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period	1,800	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards	44	☐

Target Populations:

Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
HIV/AIDS-affected families
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Volunteers
HIV positive pregnant women
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas

Burera

Gicumbi

Gatsibo

Nyamasheke

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: Central (GHAI)
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 7164
Planned Funds: $ 4,600,000.00
Activity Narrative: This activity relates to HTXS (7175), MTCT (7179), HBHC (7177), HVTB (7180), HVAB (8186), HVOP (8133), and OHPS (7218).

In FY 2006, Columbia is providing a comprehensive package of ART services at 35 sites serving 10,620 patients, including 1,076 children. The package includes treatment with ARV drugs, routine CD4 follow up, viral load testing for an estimated 800 eligible patients with decreased or stable CD4 after nine months of HAART, management of ARV drug side effects, and patient referrals to community-based care.

In FY 2007, Columbia will expand quality clinical services, continue support to the DHTs, increase sustainability through performance-based financing, and strengthen SI at all levels.

With procurement support from PFSCM, Columbia will provide ARV drugs, CD4 tests, and viral load tests to all supported sites. In order to ensure continuum of care, HIV case managers at sites will train and supervise community volunteers including CHWs, PLWHA association members, and other caretakers, in collaboration with CHAMP. Increasing pediatric patient enrollment is a major priority for all USG clinical partners in FY 2007. Case managers will ensure referrals of pediatric patients identified from PMTCT programs, PLWHA associations, and malnutrition centers. In addition, adult patients enrolled in care will be encouraged to have their children tested. To expand quality pediatric care, Rwanda's few available pediatricians will mentor other clinical providers, using the Columbia UTAP model developed in FY 2006.

In the context of decentralization, DHTs now play a critical role in the oversight and management of clinical and community service delivery. Columbia will strengthen the capacity of eight DHTs to coordinate an effective network of ARV and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities.

The Rwanda EP will continue a gradual shift in funding from input financing to performance-based financing. Through a strategic mix of input through the district support package and directly to health facilities, and output performance-based financing through the purchase of improved performance for specific HIV indicators, districts will receive the appropriate support to increase autonomy and sustainability.

In addition, Columbia will strengthen district and facility level capacity for data collection, reporting and use with focus on ARV drugs management, HIV case management, and improved quality implementation and program evaluation. Sites will generate routine summary reports of patient-level data and will interpret that data to inform their programmatic operations. Columbia will also organize periodic M&E workshops for all supported sites to discuss the collection and use of data at the site-level.

This activity supports the EP five-year strategy for national scale-up and sustainability and the Rwandan Government ART decentralization plan and addresses the key legislative issues of gender, stigma and discrimination.

Continued Associated Activity Information

Activity ID: 2787
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Columbia University Mailman School of Public Health
Mechanism: Columbia/MCAP
Funding Source: N/A
Planned Funds: $ 0.00

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

Targets

Target	**Target Value**	**Not Applicable**
Number of service outlets providing antiretroviral therapy supported with performance-based financing	0	☐
Number of service outlets providing antiretroviral therapy	35	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	10,620	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	10,301	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period	0	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards	80	☐

Target Populations:

Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
HIV/AIDS-affected families
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Volunteers
HIV positive pregnant women
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 7174
Planned Funds: $ 900,000.00
Activity Narrative: HIV/AIDS Pediatric care uptake has been slow in Rwanda because of the scarcity of pediatricians and the lack of skills from general practitioners. In COP07 PEPFAR Rwanda funded the extension of training and supervision of general practitioners by a team of pediatricians and senior MDs. With these new funds PEPFAR Rwanda will support additional training of trainers and providers in pediatric care and treatment, production and revision of pediatric HIV care and treatment manuals and tools, recruitment of needed pediatricians or medical doctors for district hospitals, and mentoring supervision of pediatric antiretroviral treatment at new USG-assisted sites. In addition to clinical management the training will emphasis on pediatric patient recruitment and follow-up. This activity will increase pediatric patient enrollment at national level.

This activity relates to HTXS (7158, 7161, 7164, 7176, 7190, 7246, 7256, 7262, 8172).

In FY 2006, Columbia UTAP supported TRAC and the MOH to revise norms and guidelines for HIV/AIDS care and treatment, including pediatric HIV/AIDS. In collaboration with IntraHealth, Columbia supported TRAC to design training curricula, clinical protocols, job aids and other tools to facilitate nurses' greater responsibilities in treating children with HIV/AIDS. In addition, Columbia established model pediatric HIV/AIDS care and treatment centers in two reference hospitals, CHK and CHUB. HIV positive children identified in VCT, PMTCT, nutrition centers, nearby PLWHA associations and outpatient clinics are referred to these centers. CHK and CHUB pediatricians conducted regular visits to other hospitals and health centers and trained 100 health care providers on pediatric HIV/AIDS management, and 18 district health teams on proper supervision. By the end of FY 2006, 800 children will be enrolled in care and 270 on ART at the two model centers.

In FY 2007, Columbia will support the MOH for the expansion of pediatric HIV care and treatment services and effective integration of HIV/AIDS services into the national health system.

Columbia will continue to support the model pediatric HIV/AIDS centers at CHK and CHUB to enroll 1,242 new patients into care, of which 360 will be on ART. Through expanded provider initiated testing and PCR testing for early infant diagnosis, additional children requiring care will be identified in PMTCT programs, nutrition rehabilitation centers and PLWHA associations. Psychosocial support, counseling, monitoring and evaluation systems will be strengthened to improve follow up. CHK and CHUB pediatricians will provide training, mentoring and supportive supervision to 200 health care providers at EP-supported ART sites. Columbia will identify barriers to improving pediatric care and treatment and devise strategies and activities to overcome them.

In order to effectively integrate HIV/AIDS services into the national health system, Columbia will provide TA to the MOH to implement district level HIV/AIDS training plans and train district medical officers on financial management and supervision.

These activities fully support the Rwanda EP five-year strategy for national scale up and sustainability, as well as the Rwandan Government ART decentralization plan.

Continued Associated Activity Information

Activity ID: 2736
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Columbia University Mailman School of Public Health

Mechanism: Columbia UTAP
Funding Source: GHAI
Planned Funds: $ 970,000.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	10 - 50
Local Organization Capacity Development	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy supported with performance-based financing		☑
Number of service outlets providing antiretroviral therapy	2	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	630	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	911	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period	660	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards	400	☐

Indirect Targets

This activity supports the Rwandan national roll out of pediatric HIV patient enrollment into care and treatment. The indirect target is 3300 from other USG partners and 3000 from non-USG sites.

Target Populations:

Faith-based organizations
Doctors
Nurses
Pharmacists
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Coverage Areas:

National

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: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 7176
Planned Funds: $ 735,350.00
Activity Narrative: This activity relates to HTXS (7158, 7161, 7164, 7176, 7185, 7213, 7222, 7246, 7262, 8172), MTCT (7179), HVAB (8186), HVOP(8133), HBHC (7177), HVTB (7180), HVCT (7178), HTXD (8170), and HLAB (7224, 8189).

In FY 2006, Columbia is providing a comprehensive package of ART services at 35 sites serving 10,620 patients, including 1,076 children. The package includes treatment with ARV drugs, routine CD4 follow up, viral load testing for an estimated 800 eligible patients with decreased or stable CD4 after nine months of HAART, management of ARV drug side effects, and patient referrals to community-based care.

In FY 2007, Columbia will expand quality clinical services to an additional seven sites, continue support to the DHTs, increase sustainability through performance-based financing, and strengthen SI at all levels. This activity will reach 3,600 new patients, including 360 children, enrolled at a total of 42 sites.

With procurement support from PFSCM, Columbia will provide ARV drugs, CD4 tests, and viral load tests to all supported sites. In order to ensure continuum of care, HIV case managers at sites will train and supervise community volunteers including CHWs, PLWHA association members, and other caretakers, in collaboration with CHAMP. Increasing pediatric patient enrollment is a major priority for all USG clinical partners in FY 2007. Case managers will ensure referrals of pediatric patients identified from PMTCT programs, PLWHA associations, and malnutrition centers. In addition, adult patients enrolled in care will be encouraged to have their children tested. To expand quality pediatric care, Rwanda's few available pediatricians will mentor other clinical providers, using the Columbia UTAP model developed in FY 2006.

In the context of decentralization, DHTs now play a critical role in the oversight and management of clinical and community service delivery. Columbia will strengthen the capacity of eight DHTs to coordinate an effective network of ARV and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities.

The Rwanda EP will continue a gradual shift in funding from input financing to performance-based financing. Through a strategic mix of input through the district support package and directly to health facilities, and output performance-based financing through the purchase of improved performance for specific HIV indicators, districts will receive the appropriate support to increase autonomy and sustainability.

In addition, Columbia will strengthen district and facility level capacity for data collection, reporting and use with focus on ARV drugs management, HIV case management, and improved quality implementation and program evaluation. Sites will generate routine summary reports of patient-level data and will interpret that data to inform their programmatic operations. Columbia will also organize periodic M&E workshops for all supported sites to discuss the collection and use of data at the site-level.

This activity supports the EP five-year strategy for national scale-up and sustainability and the Rwandan Government ART decentralization plan and addresses the key legislative issues of gender, stigma and discrimination.

Continued Associated Activity Information

Activity ID:	2798
USG Agency:	HHS/Centers for Disease Control & Prevention
Prime Partner:	Columbia University Mailman School of Public Health
Mechanism:	Columbia MCAP Supplement
Funding Source:	GHAI
Planned Funds:	$ 3,189,000.00

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	51 - 100
Health Care Financing	10 - 50
Quality Assurance, Quality Improvement 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 antiretroviral therapy supported with performance-based financing	0	☐
Number of service outlets providing antiretroviral therapy	42	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	3,600	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	3,582	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period	3,600	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards	62	☐

Target Populations:

Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
HIV/AIDS-affected families
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Prisoners
Volunteers
HIV positive pregnant women
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Coverage Areas

Karongi

Rutsiro

Ngororero

Nyabihu

Rubavu

Gasabo

Kicukiro

Nyarugenge

Table 3.3.11: Activities by Funding Mechanism

Mechanism: HIV Support to RDF
Prime Partner: Drew University
USG Agency: Department of Defense
Funding Source: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 7190
Planned Funds: $ 642,460.00
Activity Narrative: This activity relates to HBHC (7191, 7187), HVOP (8135), HKID (7186), MTCT (8122), HVTB (8146), HVCT (8165), HTXD (8170), HTXS (7213), and HLAB (7224, 7192, 8189).

RDF has three military hospitals and five brigade clinics throughout the country. In FY 2006, Drew University supported two military hospitals to provide a comprehensive package of ART services, including ARV treatment, follow-up CD4 count every six months, viral load to patients with decreased or stable CD4 after nine months of HAART, management of ARV drug side effects and patients' referral to community-based palliative care.

In FY 2007, Drew University will provide the same package to 1,170 PLWHA in three new brigade clinics and one additional military hospital. Drew will improve physical infrastructure, train providers, second technical staff, and supply materials, consumables, and equipment. At one military hospital, Drew will support the district health team to cover the civilian network of decentralized ART services within the hospital catchment area. Drew will collaborate with CHAMP to provide community services in surrounding areas, PFSCM for drugs and other commodities, and MSH to improve capacity in drug logistic management. Drew will also support PLWHA associations to promote ART services and reduce stigma.

In addition, Drew will strengthen district and facility level capacity for data collection, reporting and use with a focus on ARV drugs management, HIV case management, and improved quality implementation and program evaluation. Sites will generate routine summary reports of patient-level data and will interpret that data to inform their programmatic operations. Drew will also organize periodic M&E workshops for all supported sites to discuss the collection and use of data at the site-level.

These activities support the EP five-year strategy for national scale-up and the Rwandan Government ART decentralization plan, and address key legislative issues related to gender, stigma and discrimination.

Continued Associated Activity Information

Activity ID: 2751
USG Agency: Department of Defense
Prime Partner: Drew University
Mechanism: HIV Support to RDF
Funding Source: GHAI
Planned Funds: $ 120,375.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Quality Assurance, Quality Improvement 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 antiretroviral therapy	6	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	1,170	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	1,135	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period	450	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards	45	☐

Target Populations:

Doctors
Nurses
Pharmacists
HIV/AIDS-affected families
Military personnel
People living with HIV/AIDS
Volunteers
HIV positive pregnant women
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas

Nyamagabe

Gatsibo

Kicukiro

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:	GHAI
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	7196
Planned Funds:	$ 283,380.00

Activity Narrative: This extension will continue the activities of a current implementer to prevent treatment interruption. During the extension, implementer will make transition to follow-on awardee expected to be determined in late May.
[CONTINUING ACTIVITY FROM FY 2006 -- NO NEW FUNDING IN FY 2007]
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 perfomrnace-based contracting.

***** PLUS-UP*****
$100,000- Under the base COP06 budget, a limited amount of funding was allocated for a basic package of district support. With supplemental funding, EGPAF will provide additional personnel and TA support to one District Health Team (DHT) to further enhance supervision, transport and communications activities between health centers, district hospitals, district pharmacies and community based services for networked ART services. DHTs will have increased capacity to conduct supervision, quality assurance, and M&E within the network model.

Continued Associated Activity Information

Activity ID: 2757
USG Agency: U.S. Agency for International Development
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
Mechanism: Call to Action/EGPAF
Funding Source: GHAI
Planned Funds: $ 868,000.00

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
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy	12	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	1,750	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	1,750	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period	750	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards	50	☐

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Wrap Arounds

Food

Coverage Areas

Kigali (Rurale) (prior to 2007)

Kigali-Ville (prior to 2007)

Byumba (prior to 2007)

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: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 7205
Planned Funds: $ 950,143.00
Activity Narrative: "**This activity has funds added through both plus-up funding and reprogramming.** This extension will continue the activities of a current implementer to prevent treatment interruption. During the extension, implementer will make transition to follow-on awardee expected to be determined in late May.

This activity will support adaptation and implementation of a module for pre-service training of medical students in all aspects of HIV/AIDS care and treatment with special emphasis on ART and pediatric treatment. The current in-service curriculum will be reviewed, adapted and validated for pre-service training. This activity will significantly strengthen national long term capacity and ensure that all medical school graduates have had comprehensive training on all aspects of management of HIV/AIDS. "

This activity relates to HTXS (7161, 7174, 7176, 7190, 8172).

The effective functioning of the ART network depends on a qualified nursing workforce. The HIV/AIDS epidemic is overwhelming Rwandan nurses with an increasing patient load requiring more sophisticated care. To address this problem, the GOR eliminated the lowest-level nurses (A3, nursing assistant equivalent), upgraded the skills of mid-level nurses (A2, traditionally trained in secondary schools) to the level of registered nurses (A1), and accelerated Bachelor's of nursing education (A0).

An HIV/AIDS performance needs assessment carried out with MOH revealed the nursing schools had not incorporated HIV/AIDS curricula into their course work. In FY 2006, Capacity supported the MOH in revising its standards for nurses by developing a "Basic HIV/AIDS Care" course, and developed the new A1 nursing program being used in all five nursing schools, in collaboration with Columbia University and BTC.

In FY 2007, Capacity will continue to support nursing for HIV/AIDS care by targeting pre-service training, in-service training, and supporting the Nursing and Midwifery Task Force.

Capacity will continue to support the five nursing schools and will provide tuition for 50 A1 students selected by district leaders. The immediate goal for FY 2007 is to support the new A1 program by filling the gap in tutors, procuring training equipment, and covering some operational costs. Capacity will second regional expatriate HIV/AIDS nursing instructors, with Bachelors of Nursing or higher qualifications, for the A1 and A0 programs. These instructors will teach HIV/AIDS care and treatment to 300 A1 and 25 A0 students.

An additional 200 A2 and A1 nurses will receive in-service competency-based training focused on specific tasks nurses have to carry out to provide comprehensive HIV/AIDS care with remote physician supervision. Capacity will link in-service and pre-service training by having nursing students carry out their clinical practicum and study tours in surrounding health centers.

Capacity will support the Nursing and Midwifery Task Force to address human resource challenges such as recruitment and retention of qualified health professionals and developing standards that reflect evidence-based practices, particularly as they pertain to the expanded role for nurses in ART care.

These activities support the Rwanda EP 5-year strategy by increasing institutional and human capacity for a district managed network model of HIV clinical care and treatment services.

Continued Associated Activity Information

Activity ID:	2777
USG Agency:	U.S. Agency for International Development
Prime Partner:	IntraHealth International, Inc
Mechanism:	Capacity
Funding Source:	GHAI
Planned Funds:	$ 1,921,952.00

Emphasis Areas	% Of Effort
Human Resources	10 - 50
Local Organization Capacity Development	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	10 - 50
Training	51 - 100

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy	0	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	0	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	0	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period	0	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards	525	☐

Target Populations:

Nurses
University students
Other MOH staff (excluding NACP staff and health care workers described below)
Nurses
Implementing organizations (not listed above)

Coverage Areas:

National

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: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 7213
Planned Funds: $ 1,450,000.00
Activity Narrative: In FY06, the Emergency Plan supported a range of activities in pharmaceutical management in Rwanda. These include capacity building of district pharmacists with MSH RPM+, renovation of district hospital pharmacies with the district support block grant, and central level support (SOP's, improved stock management, etc) with SCMS and CAMERWA. As the EP extends its geographic coverage in the country (22 out of 30 districts will receive direct EP support by the end of 2007), and in response to the GOR decision to reorient WB MAP support to other priority sectors, facilities demand for HIV commodities will increasingly strain the existing passive drug distribution system.

To date, all health facilities offering ART are required to place orders for and collect commodities from Kigali. In FY 2007, the EP will support the national medical stores medium term objective of establishing an semi-active commodity distribution system by providing technical and financial assistance to upgrade existing 2 district pharmacies into regional pharmacies, which will have additional warehousing space, cold chain etc to stock sufficient commodities for all sites offering ART in their respective provinces.

MSH/RPM +, in collaboration with CAMERWA, MOH and SCMS, will strategically select the pharmacies to be upgraded. It is expected that these regional facilities will serve as warehouses and as regional medical stores for health facilities in their respective geographic areas, thereby reducing strain on the central level warehouse, and sharply cutting down on costs for re-stocking of drugs and other commodities. MSH/RPM+ will also support the adaptation of information systems for stock-management at regional pharmacy level. This information will improve the data for forecasting demand of ARV's and related commodities, and provide stronger data on site level consumption patterns. This activity supports the EP five-year strategy for national scale-up and sustainability, and the Rwandan Government administrative and ART decentralization plan by strengthening capacity of districts and sub-national institutions.

Continued Associated Activity Information

Activity ID: 2761
USG Agency: U.S. Agency for International Development
Prime Partner: Management Sciences for Health
Mechanism: RPM+
Funding Source: GHAI
Planned Funds: $ 936,037.00

Emphasis Areas	% Of Effort
Human Resources	10 - 50
Infrastructure	51 - 100
Logistics	10 - 50
Quality Assurance, Quality Improvement 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 antiretroviral therapy		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period		☑
Number of individuals receiving antiretroviral therapy by the end of the reporting period		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards	836	☐

Target Populations:

Faith-based organizations
Doctors
Nurses
Pharmacists
Policy makers
Other MOH staff (excluding NACP staff and health care workers described below)
Implementing organizations (not listed above)

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:	GHAI
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	7222
Planned Funds:	$ 746,240.00

Activity Narrative: This activity relates to HTXS (7161, 7176, 7185, 7213, 7246, 8172), MTCT (7219), HBHC (7220), HVTB (7221), and HVCT (7217).

Performance-based financing is an innovative approach to financing of health services that enhances quality of services and leads to greater efficiency and sustainability. Financial incentives provided by performance-based funding motivate health facilities to improve performance through investments in training, equipment, personnel and payment systems that better link individual pay to individual performance. PBF financing is directly applied to ART and other HIV indicators at the facility level. As a result of successful pilots implemented by CordAID, GTZ and BTC, the MOH has endorsed national scale-up of performance-based financing for all health services. The USG, in partnership with the World Bank, BTC and other donors, is supporting national implementation of performance-based financing of health services.

In FY 2006, MSH/PBF supported the GOR in collaboration with key donors to develop a national strategy, policy, and implementation model of performance-based financing that applies to all health assistance. The initial strategy for EP-supported PBF activities was to transfer USG site support from a traditional inputs–based model to a purely output purchases model as sites achieved a certain level of technical competence. However, the implementation of FY 2006 activities brought a change in the USG team's thinking about this approach. Few, if any USG supported sites were found to be ready for complete graduation to an exclusively PBF model. While PBF clearly increases performance, technical assistance and basic input support is still needed, especially in the current context of rapid decentralization and accelerated national roll-out of the PBF model by the GOR. Therefore, an adjusted strategy has been developed that provides a combination of both input and output financing to all EP-supported sites. The combination of financing modalities will properly motivate health facilities for higher performance while providing necessary resources and tools to meet the established targets.

In FY 2007, MSH/PBF will continue to provide support to the MOH Performance Based Financing department and the national PBF TWG. In addition, MSH/PBF will provide TA to DHTs in all PEPFAR districts and to USG implementing partners to effectively shift some of their input financing to output-based financing for ART and other indicators in accordance with national policy. MSH/PBF will also provide output financing to health facilities in six districts (where other clinical partners will only provide input financing) through direct performance sub-contracts with health centers and district hospitals for ART and other indicators. Output financing involves the purchase of a certain quantity of indicators with a performance incentive for the production of more than agreed upon quantities of services. Full or partially reduced payment of ART and other indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national quality supervision tool.

At the health center level, MSH/PBF will use a 'fixed price plus award fee' contract model to purchase a quantity of ART and other HIV indicators with a performance incentive. Examples of ART indicators include the number of new adult ART patients, number of new pediatric ART patients, number of patients under ART seen after one month of starting treatment, and number of ART clients who have been seen six monthly. Performance on these indicators will be measured during monthly control activities jointly conducted by the MSH/PBF district coordinator and the district's Family Health Unit and quality of services will be evaluated through the existing national supervisory and quality assurance mechanisms. The quantity and quality scores will be merged during the quarterly District PBF Steering Committee meetings and the final payments will be approved.

At the district hospital level, MSH/PBF will have sub-contracts with slightly different purpose and scope from that of health centers. In addition to the focus on increasing better quality service outputs, there is an emphasis on quality assurance, self-evaluation, and review by peers similar to an accreditation scheme. There will be payment for indicators from the national district hospital PBF scheme which reinforces the supervisory role hospitals play in district health networks.

At the district level, MSH/PBF will support the national model by 1) placing a district coordinator within the Family Health Unit to work with national family health steering committee during data collection/entry and control of indicators, 2) facilitating the quantity

control function by providing TA and paying associated costs, and 3) supporting secretarial functions for the Family Health Unit at the district level. Support to the district is critical for the proper functioning of the national PBF model since monthly HIV/AIDS invoices approved by the health center PBF management committee and MSH are presented to the district steering committee for merging with quality index and final approval before payments are made.

Performance-based financing of ART and other HIV services is a critical step to achieving the goal of sustainable, well-managed, high quality, and cost-effective ART/HIV service delivery in a comprehensive HIV/AIDS treatment network. This financing modality supports the Rwanda EP five-year strategy for increasing institutional capacity for a district managed network model of HIV clinical treatment and care services.

Continued Associated Activity Information

Activity ID: 4003
USG Agency: U.S. Agency for International Development
Prime Partner: Management Sciences for Health
Mechanism: HIV/AIDS Performance Based Financing
Funding Source: GHAI
Planned Funds: $ 400,000.00

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, Quality Improvement and Supportive Supervision	10 - 50
Strategic Information (M&E, IT, Reporting)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy supported with performance-based financing	128	☐
Number of service outlets providing antiretroviral therapy	0	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	0	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	0	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period	0	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards	0	☐

Target Populations:

Country coordinating mechanisms
Faith-based organizations
Doctors
Nurses
Pharmacists
HIV/AIDS-affected families
International counterpart organizations
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Volunteers
HIV positive pregnant women
Other MOH staff (excluding NACP staff and health care workers described below)
Laboratory workers
Implementing organizations (not listed above)
HIV positive children (5 - 14 years)

Coverage Areas

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Karongi

Rutsiro

Ngororero

Nyabihu

Nyamasheke

Rubavu

Gasabo

Kicukiro

Nyarugenge

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: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 7246
Planned Funds: $ 650,000.00

Activity Narrative: Quality assurance, improvement and control are a vital part of HIV services - particularly as more people are put on ART. Moreover greater integration of overall services (for example Nutrition with ART services) is needed to ensure successful mainstreaming and assure a quality continuum of care. Rwanda EP supports clinical partners, TRAC and MoH decentralization office for QA/QI/QC of national HIV programs. However, because the priority of the national program has been the rapid scale up of HIV services, recent field supervision has turned up variability in service quality and interpretations of the basic package of services. Furthermore, reporting and field record keeping lacks consistency and national strategic vision. With these new funds PEPFAR Rwanda will work with MOH to reinforce ART program quality through substantial strengthening of the TRAC Quality assurance and facilitative supervision function. This activity has two basic components.

One component is to reinforce the M&E unit at TRAC for ART program monitoring, joint supervision and data analysis and use to improve program quality. The second component will be to use the expertise of an international institution to support TRAC in revising the definition of the ART basic standards of care that guaranty improved service quality at individual sites, to conduct training and supervision of district health teams in those standards and their applications at lower levels of the health system. The standards will focus in three areas namely the provision of services, the link with communities and administrative services. It is anticipated that this activity will be co-funded by both GFATM and EP.

This activity relates to HTXS (7161, 7176, 7190, 7205, 7262, 8172), MTCT (7244), HBHC (7245), HVCT (7242), and HVSI (7240).

In FY 2006, TRAC with TA from EP clinical implementing partners developed national clinical norms, guidelines and tools for ART, including registers, patient forms, and clinical IEC materials for patients. TRAC undertook regular supervision to ensure that HIV services at site level comply with these national norms. In addition, TRAC conducted four training-of-trainers sessions on care and treatment, including ARV and pediatric AIDS, with a practicum component emphasizing quality of care. TRAC also organized two training sessions for district-level supervisors and two training sessions for medical doctors at new ART sites. In collaboration with Columbia University and IntraHealth, TRAC developed a TOT plan for nurses working in HIV/AIDS care and treatment, which reached 300 HIV/AIDS service providers.

In FY 2007, USG will expand support to TRAC for routine monitoring of key ART impact indicators to ensure program quality. USG clinical services staff will continue providing TA to TRAC to revise guidelines, reach an additional 200 trainers and expand new activities in joint supervision to improve program quality.

In addition, USG will support TRAC to finalize the ART patient card checklist which will be integrated into the existing patient medical record to facilitate data recording and quality supervision. USG will also support TRAC to design an innovative joint supervision format based on experiences of other EP countries. Under this new supervision format, all ART implementing partners and other related programs such as TB will participate in joint supervisions with TRAC. TRAC and partners will conduct periodic visits to ART sites with a standard checklist to assess quality of HIV services integration, whether guidelines are followed, and ARV drug prescription patterns. The joint supervision teams will provide regular feedback to sites and share best practices in ART service delivery.

This activity supports the EP five-year strategy for national scale-up and sustainability and the Rwandan Government ART decentralization plan.

Continued Associated Activity Information

Activity ID: 2745
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Treatment and Research AIDS Center
Mechanism: TRAC Cooperative Agreement
Funding Source: GHAI
Planned Funds: $ 344,135.00

Emphasis Areas	% Of Effort
Local Organization Capacity Development	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	51 - 100
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy supported with performance-based financing		☑
Number of service outlets providing antiretroviral therapy	0	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	0	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	0	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period	0	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards	200	☐

Target Populations:

Doctors
Nurses
Pharmacists
Traditional birth attendants
Other MOH staff (excluding NACP staff and health care workers described below)
Other Health Care Worker
Doctors
Laboratory workers
Nurses
Pharmacists
Other Health Care Workers

Coverage Areas:

National

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: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 7256
Planned Funds: $ 110,000.00
Activity Narrative: USAID/Rwanda has been providing local and international technical assistance to GOR agencies and limited direct grants to local NGOs since FY 2004.

In FY 2007, the EP will expand this to further build local capacity. USAID anticipates continuing financial and technical support to Rwanda NGOs in sponsoring or attending conferences, workshops and technical meetings on HIV treatment. USAID will also support direct TA to other GOR agencies as needed, in particular CNLS.

In addition, the EP will utilize the expertise and resources of USAID/EGAT to help USG clinical implementing partners better gauge and plan for the energy needs of their sites. Assistance will include in-depth assessments of energy demand profiles at supported sites and local capacity for maintenance of renewable and hybrid energy systems; adaptation of purchasing guidelines for partners; and recommended methods for partners to self-finance replacement parts to ensure sustainability of EP-supported energy systems.

Continued Associated Activity Information

Activity ID: 4970
USG Agency: U.S. Agency for International Development
Prime Partner: US Agency for International Development
Mechanism: USAID Rwanda Mission
Funding Source: GHAI
Planned Funds: $ 85,000.00

Emphasis Areas	% Of Effort
Human Resources	10 - 50
Linkages with Other Sectors and Initiatives	10 - 50
Local Organization Capacity Development	10 - 50
Needs Assessment	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period		☑
Number of individuals receiving antiretroviral therapy by the end of the reporting period		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards		☑

Target Populations:

Faith-based organizations

Non-governmental organizations/private voluntary organizations

Host country government workers

Public health care workers

Implementing organizations (not listed above)

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: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 7262
Planned Funds: $ 500,000.00
Activity Narrative: This activity relates to HTXS (7246, 7158, 7161, 7174, 7176), MTCT (8184), HBHC (8139), and HVTB (7266).

In FY 2007, CDC will continue the support of a Care and Treatment Officer who oversees planning, implementation, and M&E of CDC-direct and EP partner activities, the implementation of the national ART impact evaluation, and short-term TA for specialized areas of the EP program such as pediatric AIDS.

The long term care and treatment officer will assist TRAC in the coordination of care and treatment activities and support integration of HIV care and treatment services into the general health care system by co-chairing the national integration TWG and facilitating joint site supervisions. In addition, CDC Rwanda will assist MOH to adapt training curricula in integrated activities such as TB, nutrition, malaria, and MCH.

In addition, CDC Rwanda will continue to support the impact evaluation of the national ART program, which was introduced in FY 2006 with a two-part protocol. Part one includes the evaluation of patient retention, weight, and CD4 outcomes at six and twelve months based on available data abstracted from medical records. Part two includes the evaluation of viral load suppression at six and twelve months based on RNA PCR determination. This evaluation will be repeated annually to track program quality over time.

CDC will also continue to support TRAC in care and treatment for HIV-positive children. Through short-term TA from CDC HQ, pediatric HIV care will be integrated into MCH and PMTCT programs through the development of tools and reinforcement of M&E systems.

This activity is in line with the Rwanda EP five-year strategy to develop human capacity and build sustainability.

Continued Associated Activity Information

Activity ID: 2846
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: US Centers for Disease Control and Prevention
Mechanism: CDC Country Office GAP/TA
Funding Source: GHAI
Planned Funds: $ 315,000.00

Emphasis Areas	% Of Effort
Local Organization Capacity Development	10 - 50
Policy and Guidelines	10 - 50
Quality Assurance, Quality Improvement 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 antiretroviral therapy		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period		☑
Number of individuals receiving antiretroviral therapy by the end of the reporting period		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards		☑

Target Populations:

Country coordinating mechanisms
Faith-based organizations
Doctors
Nurses
International counterpart organizations
National AIDS control program staff
Non-governmental organizations/private voluntary organizations
Policy makers
Other MOH staff (excluding NACP staff and health care workers described below)
Laboratory workers
Implementing organizations (not listed above)

Coverage Areas:

National

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:	GHAI
Program Area:	HIV/AIDS Treatment/ARV Services
Budget Code:	HTXS
Program Area Code:	11
Activity ID:	8121
Planned Funds:	$ 0.00

Activity Narrative: [CONTINUING ACTIVITY FROM FY 2006 -- NO NEW FUNDING IN FY 2007]
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.

****PLUS-UP****
$815,000 - Under the base COP06 budget, a limited amount of funding was allocated for a basic package of district support. With supplemental funding, FHI will provide additional personnel and TA support to nine DHTs to further enhance transport and communications activities between health centers, district hospitals, district pharmacies and community based services. DHTs will have increased capacity to conduct supervision, quality assurance, and M&E of the network model.

Rwanda is facing a long-term energy crisis due to the country's small capacity for energy production and distribution. Supply of electricity to rural areas is poor, and many health facilities rely on one or more high-capacity generators just to support their most basic functions. Generators are extremely expensive to procure and maintain and are not a sustainable solution in the long term. Some USG partners have already begun investing in solar energy as a more cost-effective means of supplying power to lab machines, refrigerators and other essential equipment at ARV sites. With the funding allotted for this activity, USG will support an assessment of electrical infrastructure and supply at Rwanda's district hospitals and procure solar equipment (panels, circuitry and batteries) for the hospitals in most dire need. It is anticipated that USG will be able to provide a solar energy package for ARV services at approximately 7-9 district hospitals with the funds indicated.

Continued Associated Activity Information

Activity ID: 4770
USG Agency: U.S. Agency for International Development
Prime Partner: Family Health International
Mechanism: FHI Bridge
Funding Source: GHAI
Planned Funds: $ 3,630,200.00

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
Training	10 - 50

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy	25	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	7,240	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	6,431	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period	2,575	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards	120	☐

Key Legislative Issues

Gender

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Wrap Arounds

Food

Coverage Areas

Byumba (prior to 2007)

Gikongoro (prior to 2007)

Gitarama (prior to 2007)

Kigali (Rurale) (prior to 2007)

Kigali-Ville (prior to 2007)

Table 3.3.11: Activities by Funding Mechanism

Mechanism: NHRC
Prime Partner: US Department of Defense Naval Health Research Center
USG Agency: Department of Defense
Funding Source: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 8171
Planned Funds: $ 60,000.00
Activity Narrative: This activity relates to HTXS (7190), HBHC (7191), HVTB (8146) and HVOP (8135).

In FY 2006, two RDF physicians attended the Military International HIV Training Program in San Diego. The objective of the program is to train key foreign military clinical physicians, using a TOT approach, in state-of-the-art HIV prevention, diagnosis, clinical management and treatment with the expectation that they will transfer information into operational use in country. The program emphasizes treatment of opportunistic infections, provision of anti-retroviral therapy, prevention and clinical management of HIV, epidemiologic surveillance and clinical laboratory diagnosis.

Given the scale-up of USG support to ARV services in the military, an additional four Rwandan physicians will attend this program in FY 2007.

This activity supports the Rwanda EP 5-year strategy to develop human capacity and strengthen the capacity of the RDF to treat the military population, their families, and nearby communities.

Continued Associated Activity Information

Activity ID: 2737
USG Agency: Department of Defense
Prime Partner: US Department of Defense Naval Health Research Center
Mechanism: N/A
Funding Source: GHAI
Planned Funds: $ 40,000.00

Emphasis Areas

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

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy		
Number of individuals who ever received antiretroviral therapy by the end of the reporting period		
Number of individuals receiving antiretroviral therapy by the end of the reporting period		
Number of individuals newly initiating antiretroviral therapy during the reporting period		
Total number of health workers trained to deliver ART services, according to national and/or international standards	4	

Target Populations:

Doctors
Military personnel

Coverage Areas:

National

Table 3.3.11: Activities by Funding Mechanism

Mechanism: Refugees UNHCR
Prime Partner: United Nations High Commissioner for Refugees
USG Agency: Department of State / Population, Refugees, and Migration
Funding Source: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 8737
Planned Funds: $ 88,000.00
Activity Narrative: While limited funds were allocated for Refugee camp ARV services in FY 07, the majority of these monies were earmarked for Kiziba camp since the GOR had signaled their support for creating stand alone ARV services at this geographically isolated site. However, recently, TRAC has began to work with staff at Gihembe refugee camp to certify it as a ARV site. Consequently, the USG team would like to allocate $20,000 to the Gihembe camp for the costs associated with the accreditation process as an ARV site and to ensure that the Gihembe camp receives the full package of services that will be available at other USG sites. The package of services includes hiring dedicated staff to follow all PLWHAs from the time of diagnosis and ensure that they receive proper clinical and nutritional counseling and care.

This activity relates to MTCT (8696), HVAB (8700), HVOP (8711), HBHC (8718), HVTB (8670), HVCT (8732), HTXD (8170), and HTXS (7174, 7246, 7213).

Since 2005, USG/Rwanda has supported HIV/AIDS services in refugee camps. In FY 2007, USG will expand the package of services for the prevention, care, and treatment of PLWHA in refugee camps. EP support will be complemented by the World Bank-funded GLIA and OPEC.

Funding for this activity will support a standard package of ART services at 2 refugee camps for 120 existing patients and 60 new patients, including 10 eligible HIV-infected children. This package of services includes treatment with ARV according to national guidelines, follow-up clinical monitoring, CD4 count every six months, viral load to an estimated 5 eligible patients with decreased or stable CD4 after nine months of HAART, management of ARV drugs side effects, ongoing adherence counseling, nutritional counseling, and patient referral to community-based palliative care.

Partners will provide a full package of ART services at Kiziba camp and a more limited package of ART services at Gihembe. Nyabiheke camp will continue to work closely with Ngarama District Hospital to ensure access to ARVs. Partners will support training for the refugee camp health care workers for the provision of ART, adherence counseling, ongoing clinical monitoring, management of ART-related side effects, and referrals.

In collaboration with clinical partners, UNHCR partners will strengthen the network of services offered between the camps and the district hospital. In addition, UNHCR will ensure transportation of specimens for all laboratory tests not available at the camps, strengthened communication and referral systems, and periodic supervision by the DHT.

PFSCM will procure all ARV drugs and commodities and strengthen the supply chain management system. RPM+ will provide training in pharmaceutical and ARV drug management and rational use.

UNHCR partners will strengthen linkages between PMTCT, MCH, CT, and palliative care through improved and integrated MIS and organization of facility wide staff meetings. Where necessary, partners will adapt adherence and counseling tools for ART patients to the refugee setting. As part of the USG standard package of ART services, funds will be used to hire and train HIV case managers to strengthen linkages to community-based services and to improve follow-up of ART patients.

This activity supports the EP five-year strategy for national scale-up and sustainability and the Rwandan Government ART decentralization plan and addresses the key legislative issues of gender, stigma and discrimination.

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

Targets

Target	Target Value	Not Applicable
Number of service outlets providing antiretroviral therapy supported with performance-based financing		☑
Number of service outlets providing antiretroviral therapy	2	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	180	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	206	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period	100	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards	10	☐

Target Populations:

Community-based organizations
Doctors
Nurses
Pharmacists
HIV/AIDS-affected families
International counterpart organizations
Refugees/internally displaced persons
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Volunteers
HIV positive pregnant women
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas

Gicumbi

Gatsibo

Karongi

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: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 9732
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY 2006 -- NO NEW FUNDING IN FY 2007]

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.

Continued Associated Activity Information

Activity ID: 2809
USG Agency: U.S. Agency for International Development
Prime Partner: Community Habitat Finance International
Mechanism: CHAMP
Funding Source: GHAI
Planned Funds: $ 140,000.00

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		☑
Number of individuals who ever received antiretroviral therapy by the end of the reporting period		☑
Number of individuals receiving antiretroviral therapy by the end of the reporting period		☑
Number of individuals newly initiating antiretroviral therapy during the reporting period		☑
Total number of health workers trained to deliver ART services, according to national and/or international standards		☑

Key Legislative Issues

Stigma and discrimination

Food

Coverage Areas

Byumba (prior to 2007)

Gikongoro (prior to 2007)

Gisenyi (prior to 2007)

Gitarama (prior to 2007)

Kibungo (prior to 2007)

Kibuye (prior to 2007)

Kigali (Rurale) (prior to 2007)

Kigali-Ville (prior to 2007)

Umutara (Mutara) (prior to 2007)

Table 3.3.11: Activities by Funding Mechanism

Mechanism: FHI New Bilateral

Prime Partner: Family Health International

USG Agency: U.S. Agency for International Development

Funding Source: GHAI

Program Area: HIV/AIDS Treatment/ARV Services

Budget Code: HTXS

Program Area Code: 11

Activity ID: 15444

Planned Funds: $ 4,762,598.00

Activity Narrative: This activity relates to activities HTXS (7158, 7161, 7164, 7174, 7176, 7185, 7213, 7222, 7246, 7262), MTCT (7179), HVAB (8186), HVOP(8133), HBHC (7177), HVTB (7180), HVCT (7178), HTXD (8170), and HLAB (7224, 8189). In FY 2006, USAID partners provided a comprehensive package of ART services to 11,900 patients at 57 sites, including 952 children. The package includes treatment with ARV drugs, routine CD4 follow up, viral load testing for an estimated 2,400 eligible patients with decreased or stable CD4 after nine months of HAART, management of ARV drug side effects, and patient referrals to community-based care. In FY 2007, USAID awarded three cooperative agreements -one of the three to FHI - that will provide the same package at 57 existing sites and 18 new clinical sites. FHI was awarded a cooperative agreement that will expand quality clinical services, continue support to the DHTs, increase sustainability through performance-based financing, and strengthen SI at all levels.

This activity will reach 3540 new patients, including 350 children, enrolled at a total of 33 sites. With procurement support from PFSCM, FHI will provide ARV drugs, CD4 tests, and viral load tests to all supported sites. In order to ensure continuum of care, HIV case managers at sites will train and supervise community volunteers including CHWs, PLWHA association members, and other caretakers, in collaboration with CHAMP. Increasing pediatric patient enrollment is a major priority for all USG clinical partners in FY 2007. Case managers will ensure referrals of pediatric patients identified from PMTCT programs, PLWHA associations, and malnutrition centers. In addition, adult patients enrolled in care will be encouraged to have their children tested. To expand quality pediatric care, Rwanda's few available pediatricians will mentor other clinical providers, using the Columbia UTAP model developed in FY 2006. In the context of decentralization, DHTs now play a critical role in the oversight and management of clinical and community service delivery.

FHI will strengthen the capacity of 5 DHTs to coordinate an effective network of ARV and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities. FHI works in health facilities with widely varying existing infrastructure. In some cases, poor health facility conditions are adversely affecting implementation of HIV-related services. FHI will address urgent needs of 2-3 health facilities for upgrade and maintenance of physical infrastructure. Priority areas are ensuring basic electrical and water supply, waste management and infection control. Other necessary improvements may include incinerators, wards, waiting areas, record storage space, and water reservoirs. The Rwanda EP will continue a gradual shift in funding from input financing to performance-based financing.

Through a strategic mix of input through the district support package and directly to health facilities, and output performance-based financing through the purchase of improved performance for specific HIV indicators, districts will receive the appropriate support to increase autonomy and sustainability. In addition, FHI will strengthen district and facility level capacity for data collection, reporting and use with focus on ARV drugs management, HIV case management, and improved quality implementation and program evaluation. Sites will generate routine summary reports of patient-level data and will interpret that data to inform their programmatic operations. FHI will also organize periodic M&E workshops for all supported sites to discuss the collection and use of data at the site-level. This activity supports the EP five-year strategy for national scale-up and sustainability and the Rwandan Government ART decentralization plan and addresses the key legislative issues of gender, stigma and discrimination.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Health Care Financing	10 - 50
Infrastructure	51 - 100
Quality Assurance, Quality Improvement 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 antiretroviral therapy supported with performance-based financing		☑
Number of service outlets providing antiretroviral therapy	33	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	8,000	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	7,760	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period	3,540	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards	74	☐

Target Populations:

Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
HIV/AIDS-affected families
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Prisoners
Volunteers
HIV positive pregnant women
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Table 3.3.11: Activities by Funding Mechanism

Mechanism: IntraHealth New Bilateral
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 15445
Planned Funds: $ 2,591,184.00
Activity Narrative: This activity relates to activities HTXS (7158, 7161, 7164, 7174, 7176, 7185, 7213, 7222, 7246, 7262), MTCT (7179), HVAB (8186), HVOP(8133), HBHC (7177), HVTB (7180), HVCT (7178), HTXD (8170), and HLAB (7224, 8189). In FY 2006, USAID partners provided a comprehensive package of ART services to 11,900 patients at 57 sites, including 952 children. The package includes treatment with ARV drugs, routine CD4 follow up, viral load testing for an estimated 2,400 eligible patients with decreased or stable CD4 after nine months of HAART, management of ARV drug side effects, and patient referrals to community-based care. In FY 2007, USAID awarded three cooperative agreements - one of the three to IntraHealth - that will provide the same package at 57 existing sites and 18 new clinical sites.

IntraHealth will expand quality clinical services, continue support to the DHTs, increase sustainability through performance-based financing, and strengthen SI at all levels. This activity will reach 1296 new patients, including 130 children, enrolled at a total of 18 sites. With procurement support from PFSCM, IntraHealth will provide ARV drugs, CD4 tests, and viral load tests to all supported sites. In order to ensure continuum of care, HIV case managers at sites will train and supervise community volunteers including CHWs, PLWHA association members, and other caretakers, in collaboration with CHAMP. Increasing pediatric patient enrollment is a major priority for all USG clinical partners in FY 2007. Case managers will ensure referrals of pediatric patients identified from PMTCT programs, PLWHA associations, and malnutrition centers. In addition, adult patients enrolled in care will be encouraged to have their children tested.

To expand quality pediatric care, Rwanda's few available pediatricians will mentor other clinical providers, using the Columbia UTAP model developed in FY 2006. In the context of decentralization, DHTs now play a critical role in the oversight and management of clinical and community service delivery. IntraHealth will strengthen the capacity of 4 DHTs to coordinate an effective network of ARV and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities. The Rwanda EP will continue a gradual shift in funding from input financing to performance-based financing. Through a strategic mix of input through the district support package and directly to health facilities, and output performance-based financing through the purchase of improved performance for specific HIV indicators, districts will receive the appropriate support to increase autonomy and sustainability.

In addition, IntraHealth will strengthen district and facility level capacity for data collection, reporting and use with focus on ARV drugs management, HIV case management, and improved quality implementation and program evaluation. Sites will generate routine summary reports of patient-level data and will interpret that data to inform their programmatic operations. IntraHealth will also organize periodic M&E workshops for all supported sites to discuss the collection and use of data at the site-level. This activity supports the EP five-year strategy for national scale-up and sustainability and the Rwandan Government ART decentralization plan and addresses the key legislative issues of gender, stigma and discrimination.

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Health Care Financing	10 - 50
Infrastructure	51 - 100
Quality Assurance, Quality Improvement 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 antiretroviral therapy supported with performance-based financing		☑
Number of service outlets providing antiretroviral therapy	18	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	5,159	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	5,004	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period	1,296	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards	116	☐

Target Populations:

Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
HIV/AIDS-affected families
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Prisoners
Volunteers
HIV positive pregnant women
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Table 3.3.11: Activities by Funding Mechanism

Mechanism: EGPAF New Bilateral
Prime Partner: Elizabeth Glaser Pediatric AIDS Foundation
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 15446
Planned Funds: $ 2,012,958.00
Activity Narrative: This activity relates to activities HTXS (7158, 7161, 7164, 7174, 7176, 7185, 7213, 7222, 7246, 7262), MTCT (7179), HVAB (8186), HVOP(8133), HBHC (7177), HVTB (7180), HVCT (7178), HTXD (8170), and HLAB (7224, 8189). In FY 2006, USAID partners provided a comprehensive package of ART services to 11,900 patients at 57 sites, including 952 children. The package includes treatment with ARV drugs, routine CD4 follow up, viral load testing for an estimated 2,400 eligible patients with decreased or stable CD4 after nine months of HAART, management of ARV drug side effects, and patient referrals to community-based care. In FY 2007, USAID will issue one RFA for three cooperative agreements that will provide the same package at 57 existing sites and 18 new clinical sites. EGPAF was awarded a cooperative agreement that will expand quality clinical services, continue support to the DHTs, increase sustainability through performance-based financing, and strengthen SI at all levels.

This activity will reach 2364 new patients, including 236 children, enrolled at a total of 24 sites. With procurement support from PFSCM, EGPAF will provide ARV drugs, CD4 tests, and viral load tests to all supported sites. In order to ensure continuum of care, HIV case managers at sites will train and supervise community volunteers including CHWs, PLWHA association members, and other caretakers, in collaboration with CHAMP. Increasing pediatric patient enrollment is a major priority for all USG clinical partners in FY 2007. Case managers will ensure referrals of pediatric patients identified from PMTCT programs, PLWHA associations, and malnutrition centers. In addition, adult patients enrolled in care will be encouraged to have their children tested. To expand quality pediatric care, Rwanda's few available pediatricians will mentor other clinical providers, using the Columbia UTAP model developed in FY 2006.

In the context of decentralization, DHTs now play a critical role in the oversight and management of clinical and community service delivery. EGPAF will strengthen the capacity of 5 DHTs to coordinate an effective network of ARV and other HIV/AIDS services. The basic package of financial and technical support includes staff for oversight and implementation, transportation, communication, training of providers, and other support to carry out key responsibilities. EGPAF works in health facilities with widely varying existing infrastructure. In some cases, poor health facility conditions are adversely affecting implementation of HIV-related services. EGPAF will address urgent needs of 2-3 health facilities for upgrade and maintenance of physical infrastructure. Priority areas are ensuring basic electrical and water supply, waste management and infection control. Other necessary improvements may include incinerators, wards, waiting areas, record storage space, and water reservoirs. The Rwanda EP will continue a gradual shift in funding from input financing to performance-based financing.

Through a strategic mix of input through the district support package and directly to health facilities, and output performance-based financing through the purchase of improved performance for specific HIV indicators, districts will receive the appropriate support to increase autonomy and sustainability. In addition, EGPAF will strengthen district and facility level capacity for data collection, reporting and use with focus on ARV drugs management, HIV case management, and improved quality implementation and program evaluation. Sites will generate routine summary reports of patient-level data and will interpret that data to inform their programmatic operations. EGPAF will also organize periodic M&E workshops for all supported sites to discuss the collection and use of data at the site-level. This activity supports the EP five-year strategy for national scale-up and sustainability and the Rwandan Government ART decentralization plan and addresses the key legislative issues of gender, stigma and discrimination.

Emphasis Areas	**% Of Effort**
Development of Network/Linkages/Referral Systems	51 - 100
Health Care Financing	10 - 50
Infrastructure	10 - 50
Quality Assurance, Quality Improvement 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 antiretroviral therapy supported with performance-based financing		☑
Number of service outlets providing antiretroviral therapy	24	☐
Number of individuals who ever received antiretroviral therapy by the end of the reporting period	47,514	☐
Number of individuals receiving antiretroviral therapy by the end of the reporting period	4,609	☐
Number of individuals newly initiating antiretroviral therapy during the reporting period	2,364	☐
Total number of health workers trained to deliver ART services, according to national and/or international standards	38	☐

Target Populations:

Community-based organizations
Faith-based organizations
Doctors
Nurses
Pharmacists
HIV/AIDS-affected families
Non-governmental organizations/private voluntary organizations
People living with HIV/AIDS
Prisoners
Volunteers
HIV positive pregnant women
Laboratory workers
Other Health Care Worker
HIV positive infants (0-4 years)
HIV positive children (5 - 14 years)

Key Legislative Issues

Increasing gender equity in HIV/AIDS programs

Stigma and discrimination

Coverage Areas

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Gasabo

Kicukiro

Nyarugenge

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Table 3.3.11: Activities by Funding Mechanism

Mechanism: BASICS
Prime Partner: Partnership for Child HealthCare Inc.
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 15447
Planned Funds: $ 120,000.00
Activity Narrative: BASICS will continue to support the development of the UNICEF/WHO Pediatric HIV programming framework and work in synergy with TRAC, the MCH Task Force, through its work on IMCI, and with USG partners' HIV/AIDS programs in Rwanda, including EGPAF and the CHAMP project, and in collaboration with other child health projects such as those under Concern Worldwide and IRC, in the area of pediatric HIV/AIDS. BASICS' efforts will focus on the identification, care and treatment of HIV infected children under five through community and facility services. To this end, BASICS will collaborate with USG implementing clinical and community partners to ensure access to care and treatment services, tracking, follow up and continued care for infants and children. There are many missed opportunities to reach infants and children with HIV at multiple entry points to care, including at MCH services, PMTCT programs, pediatric inpatient wards, through home based care programs, and others.

To reduce missed opportunities, BASICS will help strengthen functional referral networks, and active communication and collaboration between units within facilities, between different levels of facilities and between the facilities and surrounding communities through community health workers (e.g., agents de sante communitaire), NGOs and CBOs. Several of BASICS COP06 activities including the integration of PMTCT into MCH, integration of HIV into IMCI, and essential newborn care support moving towards these improvements but will require ongoing reinforcement, as well as expansion to additional regions, and evaluation over time. BASICS will continue providing technical support to other USG partners to integrate post partum care packages for newborns and mothers, family planning and safe motherhood activities into their current PMTCT work .This will include developing job aids and training tools and conducting training of health workers at the facility and community levels of care to increase early identification, referral to care and treatment services, tracking, follow up and continued care for infants and children exposed to HIV.

BASICS will draft and pre-test a pediatric HIV orientation module for HCWs and PLWHA groups who do not need training at the level addressed in pediatric ART courses for prescribers and who might not be an appropriate audience for IMCI-HIV training. This will allow this audience to increase their index of suspicion for infants and children with HIV, and to appreciate the importance of diagnosing HIV, and the benefits of OI prophylaxis and ART and the follow up needs of children and families once children start on ART. The development of this module would proceed based on formative research with the target groups in several sample communities and will be undertaken in collaboration with CHAMP and other stakeholders. BASICS will adapt and harmonize job aids for pediatric HIV identification, care and treatment for use in MCH, PMTCT, and care and treatment settings. These job aids will be developed with and for the use by all USG partner ART sites, as well as government and other private sites who desire to use them.

Following an agreed upon period of time, BASICS will conduct an evaluation of the effectiveness of the job aids developed, its impact in increasing number of infants and children reached and update them as needed, in collaboration with TRAC, the MCH Task Force, and USG partners delivering ART services.BASICS' technical support to improve earlier and expanded identification of infants exposed to HIV will substantially increase the number of infants and children accessing care and treatment services. There is also an excellent opportunity for synergy in funding since the funds secured under COP 07 will be utilized with additional CSH funds available to BASICS.

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: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 19250
Planned Funds: $ 200,000.00
Activity Narrative: n/a

Table 3.3.11: Activities by Funding Mechanism

Mechanism: Twubakane
Prime Partner: IntraHealth International, Inc
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: HIV/AIDS Treatment/ARV Services
Budget Code: HTXS
Program Area Code: 11
Activity ID: 19251
Planned Funds: $ 200,000.00
Activity Narrative: n/a

Table 3.3.12: Program Planning Overview

Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12

Total Planned Funding for Program Area: $ 5,677,880.00

Program Area Context:

The EP provides support and technical assistance to two key GOR institutions, the NRL and KHI to improve laboratory infrastructure and capacity at the national level for HIV testing, care and treatment. As in previous years, EP technical support for laboratory infrastructure in FY 2007 will continue to focus on key reference laboratory functions, including training, QA 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. All laboratory-related procurement will be consolidated into a single national system in FY 2007.

FY 2007 will continue an important shift in the utilization of USG resources and laboratory partner expertise to support laboratory infrastructure, with increasing emphasis on direct support to GOR. USG will increase direct support to NRL through the CDC cooperative agreement to manage certain key training and logistical functions, as well as support for HIV and TB-related QA activities. USG will continue funding ASCP to expand support for pre-service training of laboratory technicians at KHI through curriculum improvements and direct training support. These two partners are taking over activities that were initiated by CDC and Columbia UTAP in previous years. These shifts will allow Columbia and CDC to continue to focus more narrowly on laboratory service quality concerns, while broadening efforts against TB and malaria. 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.

In FY 2007 CDC will continue to provide TA for training in OI diagnosis with emphasis on MDR and extrapulmonary TB and parasitic infections, new techniques to support program evaluation and surveillance, and molecular virology techniques for HIV drug resistance surveillance. 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. Columbia UTAP will also continue bolstering management and financial capacity at NRL by maintaining the long-term laboratory management advisor position and supporting improvements to the data management system for tracking specimens and reporting functions. All USG clinical implementing partners will have increasing responsibility for coordinating specimen transport and QA systems at the peripheral and district levels.

EP laboratory efforts face challenges as well. The BTC has long supported the TB section of the NRL; however this project is scheduled to end in FY 2007 with future funding uncertain. In response, USG plans expanded support for NRL TB QA/QC activities through the NRL cooperative agreement, Columbia UTAP and CDC. Another challenge for USG in the laboratory infrastructure area has been the long process of securing a fourth CDC direct hire employee to manage the EP laboratory portfolio. CDC hopes to have the position approved and filled before start of FY 2008 and will continue recruitment of an interim laboratory coordinator funded in FY 2006.

In FY 2007, PFSCM will be responsible for the procurement of all EP commodities through direct support to CAMERWA for the procurement, storage and distribution of all medicines, equipment and laboratory supplies. This consolidated approach to procurement will increase cost savings, and improve efficiencies in procurement and distribution of commodities. PFSCM will also take over the support of the CPDS and logistics management activities to ensure smooth functioning of the CPDS system, quality data for quantification, and strong communication between districts and CAMERWA.

Program Area Target:

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	963,000
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	55
Number of individuals trained in the provision of laboratory-related activities	270

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: GHAI
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 7154
Planned Funds: $ 0.00
Activity Narrative: Reprogramming 8/07: THis activity has been abandoned.

This activity relates to activities in HLAB (7172, 7263).

In FY 2006, the EP begins a partnership with ASCP, building upon FY 2005 activities initiated by CDC and Columbia UTAP in support of KHI. CDC and Columbia renovated and equipped KHI's training laboratory, more than tripling their classroom capacity. ASCP's FY 2006 activities are expected to begin in October 2006. In FY 2007 ASCP will provide TA 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. Training activities will place particular emphasis on HIV/AIDS, tuberculosis, and malaria diagnostics. ASCP will continue its laboratory pre-service internship training activity under which KHI lab students are 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.

Continued Associated Activity Information

Activity ID: 4979
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: American Society of Clinical Pathology
Mechanism: American Society of Clinical Pathology
Funding Source: GHAI
Planned Funds: $ 200,000.00

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

Targets

Target	Target Value	Not Applicable
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		☑
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	0	☐
Number of individuals trained in the provision of laboratory-related activities	0	☐

Target Populations:

Laboratory workers

Coverage Areas:

National

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: GHAI
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 7172
Planned Funds: $ 600,000.00

Activity Narrative: This activity relates to activities in HLAB (7262, 7244, 8189).

In FY 2006, Columbia provided management and technical assistance to the NRL through long-term advisors, as well as through short-term consultant support. Key FY 2006 accomplishments in the management area include the development of a costed five-year strategic plan for NRL, and the submission of an application for a CDC cooperative agreement. In technical areas, through a subagreement and TA, Columbia assisted NRL to maintain its QA systems for HIV serology and CD4 testing, with over 60,000 serology specimens tested for quality, and all CD4 laboratories participating in the national QA system. Columbia began development of a data management system for NRL and the peripheral laboratory network through an expert consultancy and stakeholder discussions. Columbia also led the development of a protocol for laboratory evaluation of DPS specimen collection for viral load testing for hard-to-reach health facilities.

In FY 2007, Columbia 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 will be continued in FY 2007. The first is an international-hire position providing support for quality HIV-related laboratory services, including evaluating new technologies, technician trainings, 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. These technical advisors will continue to transfer skills, knowledge and capacity, ensuring sustained impact. Short-term advisors will also be utilized as needed for specific projects.

TB services at NRL require strengthening to meet the EP priority of providing quality direct AFB microscopy at the health facility level. Columbia will expand laboratory TA to the NRL TB laboratory to ensure high quality QA of smear microscopy, culture and drug sensitivity testing capability. These activities are essential to improve the diagnostic capability of the 174 TB diagnostic and treatment centers in Rwanda, in order to provide adequate access of basic QA smear microscopy services to all PLWHA that have active TB disease. This is also essential to support the management of patients with MDR TB and to avoid potential development and transmission of resistant disease among those PLWHA with active TB disease.

Columbia will continue to improve reference laboratory management through support for an international-hire management advisor. The laboratory management advisor will help develop management systems for finances, logistics, program data, transport and commodities and will mentor the new NRL Director of Finance position funded under the CDC cooperative agreement. The management advisor position continues to be critical in strengthening NRL's capacity to effectively manage multiple streams of funding, including substantial USG EP resources.

In collaboration with CDC, Columbia will continue the planning and implementation of a laboratory information system for NRL and district hospitals. Columbia will adapt existing software systems developed through CDC partnerships in other countries for use in Rwanda. The laboratory information system will streamline financial record keeping, as well as specimen tracking, inventory control, and programmatic indicator tracking. This activity was funded in FY 2006, but the anticipated implementation partnership could not be finalized and so the activity will be carried over into FY 2007.

These activities are consistent with Rwanda EP five-year strategic goals of strengthening NRL capacity to manage a national network of laboratories and the standardization of technical approaches and QA of HIV-related services throughout the national laboratory network.

Continued Associated Activity Information

Activity ID: 2734
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Columbia University Mailman School of Public Health

Mechanism: Columbia UTAP
Funding Source: GHAI
Planned Funds: $ 755,000.00

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

Targets

Target	Target Value	Not Applicable
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		☑
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 laboratory-related activities	20	☐

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:	GHAI
Program Area:	Laboratory Infrastructure
Budget Code:	HLAB
Program Area Code:	12
Activity ID:	7224
Planned Funds:	$ 400,000.00

Activity Narrative: This activity relates to activities in HLAB (7262, 7172, 7154, 8189).

In FY 2006, the EP developed 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 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 marked the beginning of a shift toward direct EP funding to NRL. Substantial resources have already been invested in NRL by CDC and Columbia UTAP support for infrastructure, technical activities, and management capacity. Support will continue in FY 2007 through CDC direct technical support, Columbia UTAP long-term technical advisors, and through continued funding of this cooperative agreement (at the time of writing, the cooperative agreement had not yet been awarded to NRL).

NRL cooperative agreement activities in FY 2006 include support for human resources (technical positions and training), infrastructure maintenance, and select QA activities. One-time additional funds were added to the cooperative agreement in FY 2006 for procurement of CD4 supplies, equipment and kits, as well as to support the logistics of maintaining the network of CD4 laboratories. In FY 2007, NRL activities will again focus on selected infrastructure maintenance, human resources, and QA activities.

Among its infrastructure-related activities, NRL will expand PCR testing capacity to a second reference laboratory in Butare to support the expanding early infant diagnosis program. NRL cooperative agreement funds will support the renovations needed to prepare this laboratory and the training of Butare staff. The NRL will also continue a maintenance contract for all of its central-level equipment through the MOH maintenance unit, as well as conduct small repairs and preventive maintenance in the ART site laboratories, secure warehouse storage space, and transport laboratory equipment and reagents to sites.

NRL will support technical staff needed to carry out surveillance and M&E activities that have laboratory components, such as ANC sentinel surveillance and the national ART program evaluation activities. A modest amount of funding will be made available to support participation of key senior technical staff in international trainings and conferences directly relevant to increasing capacity for HIV-related laboratory techniques.

Throughout the national laboratory network, 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 eight trainer/supervisors placed both centrally and in regional laboratories. As part of its QA activities for TB diagnosis, NRL will also provide refresher training for laboratory technicians in health centers and district hospitals to maintain skill levels in sputum examination for TB by direct AFB smear microscopy.

To ensure quality HIV-related services, this NRL cooperative agreement will continue to fund operational costs (such as specimen transport, supervision costs) associated with the implementation of HIV QA/QC activities in peripheral lab sites, including QA for HIV serology, CD4 testing, chemistry/hematology, and good laboratory practices. Commodities needed to conduct all of the above activities will be procured through the PFSCM activity in FY 2007.

Continued Associated Activity Information

Activity ID: 4976
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: National Reference Laboratory
Mechanism: National Reference Laboratory
Funding Source: GHAI
Planned Funds: $ 600,000.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	51 - 100
Infrastructure	10 - 50
Quality Assurance, Quality Improvement and Supportive Supervision	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
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	963,000	☐
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	53	☐
Number of individuals trained in the provision of laboratory-related activities	160	☐

Target Populations:

Laboratory workers

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: GHAI
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 7263
Planned Funds: $ 320,000.00
Activity Narrative: This activity relates to activities in HLAB (7244, 7172, 7154, 8189).

CDC provides direct support for laboratory infrastructure activities through CDC technical staff in-country as well as through short-term TA from CDC headquarters. In FY 2006, CDC's DPDx group developed a set of training materials and conducted procurement of supplies needed for a week-long training of trainers in parasitology diagnostics to be conducted in November 2006. CDC also provided TA for the development of the laboratory component of an ongoing national ART program evaluation. CDC is currently recruiting a full time laboratory advisor to be placed at the CDC office.

In FY 2007, CDC will continue direct support for laboratory infrastructure activities through the long-term lab position described above. This laboratory advisor 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 OIs remains limited, CDC will continue to support laboratory capacity for 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 technician trainers, as well as TA for improving NRL's supervision capacity and systems, particularly in malaria diagnosis. CDC will continue to provide TA to lab professionals in evaluating new techniques for specimen collection for viral load testing, and for applying these new techniques for public health program evaluation. CDC will work closely with Columbia University to adapt laboratory management information system software previously developed by CDC in other countries for use in Rwanda's NRL and select district hospitals.

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. DPDX's ongoing procurement, training and QA activities will provide an excellent platform upon which to further strengthen laboratory capacity and systems under PMI.

Continued Associated Activity Information

Activity ID: 2847
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: US Centers for Disease Control and Prevention
Mechanism: CDC Country Office GAP/TA
Funding Source: GHAI
Planned Funds: $ 80,000.00

Emphasis Areas	% Of Effort
Quality Assurance, Quality Improvement and Supportive Supervision	51 - 100
Strategic Information (M&E, IT, Reporting)	10 - 50
Training	10 - 50

Targets

Target	Target Value	Not Applicable
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		☑
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 laboratory-related activities	15	☐

Target Populations:

Laboratory workers

Coverage Areas:

National

Table 3.3.12: Activities by Funding Mechanism

Mechanism: SCMS
Prime Partner: Partnership for Supply Chain Management
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Laboratory Infrastructure
Budget Code: HLAB
Program Area Code: 12
Activity ID: 8189
Planned Funds: $ 4,357,880.00
Activity Narrative: This activity relates to activities in HLAB (7263, 7172, 7224).

In FY 2007, PFSCM will be responsible for the procurement of all EP commodities through direct support to CAMERWA for the procurement, storage and distribution of all medicines, equipment and laboratory supplies. This consolidated approach to procurement will increase cost savings, and improve efficiencies in procurement and distribution of commodities. PFSCM will also take over the support of the CPDS and LMIS activities to ensure smooth functioning of the CPDS system, quality data for quantification, and strong communication between districts and CAMERWA.

PFSCM will conduct all commodity procurement for 100 EP-supported site laboratories (67 existing and 33 new laboratories), including equipment, supplies, and reagents for biochemistry, hematology, parasitology, and biosafety. PFSCM will procure all CD4 kits and supplies for the estimated 175,000 tests needed in FY 2007 for EP-supported patients. National ART treatment guidelines call for viral load testing in cases of suspected treatment failure. PFSCM will procure viral load reagents sufficient to cover the estimated needs of 6,000 EP-supported patients. In addition to this site-level laboratory procurement, PFSCM will procure equipment, supplies and reagents for specific central-level activities and functions, such as an estimated 6,000 PCR kits and supplies for the national infant diagnosis program, an estimated 1,000 additional viral load kits and associated supplies for the laboratory component of the national ART program impact evaluation, test kits and supplies for continuing HIV serology and CD4 testing QA systems, PCR equipment, supplies and reagents for expansion of PCR capacity to CHU Butare, supplies and reagents for OI diagnosis, as well as supplies for ongoing parasitology and other OI diagnostics for regional and district-level trainings.

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

Target Populations:

Other MOH staff (excluding NACP staff and health care workers described below)
Laboratory 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: $ 5,778,680.00

Program Area Context:

At the outset of the EP in Rwanda, inefficiencies in the MOH HMIS, combined with the immediate demand for data for rapid scale-up, led to the design and implementation of vertical information systems for the HIV/AIDS program in Rwanda. Limited MOH capacity for data analysis and dissemination at all levels further contributed to poor use of data for programmatic and decision-making purposes.

In FY 2006, the EP supported the CNLS, RDF, TRAC and MOH strategic information activities, with a focus on TA for harmonizing tools for improved reporting, and extending physical infrastructure. Specific support included updating indicators and reporting requirements, undertaking an HMIS assessment, procuring IT equipment, providing internet connectivity for EP-supported district hospitals, conducting ANC surveillance, performing secondary analysis of data from population-based studies funded in FY 2005, preparing facility surveys, and carrying out targeted evaluations to inform programming through improved data analysis and use. The EP also assisted the GOR with its successful application to the WHO Health Metrics Network (HMN).

Capacity building is at the center of the EP support for strategic information in FY 2007. The proposed HVSI activities for FY 2007 will strengthen the collection, analysis, reporting and use of information for decision support, including program management and coordination. The proposed support and activities will enhance in-country SI capacity in M&E, surveillance, and HMIS; facility and population-based data collection, analysis, and use; public health evaluations; as well as coordination and collaboration to support the unified M&E system for the Three Ones to better coordinate the scale up of the national response in Rwanda.

In FY 2007, the EP will support training in data quality and resource allocation models to promote results-based management and will continue support to the CNLS to operationalize the National HIV/AIDS M&E System. The EP will add GIS functionality to CNLS databases, continue support to implement and monitor the decentralized reporting system, as well as fund the organization of an annual HIV/AIDS Research Conference. GIS activities will support three categories of EP information management, namely results and reporting, program planning and management, and spatial analysis.

Through partnerships with UNAIDS, the Global Fund, WHO, and BTC, and informed by the results of the WHO HMN assessment, EP Rwanda will support the redesign of the HMIS, to strengthen data access and standards, and improve data analysis and use. EP will collaborate with PMI to enhance the Rwanda health information infrastructure by supporting the follow-on to TRACnet, a phone and web-based reporting database that collects monthly aggregate programmatic data on ART, PMTCT and VCT, information on drug shortages and stock-outs, and facilitates remote retrieval of laboratory results. TRACnet will also introduce an HIV case reporting registry to improve tracking of discordant couples to set the foundation for establishing a state of the art surveillance system in Rwanda. The EP will also provide direct support to the MOH/HMIS unit to strengthen its data warehouse infrastructure, human capacity and ability to analyze, use and disseminate HIV data to districts and sites.

EP will continue support for strategic information activities that provide critical information for the EP program. ANC surveillance will be conducted at sentinel sites to monitor HIV prevalence at the national level. The EP will also support training in epidemiology and surveillance through CDC, and in HIV projection models to analyze trends for change in prevalence and linking these to the 2005 RDHS-III and 2005 PLACE study results. In FY 2007, the EP will continue to support finalization of the SPA, which will include modules for MCH with a specific sub-module on malaria, HIV/AIDS, laboratory and pharmacy, and survey and validate GIS coordinates for all MOH-registered health facilities in Rwanda.

To improve program oversight, the EP will adapt the MEEPP reporting system from EP-Uganda to set up a Rwanda Partner Reporting System (RPRS), a web-based database system to collect, store, aggregate, and

share data between USG-funded partners, GOR, external stakeholders and the Rwanda EP Team. The RPRS will further support improving EP data completeness and quality in order to improve service delivery.

The EP SI Team will continue their regular collaboration with GOR, UNAIDS, Global Fund and World Bank counterparts, provide in-country TA, participate in SI-related TWGs, and assist with the preparation of the annual UNGASS report.

Program Area Target:

Number of local organizations provided with technical assistance for strategic information activities	66
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	1,250

Table 3.3.13: Activities by Funding Mechanism

Mechanism: HIV Support to RDF
Prime Partner: Drew University
USG Agency: Department of Defense
Funding Source: GHAI
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 7193
Planned Funds: $ 200,000.00
Activity Narrative: This activity relates to HVAB (7230), HVOP (8135), HVCT (8165), HTXS (7190), and HLAB (7190).

The RDF has three military hospitals and five brigade clinics throughout the country.
In FY 2006, Drew University is supporting two military hospitals and working with the RDF to improve IT infrastructure for data entry and patient monitoring at hospital and brigade clinics by training 20 RDF personnel in strategic information. This support will expand the RDF's capacity to follow the health status of HIV-positive soldiers and civilians receiving care within the military health system, improve referrals, and the quality of treatment, prevention and care services.

In FY 2007, Drew will continue these activities and train 45 data entry technicians in data collection, analysis and use. In addition, Drew University will provide materials and TA to improve the military HMIS in order to track routine HIV testing of all military personnel. Drew will assist the RDF in the implementation of existing GOR data reporting tools to monitor HIV treatment, care and outreach activities. To provide better care and referrals for military spouses, partners and family members, Drew will support RDF to implement a family-centered approach.

To strengthen and monitor services, a steering committee linking RDF, TRAC and partners will be established to review and utilize data to improve the RDF healthcare system, direct policies, and improve the quality and cost-effectiveness of HIV treatment and care in RDF settings. To improve access to patient data, RDF will develop a system to allow HIV treatment and care providers at all RDF sites to update data at a main server using access codes and create a coding system for all patients receiving care in RDF health facilities. Drew will pilot the introduction of personal digital assistants to increase the use of electronic medical records, enabling providers to record firsthand health information of HIV-positive patients generated through one or more provider-patient encounters. Drew will train RDF health providers and policymakers to analyze and use collected data to streamline clinicians' workflow in HIV services, monitor quality, and facilitate the identification of gaps in HIV services.

This activity reflects the ideas presented in the EP Five-Year HIV/AIDS Strategy in Rwanda and the GOR National multi-sectoral strategic plan for HIV/AIDS Control (2005-2009) by directly supporting the development of a sustainable strategic information system for the national HIV/AIDS program.

Continued Associated Activity Information

Activity ID: 2754
USG Agency: Department of Defense
Prime Partner: Drew University
Mechanism: HIV Support to RDF
Funding Source: GHAI
Planned Funds: $ 201,722.00

Emphasis Areas	% Of Effort
Information Technology (IT) and Communications Infrastructure	10 - 50
Monitoring, evaluation, or reporting (or program level data collection)	10 - 50

Targets

Target	Target Value	Not Applicable
Number of district level PBF Management Committee members trained in the verification of HIV/AIDS indicator invoices		☑
Number of health facility level PBF Steering Committee members trained in data collection for HIV/AIDS indicator invoices		☑
Number of local organizations provided with technical assistance for strategic information activities	1	☐
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	45	☐

Target Populations:

Military personnel

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: GHAI
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 7210
Planned Funds: $ 450,000.00
Activity Narrative: This activity relates to MTCT (7179, 8122, 8185, 8698), HMBL (7223, 8860), HBHC (9637, 7163, 7177, 7191, 7245), HVTB (7162, 7169, 7180, 8146, 8147), HVCT (7178, 8164, 8168), HTXS (7161, 7174, 7164, 7176, 7190, 7246, 8172) and HLAB (7154, 7172, 7224).

The MOH and ONAPO conducted the 2001 Rwanda SPA, the first nationwide survey of its kind in Rwanda, with TA from ORC Macro and financial support from USAID.

With EP and PMI support, ORC Macro will begin initial preparations for a second SPA in FY 2006. Activities will include setting up the Steering Committee co-chaired by the MOH and the NIS, adapting the SPA modules for MCH, HIV/AIDS, laboratory and pharmacy, recruiting and training surveyors, and conducting field activities to collect information on the national capacity to deliver specific services and the quality of services using facility-based indicators required by the EP and PMI. The survey will assess all district, reference and university hospitals, the NRL, as well as government and private clinics and health centers, of which GIS coordinates will be confirmed during the survey.

In FY 2007, the EP will procure TA for the implementation of a national targeted facility survey through MEASURE/DHS., and also carry out a range of dissemination and capacity building activities.

To increase access to and use of the SPA data, ORC Macro will publish, in French and English, a final report and a summary of findings outlining the major results of the SPA; a wall chart listing major indicators; as well as organize a national dissemination seminar in Kigali.

ORC Macro will undertake additional activities to ensure that the SPA findings reach major policymakers, program staff, and evaluation specialists who need them most. These activities include both print materials and topic specific seminars targeting policymakers, researchers, program managers, and staff from the MOH and cooperating agencies.

In view of Rwanda's decentralized system of governance, ORC will conduct district seminars for major stakeholders to apply findings to district level planning, budgeting, and monitoring and evaluation activities will be organized. ORC will also develop district chart books and/or fact sheets, which will highlight the major indicators for each district, and compare each district to the national average.

This activity reflects the ideas presented in the EP Five-Year HIV/AIDS Strategy in Rwanda and the GOR National multi-sectoral strategic plan for HIV/AIDS Control (2005-2009) by directly supporting the development of a sustainable strategic information system for the national HIV/AIDS program.

Continued Associated Activity Information

Activity ID: 4779
USG Agency: U.S. Agency for International Development
Prime Partner: Macro International
Mechanism: Measure DHS
Funding Source: GHAI
Planned Funds: $ 480,000.00

Emphasis Areas	% Of Effort
Facility survey	51 - 100

Targets

Target	Target Value	Not Applicable
Number of district level PBF Management Committee members trained in the verification of HIV/AIDS indicator invoices		☑
Number of health facility level PBF Steering Committee members trained in data collection for HIV/AIDS indicator invoices		☑
Number of local organizations provided with technical assistance for strategic information activities	2	☐
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	70	☐

Target Populations:

National AIDS control program staff

Policy makers

Other MOH staff (excluding NACP staff and health care workers described below)

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: HIV/AIDS Reporting System
Prime Partner: Voxiva, Inc.
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 7237
Planned Funds: $ 850,000.00
Activity Narrative: One of the key activities to be implemented by Voxiva in FY07 is the design and implementation of an population based HIV registry. Voxiva, in close collaboration with TRAC, have revised the key data elements to be included in this registry. Initial funds allocated for the roll-out of this approved activity in the Voxiva workplan allowed for limited deployment of the registry (1 to 2 districts). The additional funds will support a nationwide patient information data entry exercise over a period of 6 months. This will result in an operational HIV patient registry. The supplemental resources will also support the development of SOPs for outlining roles and responsibilities of health facility personnel, implementing partners, TRAC and the MOH to keep the patient data current.

This activity relates to HVSI (7238, 7240, 7193, 9252), MTCT (7179, 8122, 8185, 8698), HVCT (7178, 8164, 8168), and HTXS (7161, 7174, 7164, 7176, 7190, 7246, 8172).

The overall objective of the TRACnet project is to establish a comprehensive information system for the HIV/AIDS program in Rwanda. Since FY 2004, TRACnet evolved from a pilot to a national ART program reporting system. It collects monthly programmatic indicators via telephone and internet, and has limited lab result collection and drug shortage/stock out reporting capacity.

In FY 2006, the system will expand to collect programmatic data from PMTCT and VCT programs. By the end of FY 2006, TRACnet will be aggregating programmatic data from all health facilities offering PMTCT, VCT and ART in Rwanda. In cooperation with the data analysis and use task order, the information stored in the TRACnet database will be increasingly used in decision-making and information dissemination.

In FY 2007, TRACnet will continue collecting data on PMTCT, VCT and ART programs, and the contractor will transfer more responsibility for system management to TRAC, with the objective of transferring all responsibility for managing the system to TRAC by FY 2008. The major addition to the system in FY 2007 will be the development of an HIV case reporting module, with an initial focus on discordant couples. Approximately 180,000 Rwandans are HIV-positive, and of these, an estimated 50,000 persons are the HIV-positive partners in discordant couples. Unfortunately, few persons testing positive at VCT present for HIV testing as a couple.

As the Rwanda EP matures, it is increasingly important to reduce missed opportunities and improve quality. To this end, the HIV case registry, as a component of the TRACnet system, will build on the family-centered, contact-tracing efforts that are a new focus of VCT in Rwanda. The emphasis will expand previously initiated efforts, which until now have been limited to maintaining a research cohort, into a population-based registry. While only a subset of the broader case-report based HIV registry envisioned for Rwanda, this registry of discordant couples will have unique utility in HIV prevention efforts to monitor issues tied to drug resistance, adherence, reduce losses to follow up and allow caregivers to better monitor their patients. In FY 2007, EP-Rwanda team will draw upon USAID and CDC expertise to pilot this system in selected districts, and evaluate that effort prior to a national rollout. USG will also provide TA to the GOR to develop the necessary legislative framework required for the operation of the case registry system.

This activity reflects the ideas presented in the EP Five-Year HIV/AIDS Strategy in Rwanda and the GOR National multi-sectoral strategic plan for HIV/AIDS Control by directly supporting the development of a sustainable strategic information system for the national HIV/AIDS program.

Continued Associated Activity Information

Activity ID:	4987
USG Agency:	HHS/Centers for Disease Control & Prevention
Prime Partner:	Voxiva
Mechanism:	HIV/AIDS Reporting System
Funding Source:	GHAI
Planned Funds:	$ 600,000.00

Emphasis Areas	**% Of Effort**
Health Management Information Systems (HMIS)	51 - 100
HIV Surveillance Systems	10 - 50
Information Technology (IT) and Communications Infrastructure	10 - 50
Monitoring, evaluation, or reporting (or program level data collection)	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of district level PBF Management Committee members trained in the verification of HIV/AIDS indicator invoices		☑
Number of health facility level PBF Steering Committee members trained in data collection for HIV/AIDS indicator invoices		☑
Number of local organizations provided with technical assistance for strategic information activities	2	☐
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	500	☐

Target Populations:

Doctors
Nurses
Pharmacists
International counterpart organizations
National AIDS control program staff
Policy makers
Host country government workers
Public health care workers
Laboratory 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: GHAI
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 7240
Planned Funds: $ 400,000.00
Activity Narrative: This activity relates to MTCT (7244), HBHC (7245), HVCT (7242), HTXS (7246), and HVSI (7237 9252).

In FY 2006, TRAC is undertaking multiple surveillance activities aimed at better understanding the state of the HIV epidemic in Rwanda. TRAC, in collaboration with CDC, is leading sentinel surveillance at 30 antenatal care facilities, training 60 site personnel, procuring tests and other materials, and supervising sites. The data collection for BSS among high risk groups including sex workers, truck drivers and youth, was carried out in FY 2005, and the data analysis and results publication is ongoing in FY 2006. In addition, TRAC is continuing its collaboration with CDC and the NRL on the survey of ARV drug resistance. Protocol development is completed and will be submitted to the National Ethics Committee and IRB for approval. TRAC staff continues to provide on-site IT training to all ART sites, including the use of TRACnet (Rwanda's phone-and web-based reporting system for HIV/AIDS) for reporting of ARV drug and program indicators.

In FY 2007, in collaboration with CDC, TRAC will continue ANC sentinel surveillance at 30 sites, training 90 personnel. TRAC will also begin preparations for the 2008 BSS among high-risk groups (questionnaire design, revision of tools, and training of interviewers). In addition, TRAC will continue its collaboration with CDC and the NRL in the area of HIV incidence surveillance, continuing the BED or other appropriate incidence assay using specimens from FY 2005 and FY 2006 sentinel surveillance. TRAC will also conduct a second threshold survey of ARV drug resistance including analysis and dissemination of results.

In the area of M&E, TRAC will continue to support data analysis and use on clinical care, treatment, and PMTCT services as needed to monitor quality of services. The TRAC M&E unit will continue to maintain the postings and organization of the digital library.

This activity reflects the ideas presented in the EP Five-Year HIV/AIDS Strategy in Rwanda and the GOR national multi-sectoral Strategic Plan for HIV/AIDS Control (2005-2009).

Continued Associated Activity Information

Activity ID: 2739
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Treatment and Research AIDS Center
Mechanism: TRAC Cooperative Agreement
Funding Source: GHAI
Planned Funds: $ 525,000.00

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

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for strategic information activities	30	☐
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	90	☐

Target Populations:

Country coordinating mechanisms
Faith-based organizations
International counterpart organizations
National AIDS control program staff
Non-governmental organizations/private voluntary organizations
Policy makers
Other MOH staff (excluding NACP staff and health care workers described below)
Implementing organizations (not listed above)

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: GHAI
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 7248
Planned Funds: $ 550,000.00
Activity Narrative: This activity relates to HVSI (7210, 7237, 7240, 7250) and 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 monitoring and reporting. In addition, Tulane University will assist CNLS with 1) the preparation of the Mid-Term Review of the National HIV/AIDS Strategic Framework (2005 – 2009), and 2) the implementation of the national district level reporting system. Tulane also provided TA for validation and improvement of PMTCT, VCT and ART data. From FY 2004 to FY 2006, Tulane assisted TRAC in developing a national database for PMTCT and VCT data. In FY 2007, Tulane will collaborate with Voxiva, Inc. to support TRAC's ICT unit for the integration of PMTCT and VCT reporting into TRACnet, with a special focus on assuring that outputs are usable and used, as well as strengthening data validation procedures at the central and district levels. Tulane will also assist TRAC to extend its M&E framework to include TB and malaria.

The second component focuses on expanding the content and usability of the HIV/AIDS digital libraries developed by Tulane for TRAC and CNLS in FY 2004 and FY 2005. Tulane will work with the ICT units at TRAC and CNLS to assure that different actors are using/referencing existing works in the digital libraries, and to assist the contributing agencies to augment the proportion of verified collections.

The third component will provide support to TRAC to refine the 2005 BSS questionnaires and sampling in preparation for the 2008 BSS survey. Tulane will build on the more general survey/questionnaire development training conducted with TRAC in FY 2006 by adding BSS specific training to the TRAC Epidemiologic Surveillance Unit to expand TRAC's role in the design phase of future behavioral surveillance and reduce dependence on external TA.
The fourth component focuses on strengthening capacity to use GIS. USG (through USAID Rwanda Economic Growth Unit) has supported a range of GIS activities in Rwanda, including the Center for Geographic Information Systems (CGIS) at the National University of Rwanda. CGIS focuses on multi-variate spatial analysis and general GOR mapping needs. The location of CGIS in Butare severely limits the number of decision makers, program managers, directors and technicians who can attend courses. Tulane will facilitate extending teaching and services that focus on the practical application of mapping for decision-support and reporting to Kigali, in collaboration with TRAC's ICT Unit and others.

As a result of this activity, CNLS and TRAC will be provided with TA and 150 individuals will be trained in SI for HIV prevention, care and treatment.

This activity reflects the ideas presented in the EP Five-Year HIV/AIDS Strategy in Rwanda and the GOR National multi-sectoral strategic plan for HIV/AIDS Control by directly supporting the development of a sustainable strategic information system for the national HIV/AIDS program.

Continued Associated Activity Information

Activity ID: 2747
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Tulane University

Mechanism: UTAP
Funding Source: GHAI
Planned Funds: $ 580,000.00

Emphasis Areas	**% Of Effort**
AIS, DHS, BSS or other population survey	10 - 50
Monitoring, evaluation, or reporting (or program level data collection)	51 - 100
Other SI Activities	10 - 50

Targets

Target	**Target Value**	**Not Applicable**
Number of local organizations provided with technical assistance for strategic information activities	2	☐
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	150	☐

Target Populations:

National AIDS control program staff
Policy makers
Host country government workers
Public health care workers

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: GHAI
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 7250
Planned Funds: $ 0.00
Activity Narrative: n/a

Continued Associated Activity Information

Activity ID: 2758
USG Agency: U.S. Agency for International Development
Prime Partner: University of North Carolina
Mechanism: Measure Eval
Funding Source: GHAI
Planned Funds: $ 353,138.00

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
Other SI Activities	51 - 100

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for strategic information activities	8	☐
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	78	☐

Target Populations:

Community-based organizations
Country coordinating mechanisms
Faith-based organizations
International counterpart organizations
National AIDS control program staff
Non-governmental organizations/private voluntary organizations
Policy makers
Other MOH staff (excluding NACP staff and health care workers described below)
Implementing organizations (not listed above)

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: GHAI
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 7257
Planned Funds: $ 525,000.00
Activity Narrative: This activity relates to HVSI (7264, 7269) and supports all FY 2007 activities.

This activity funds two EP staff dedicated to strategic information – an SI Liaison Officer and an FSN M&E Program Manager. The SI Liaison is a member of the SI country team and serves as the principal field counterpart to the Core Team SI Advisor, and although employed by USAID, supports all USG agencies.

The SI Liaison facilitates SI Team Coordination - orienting new USG SI staff, country counterparts, and other donors to Emergency Plan SI guidance and reporting standards; program monitoring and reporting, working closely with the Emergency Plan Coordinator and USG team to prepare the semi-annual and annual reports, and coordinating all communications with HQ SI on results measurement/indicator issues; leads the Five Year SI Strategy implementation and coordination of inputs and activities overseen by other members of the SI team (surveillance, HMIS, M&E, targeted evaluations); participates in Country Operation Development, managing and coordinating processes required for the development of the SI section of the annual COP; fiscal year and planning year target setting; and partner input for strategic information planning and producing all summary targets for the given program areas in the COP, and ensuring that the final FY targets established are consistent with those included in the country Executive Summary; serves as the USG Emergency Plan representative to donor coordinating bodies (UNAIDS, WHO, Global Fund, World Bank) to address the SI/M&E component of the Three Ones; and participates in Communications and Working Groups, communicating SI issues, challenges, and policy questions to senior USG Emergency Plan managers, to other USG SI representatives, to other relevant country partners and to Headquarters and working closely with the Rwanda Country Team to respond to Congressional inquires; to prepare press releases and other country communications, upon the request of the OGAC.

The M&E Program Manager manages reporting requirements for the EP and provides technical assistance to SO Teams on all monitoring and evaluation activities. The primary responsibility is to focus on EP monitoring and reporting activities. This includes working with partners about reporting requirements, and required indicators, update partners regarding any changes, and check for the completeness of documentation, and updating partners regarding any changes, checking for the completeness of documentation and quality control of data received. The Program Manager manages the synthesis, analysis and transmission of all EP-funded partner reports, correspondence and work plans. The Program Manager works with the SI Liaison to answer requests from the State Department, and OGAC and drafts the EP Rwanda quarterly progress report and the semi-annual and annual reports for OGAC.

The M&E Program Manager also holds partner meetings to conduct M&E training sessions, and communicates with the GOR, EP partners, donors, USAID/Washington and other partners on M&E matters, and serves as a key contact for M&E related issues for EP funded partners and cooperating agencies.

In addition to these key SI positions, USAID/Rwanda anticipates continuing financial and technical support to Rwanda NGOs in sponsoring or attending conferences, workshops and technical meetings on HIV treatment. USAID will also support direct TA to other GOR agencies as needed, in particular CNLS.

Continued Associated Activity Information

Activity ID:	4972
USG Agency:	U.S. Agency for International Development
Prime Partner:	US Agency for International Development
Mechanism:	USAID Rwanda Mission
Funding Source:	GHAI
Planned Funds:	$ 509,000.00

Emphasis Areas	% Of Effort
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 district level PBF Management Committee members trained in the verification of HIV/AIDS indicator invoices		☑
Number of health facility level PBF Steering Committee members trained in data collection for HIV/AIDS indicator invoices		☑
Number of local organizations provided with technical assistance for strategic information activities	3	☐
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	0	☐

Target Populations:

National AIDS control program staff

USG in-country staff

USG headquarters staff

Other MOH staff (excluding NACP staff and health care workers described below)

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: GHAI
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 7264
Planned Funds: $ 649,000.00

Activity Narrative: PEPFAR Rwanda has supported provision of internet connectivity to 30 health facilities in Rwanda. This will increase the capacity of several EP supported sites to deploy and use electronic health information systems (TRACnet, ETRnet, OpenMRS) etc to avail rich data to program managers at district and national level, and provide better services to patients receiving care. The additional funds will allow CDC to provide internet connectivity to an additional 34 sites (64 total), thereby achieving 100% availability of connectivity in all EP supported sites in Rwanda. The funds for this activity are reprogrammed from activities 8139 ($25K) and 9388 ($75K).

This activity relates to HVSI (7237, 7240, 7250, 7257, 7264, 8741, 9252).

In FY 2007, CDC SI activities will include both short and long term TA in surveillance, IT, HMIS and M&E. CDC will continue support for key SI positions and will maintain support, through clinical partners, for internet connectivity in all EP health districts.

In FY 2004 through FY 2006, the EP scaled up key IT infrastructure in all EP districts. This included procuring and installing IT equipment, and providing internet connectivity for 30 district level facilities through a local contractor. This infrastructure will greatly enhance Rwanda's capacity for program reporting, secure transfer of patient information, and access to national databases (e.g., TRACnet, CNLS database, etc).

CDC will continue to support an epidemiologist on the EP SI Team as the surveillance focal point to provide ongoing TA to TRAC and the NRL for their surveillance activities. FY 2007 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 will complement TRAC's proposed surveillance activities in FY 2007.

CDC will also continue to support an EP HMIS Coordinator to coordinate HMIS activities with the GOR, USG agencies, USG partners, and with multilateral organizations such as the WHO and UNAIDS. The Coordinator, a key member of the USG SI team, will assist GOR in strategic planning for information systems in the health sector and will help strengthen GOR capacity in information systems development, implementation, management and data use to collect critical data for broader HMIS development. The EP HMIS Coordinator will also provide technical support to the MOH to implement the WHO Health Metrics Network assessment tool.

CDC will build epidemiological and research skills for select key staff at MOH institutions. Rwanda has a shortage of trained service providers and academics that has been exacerbated by the 1994 genocide. Three senior staff will be sent to CDC's Field Epidemiology (and Laboratory) Training Program [FE(L)TP]. The FE(L)TP program primarily works with Ministries of Health to build the capacity of key staff to produce data-driven decision making to respond to public health challenges. The program is currently offered in a number of countries including Kenya and South Africa. The objectives of the training would include; strengthening the public health skills and capacity of a cohort of key staff in the MOH, particularly in applied epidemiology; strengthen research and analytic skills of participants; strengthen national surveillance systems; and strengthen laboratory participation in surveillance and field investigation.

CDC will also provide short term TA to support HMIS activities, including design of the HIV case registry, behavioral surveillance, and EP strategic information activities. These funds will also continue to support one local hire position, a data manager at TRAC.

This activity reflects the ideas presented in the EP Five-Year HIV/AIDS Strategy in Rwanda and the GOR national multi-sectoral strategic plan for HIV/AIDS Control (2005-2009) by directly supporting the development of sustainable strategic information systems for the national HIV/AIDS program.

Continued Associated Activity Information

Activity ID: 2848
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: US Centers for Disease Control and Prevention

Mechanism: CDC Country Office GAP/TA
Funding Source: GHAI
Planned Funds: $ 500,000.00

Emphasis Areas	% Of Effort
Health Management Information Systems (HMIS)	10 - 50
HIV Surveillance Systems	10 - 50
Information Technology (IT) and Communications Infrastructure	10 - 50
Proposed staff for SI	51 - 100

Targets

Target	Target Value	Not Applicable
Number of district level PBF Management Committee members trained in the verification of HIV/AIDS indicator invoices		☑
Number of health facility level PBF Steering Committee members trained in data collection for HIV/AIDS indicator invoices		☑
Number of local organizations provided with technical assistance for strategic information activities	2	☐
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	8	☐

Target Populations:

International counterpart organizations
National AIDS control program staff
Policy makers
USG in-country staff
USG headquarters staff
Host country government workers
Other MOH staff (excluding NACP staff and health care workers described below)
Implementing organizations (not listed above)

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 / African Affairs
Funding Source: GHAI
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 7269
Planned Funds: $ 20,000.00
Activity Narrative: This activity is related to HVSI (8741, 7237, 7248, 7257, 7264, 7250).

EP Rwanda will support technical assistance from OGAC for improving the use of geographic information systems (GIS) among EP partners for EP information management. Two TA visits are planned during FY 2007.

Continued Associated Activity Information

Activity ID: 4050
USG Agency: Department of State / African Affairs
Prime Partner: US Department of State
Mechanism: Embassy Rwanda
Funding Source: GHAI
Planned Funds: $ 0.00

Emphasis Areas	**% Of Effort**
Other SI Activities	51 - 100

Targets

Target	**Target Value**	**Not Applicable**
Number of district level PBF Management Committee members trained in the verification of HIV/AIDS indicator invoices		☑
Number of health facility level PBF Steering Committee members trained in data collection for HIV/AIDS indicator invoices		☑
Number of local organizations provided with technical assistance for strategic information activities	2	☐
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)		☑

Indirect Targets

NA

Target Populations:

National AIDS control program staff
Policy makers
USG in-country staff
Other MOH staff (excluding NACP staff and health care workers described below)

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism:	COPRS
Prime Partner:	Social and Scientific Systems
USG Agency:	U.S. Agency for International Development
Funding Source:	GHAI
Program Area:	Strategic Information
Budget Code:	HVSI
Program Area Code:	13
Activity ID:	8176
Planned Funds:	$ 0.00

Activity Narrative: Reprogramming 8/07: USG Rwanda will use another mechanism (TBD) to implement this activity.

This activity supports the adaptation of the EP Uganda's comprehensive performance management, monitoring and reporting program, MEEPP, for use by EP Rwanda as the Rwanda Partner Reporting System (RPRS). MEEPP collects reports and validates data from HIV/AIDS activities and partners, and has successfully improved the quality of data at all levels. The RPRS will be a web-based system to collect, store, aggregate, and share data between USG-funded partners and the EP Rwanda Team. The reporting system will comply with OGAC reporting requirements, and will be compatible with COPRS—while also supporting the GOR national HIV/AIDS monitoring and evaluation plan and implementation of the Third One.

The RPRS will collect, aggregate, and report data by pre-coded districts as well as by facility type. It will support reporting to the EP and be able to import data from the CNLS district-based decentralized reporting system.

The RPRS will be hosted in Kigali and supported by staff based in the MEEPP office in Kampala and SSS' Maryland headquarters. All RPRS users will have individual accounts and passwords with varying security levels – and access to partner's data and published EP reports. Each account is attached to a USG EP or GOR prime partner. The system will include a variety of standard reports focusing on program-level indicator totals to be sent to the USG and GOR EP partners for feedback and review. It will also allow for the manipulation of data, using statistical and analytical tools including GIS, to produce ad hoc reports as may be required by the USG and GOR. Additionally, all USG Rwanda EP data reported to COPRS since 2004 will be entered into the RPRS to allow for multi-year analysis.

SSS will recruit a local project manager and support staff who will work closely with the EP SI Team and USG partners to implement a comprehensive performance monitoring, planning, evaluation, and reporting system. His/her responsibilities will include reviewing Partner Performance Monitoring Plans, tracking EP performance, developing analytical reports, conducting Data Quality Assessments in collaboration with MEASURE Evaluation, providing evaluation assistance including analysis of monitoring and evaluation plans and guidance on key evaluation activities for USG, and performing additional M&E responsibilities in line with strategic planning and technical implementation of the project work plan.

The RPRS will play a significant role in improving EP data completeness and quality and will also facilitate information sharing amongst USG, GOR, and external stakeholders in order to improve service delivery and the use of data for decision-making.

This activity reflects the ideas presented in the EP Five-Year HIV/AIDS Strategy in Rwanda and the GOR national multi-sectoral strategic plan for HIV/AIDS control.

Targets

Target	Target Value	Not Applicable
Number of district level PBF Management Committee members trained in the verification of HIV/AIDS indicator invoices		☑
Number of health facility level PBF Steering Committee members trained in data collection for HIV/AIDS indicator invoices		☑
Number of local organizations provided with technical assistance for strategic information activities	0	☐
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	0	☐

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: Health Policy Initiative
Prime Partner: The Futures Group International
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 8741
Planned Funds: $ 0.00
Activity Narrative: N/A

Emphasis Areas	% Of Effort
Other SI Activities	51 - 100

Targets

Target	Target Value	Not Applicable
Number of district level PBF Management Committee members trained in the verification of HIV/AIDS indicator invoices		☑
Number of health facility level PBF Steering Committee members trained in data collection for HIV/AIDS indicator invoices		☑
Number of local organizations provided with technical assistance for strategic information activities	0	☐
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	0	☐

Target Populations:

Community leaders
Community-based organizations
Country coordinating mechanisms
Faith-based organizations
National AIDS control program staff
Non-governmental organizations/private voluntary organizations
Policy makers
Program managers
Religious leaders
Other MOH staff (excluding NACP staff and health care workers described below)

Coverage Areas:

National

Table 3.3.13: 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:	GHAI
Program Area:	Strategic Information
Budget Code:	HVSI
Program Area Code:	13
Activity ID:	8743
Planned Funds:	$ 559,680.00

Activity Narrative: This activity relates to MTCT (7219), HBHC (7220), HVTB (7221), HVCT (7217), HTXS (7222).

Performance-based financing is an innovative approach to financing of health services that enhances quality of services and leads to greater efficiency and sustainability. Financial incentives provided by performance-based funding motivate health facilities to improve performance through investments in training, equipment, personnel and payment systems that better link individual pay to individual performance. PBF financing is directly applied to 14 key HIV indicators at the facility level. As a result of successful pilots implemented by CordAID, GTZ and BTC, the MOH has endorsed national scale-up of performance-based financing for all health services. The USG, in partnership with the World Bank, BTC and other donors, is supporting national implementation of performance-based financing of health services.

In FY 2006, MSH/PBF supported the GOR in collaboration with key donors to develop a national strategy, policy, and implementation model of performance-based financing that applies to all health assistance. The initial strategy for EP-supported PBF activities was to transfer USG site support from a traditional inputs–based model to a purely output purchases model as sites achieved a certain level of technical competence. However, the implementation of FY 2006 activities brought a change in the USG team's thinking about this approach. Few, if any USG supported sites were found to be ready for complete graduation to an exclusively PBF model. While PBF clearly increases performance, technical assistance and basic input support is still needed, especially in the current context of rapid decentralization and accelerated national roll-out of the PBF model by the GOR. Therefore, an adjusted strategy has been developed that provides a combination of both input and output financing to all EP-supported sites. The combination of financing modalities will properly motivate health facilities for higher performance while providing necessary resources and tools to meet the established targets.

In FY 2007, MSH/PBF will continue to provide support to the MOH Performance Based Financing department and the national PBF TWG. In addition, MSH/PBF will provide TA to DHTs in all PEPFAR districts and to USG implementing partners to effectively shift some of their input financing to output-based financing for the 14 key HIV indicators in accordance with national policy. MSH/PBF will also provide output financing to health facilities in 6 districts (where other clinical partners will only provide input financing) through direct performance sub-contracts with health centers and district hospitals for the 14 key HIV indicators. Output financing involves the purchase of a certain quantity of indicators with a performance incentive for the production of more than agreed upon quantities of services. Full or partially reduced payment of indicators is contingent upon the quality of general health services as measured by the score obtained using the standardized national Quality Supervision tool.

At the health center level, MSH/PBF will use a 'fixed price plus award fee' contract model to purchase a quantity of each of the 14 key HIV indicators with a performance incentive. Performance on these indicators will be measured during monthly control activities jointly conducted by the MSH/PBF district coordinator and the district's Family Health Unit and quality of services will be evaluated through the existing national supervisory and quality assurance mechanisms. The quantity and quality scores will be merged during the quarterly District PBF Steering Committee meetings and the final payments will be approved.

At the district hospital level, MSH/PBF will have sub-contracts with slightly different purpose and scope from that of health centers. In addition to the focus on increasing better quality service outputs, there is an emphasis on quality assurance, self-evaluation, and review by peers similar to an accreditation scheme. There will be payment for indicators from the National District Hospital PBF Scheme which reinforces the supervisory role hospitals play in district health networks.

At the District level, MSH/PBF will support the national model by 1) placing a district coordinator within the Family Health Unit to work with national family health steering committee during data collection/entry and control of indicators, 2) facilitating the quantity control function by providing TA and paying associated costs, and 3) support secretarial functions for the Family Health Unit at the District level. Support to the District is critical

for the proper functioning of the national PBF model since monthly HIV/AIDS invoice approved by the health center PBF management committee (COGE) and MSH are presented to the district steering committee for merging with quality index and final approval before payments are made.

Performance-Based financing of HIV services is a critical step to achieving the goal of sustainable, well-managed, high quality, and cost-effective HIV service delivery in a comprehensive health network. This financing modality supports the Rwanda EP five-year strategy for increasing institutional capacity for a district managed network model of HIV clinical treatment and care services.

Emphasis Areas	% Of Effort
Monitoring, evaluation, or reporting (or program level data collection)	51 - 100

Targets

Target	Target Value	Not Applicable
Number of district level PBF Management Committee members trained in the verification of HIV/AIDS indicator invoices	45	☐
Number of health facility level PBF Steering Committee members trained in data collection for HIV/AIDS indicator invoices	300	☐
Number of local organizations provided with technical assistance for strategic information activities	23	☐
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	69	☐

Target Populations:

Country coordinating mechanisms
Non-governmental organizations/private voluntary organizations
Policy makers
Volunteers
Other MOH staff (excluding NACP staff and health care workers described below)
Public health care workers
Implementing organizations (not listed above)

Key Legislative Issues

Gender

Coverage Areas

Gakenke

Gicumbi

Rulindo

Kamonyi

Muhanga

Nyamagabe

Nyaruguru

Ruhango

Gatsibo

Kayonza

Ngoma

Nyagatare

Rwamagana

Karongi

Rutsiro

Ngororero

Nyabihu

Nyamasheke

Rubavu

Gasabo

Kicukiro

Nyarugenge

Table 3.3.13: Activities by Funding Mechanism

Mechanism: MoH CoAg
Prime Partner: Ministry of Health, Rwanda
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 9252
Planned Funds: $ 250,000.00
Activity Narrative: This activity relates to HVSI (7237, 7264, 4985, 8743).

The purpose of this activity is to strengthen the national routine HMIS to better collect, analyze, and disseminate HIV data. This will be accomplished by supporting the MOH to develop and implement integrated site and district level HIV data collection systems, as part of routine HMIS data collection. This activity will build on FHI's work in FY 2006 to establish simple data analysis guidelines at facility, district, and national levels. This activity will also help the HMIS Unit to publish and disseminate quarterly bulletins on the HIV situation in Rwanda.

The EP will support the HMIS Unit to build a data warehouse that will interlink with other information systems housed at TRAC and the CNLS. In coordination with CDC direct activities providing additional in-country and international TA, the MOH/HMIS will receive support to coordinate all health related databanks in Rwanda.

This activity complements the work underway by the WHO Health Metrics Network (HMN) to identify overall gaps in the national HMIS.

EP will collaborate with PMI to reinforce human resources and technical capacity to strengthen the HMIS in Rwanda. The EP will also provide TA and financial support to the MOH HMIS Unit to produce a national health information policy document to define the framework for future EP and PMI support to HMIS.

This activity reflects the ideas presented in The EP Five-Year HIV/AIDS Strategy in Rwanda and the GOR National Multi-sectoral Strategic Plan for HIV/AIDS Control (2005-2009) by strengthening strategic information systems for health.

Emphasis Areas	% Of Effort
Health Management Information Systems (HMIS)	51 - 100
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 local organizations provided with technical assistance for strategic information activities	1	☐
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	120	☐

Coverage Areas:

National

Table 3.3.13: Activities by Funding Mechanism

Mechanism: Data Analysis and Use
Prime Partner: Family Health International
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 10166
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY 2006 -- NO NEW FUNDING IN FY 2007] This activity is related to HVSI (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.

Continued Associated Activity Information

Activity ID: 4985
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: To Be Determined
Mechanism: Data Analysis and Use
Funding Source: GHAI
Planned Funds: $ 387,000.00

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 local organizations provided with technical assistance for strategic information activities	29	☐
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	100	☐

Target Populations:

Doctors
Pharmacists
National AIDS control program staff
Policy makers
Host country government workers
Other MOH staff (excluding NACP staff and health care workers described below)
Laboratory workers

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: GHAI
Program Area: Strategic Information
Budget Code: HVSI
Program Area Code: 13
Activity ID: 12301
Planned Funds: $ 100,000.00
Activity Narrative: MEASURE DHS will conduct an Interim DHS in FY 2007 adding a module on MC. The 2005 Rwanda Demographic and Health Survey results were released in November 2006. The RDHS III included HIV prevalence rates based on a population-based sample. Rwanda has a generalized HIV epidemic with a reported low prevalence of male circumcision. The inclusion of the MC module in the Interim DHS will better report on the prevalence of circumcision and also male attitudes towards circumcision. These data will inform on strategy and future activities regarding male circumcision services promotion and expansion within the context of ensuring universal access to comprehensive HIV prevention, treatment, care and support.

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: $ 3,922,000.00

Program Area Context:

There is an acute shortage of qualified professionals in Rwanda. According to the 2005 RDHS-III, only 1.2% and 1.5% of men and women, respectively, have completed secondary school, which is a requirement for further technical training. Therefore, since its inception in FY 2004, the EP has invested significantly in at least four distinct strata of capacity building: 1) the health systems, 2) the organizational level, 3) the human resource level and 4) the individual/community level. The EP investments have supported a variety of activities including policy development, TA to key GOR institutions, and seconding staff. In coordination with the WB, GFATM and other donors, investment in each of these levels of capacity building has strengthened the GOR's ability to provide quality HIV national prevention, care and treatment services. Given that these four levels of capacity building are interlinked and collectively contribute to a strong health system, the EP has prioritized capacity building as a cross-cutting issue. Several activities listed in other sections of this FY 2007 COP also contribute to the dual objectives of both building the MOH's capacity of providing HIV services and advancing the sustainability of the EP program.

At the heath system level, the EP provides long-term TA to CNLS, TRAC, and PNILT for the development of national policies for HIV care and treatment and to strengthen GOR HIV coordination mechanisms. In FY 2005, the EP partners supported two technical advisors at PNILT and TRAC, which advanced TB and HIV integration thorough establishment of national protocols, policies and operational tools such as the revised TB/HIV register. In FY 2006, CHAMP is developing a national palliative care policy. CHAMP is also providing staff support to MIGEPROF to integrate policies that will advance gender equity in HIV services. In FY 2007, the EP will continue to support GOR at the systems level through funding for the National Health Account and by continuing to purchase output indicators through PBF. These activities will enhance the GOR's ability to map HIV resource flows in relation to other health sector funding.

At the organizational level, the EP has similarly supported capacity building for GOR and other Rwandan NGOs since FY 2004. The strategies used included: financial and management assistance; skills building in M&E; and commodities and logistics management. The EP has historically built capacity for HIV and CD4 testing at laboratories, particularly at the NRL. At the request of MOH, RPM+ supported CAMERWA at the central level and helped to establish a NDA at the district level to ensure and monitor drug quality in FY 2005 and FY 2006. In FY 2007, the NDA will create a quality control system and standardized training for district pharmacies. The EP will also provide commodities and logistics management to CAMERWA and district health pharmacies. This expansion of capacity building from the national to the district level parallels the GOR decentralization process. Concomitantly, the EP will expand its support beyond GOR institutions to civil society groups. CHAMP, which is funded to undertake the majority of EP community services, will support 12 local NGOs in financial management, and M&E through on-going training and skills-building.

At the human resource level, the EP supports pre-service, in-service, and refresher training of health professionals. Since FY 2005, the EP has actively supported pre-service nursing training and the Rwanda HIV/AIDS Public Interest Fellowship to develop a cadre of program managers. In FY 2006, CAPACITY and Columbia University collaboratively developed pre-service nursing curricula. CAPACITY also supported a Human Resource Advisor at the MOH to help develop the national HRH policy and strategic plan, and established a human resource database to track and properly distribute health workers countrywide.

In FY 2007, many existing implementers will continue their capacity building efforts: CAPACITY will implement the national curricula in collaboration with the GOR; ASCP will conduct pre-service training of laboratory technicians in the HIV, TB and malaria; CDC will assign a dedicated staff member to monitor the EP laboratory portfolio and provide TA to the NRL and other key MOH institutions; and Columbia will provide staff support to NRL to build its technical, financial and commodities management systems.

In FY 2007, the EP will also continue to support at least three pre-service training initiatives given the acute

shortage of health care providers and HIV program managers. The EP will complete and implement the nursing curricula, expand the number of participants in the Public Interest Fellowship, and initiate a social work certificate program to strengthen the continuum of care for PLWHAs. The EP will continue to support in-service training and supervision through PBF and other activities.

At the individual and community level, the EP uses its community partners to conduct TOT on an integrated health message. In FY 2006, CHAMP is training individuals to link clinical services and community care. Individuals will discuss and strategize ways to improve the quality of HIV services with representatives from health facilities. CHAMP will also train women leaders about a recently passed GOR bill that addresses rights for victims of GBV. In FY 2007, the EP will increase the number of individuals trained and expand the geographical coverage from 20 to 22 districts. According to the 2005 RDHS-III, 33.9% of the total households in Rwanda are women-headed. Moreover, 33.2% of widowed women reported being dispossessed of property. The EP will also continue to develop policies affecting PLWHA and widows who are dispossessed of their land.

Host government and donor collaboration is a critical element of system strengthening for the Rwanda EP. At the request of the GOR, the WB will decrease its HIV activities in Rwanda beginning in December 2006 and intends to stop the MAP by December 2007. The EP will continue to coordinate with the GFATM to absorb the existing WB MAP activities. To support the GOR, the EP will also continue TA and staff support to MOH, MIGEPROF, MINALOC, and MINEDEF.

In order to measure the link between multi-sector investment in the health system and long-term sustainability of HIV/AIDS programs in Rwanda, the EP will conduct a strategic assessment to inform and refine its medium- to long-term strategy on capacity building. The assessment, which will be followed by a comprehensive evaluation in FY 2008, will examine the efficacy of past EP approaches to capacity building and provide recommendations on all four levels, including effective strategies to work with the GOR. The EP has invested in activities with measurable outputs in FY 2007. The Rwanda team aims to advance the EP's global objectives on sustainability.

Program Area Target:

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	76
Number of individuals trained in HIV-related policy development	8
Number of individuals trained in HIV-related institutional capacity building	215
Number of individuals trained in HIV-related stigma and discrimination reduction	3,000
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	3,000

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: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 7189
Planned Funds: $ 500,000.00
Activity Narrative: This activity relates to MTCT (7181), HVAB (7183), HVOP (7184), HVCT (7182), HBHC (7187), and HKID (7186).

Through financial support and technical and institutional capacity building for Rwandan partner organizations, CHAMP is working to ensure Rwandan communities have equitable access to a high quality, sustainable continuum of care through HIV and AIDS services. CHAMP supports the provision of community services in all EP-supported districts, especially around EP-supported health facilities.

In FY 2006, CHAMP is providing financial and technical support to nine sub-grantees in 20 districts to reach over 17,000 OVC and 20,000 PLWHA with various support services. In addition, CHAMP sub-grantees is delivering prevention messages to 13,000 individuals and trained over 2,000 volunteers in the promotion of abstinence, fidelity, condom use, counseling testing, PMTCT, and a menu of services for OVC and PLWHA.

This support was largely provided through local Rwandan NGOs, of which CHAMP currently counts nine organizations as partners. Of these nine, three are considered "umbrella" organizations which collectively support over 1,000 associations representing women, PLWHA and the religious community. In FY 2006, capacity building activities started with a brief assessment of each organization's management capacities, including financial, human resources, strategic planning, M&E, QA, and fundraising. Individual capacity building plans were developed based on these initial assessments. CHAMP is also working with partners to develop five-year strategic plans and is organizing a workshop on financial and grants management.

In FY 2007, CHAMP will work with these sub-grantees (and their associations as appropriate) to build their capacity to manage programs, finances, and human resources with the ultimate goal of directly receiving donor funding in the future. CHAMP will not only provide trainings to improve management capacities, but will also look at linking Rwandan NGOs with international organizations that are present and active in Rwanda for mentoring purposes. CHAMP will add an additional three sub-grantees in FY 2007.

In addition to managerial capacity building, CHAMP will continue to provide TA to these sub-grantees and their members to provide comprehensive, quality services, especially for OVC and PLWHA as well as their families and caregivers. The direct outputs of this activity is the provision of financial and managerial skills-building to 12 Rwandan NGOs and build the human resource capacity of 60 individuals.

This activity reflects the Rwanda EP five-year strategy to achieve sustainability by developing organizational and human resource capacity.

Continued Associated Activity Information

Activity ID: 5183
USG Agency: U.S. Agency for International Development
Prime Partner: Community Habitat Finance International
Mechanism: CHAMP
Funding Source: GHAI
Planned Funds: $ 160,000.00

Emphasis Areas	% Of Effort
Development of Network/Linkages/Referral Systems	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 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	12	☐
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	3,000	☐
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	3,000	☐

Target Populations:

Community leaders
Community-based organizations
Faith-based organizations
Orphans and vulnerable children
People living with HIV/AIDS
Volunteers
Caregivers (of OVC and PLWHAs)
Religious leaders

Coverage Areas:

National

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: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 7204
Planned Funds: $ 275,000.00
Activity Narrative: This activity is related to OHPS (7249) and to HTXS (7205)

This activity will provide human resource expertise to the MOH to strengthen the management of the national health workforce. CAPACITY emphasizes staff retention, performance and promotion of professional expertise of medical and nursing staff for providing HIV/AIDS care. CAPACITY also supports the implementation of the 2005-2009 HRH Strategic Plan, HRH national policies and procedures with TA and staff support as requested by the MOH.

In FY 2007, CAPACITY will support the MOH to develop clearly defined job descriptions for all employee categories and expand the personnel management system established in FY 2006 to help create effective supervision, feedback, and goal setting in accordance with existing civil service procedures. CAPACITY will support the utilization of a human resource information system, including a web-based database. 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. The web-based software will be connected to central and district offices and hospitals that have internet connectivity supported by the EP. This will allow central and district health planners to evaluate current and future human resource needs by cadre; compare the needs to currently available and projected human resources; and test various interventions to find the best way to close the gap between demand and supply of needed health care workers.

To further strengthen human resource planning and management, CAPACITY will support a team of three Rwandan Human Resources specialists (HR advisor, IT database administrator, personnel specialist) to provide workforce planning and personnel management TA and capacity building to the MOH. The seconded CAPACITY human resource advisor will be instrumental in the implementation of the 2005-2009 HRH Strategic Plan supported in FY 2006. The HRH Advisor will research employee retention, participate in donor HRH studies and conduct focus group research to document retention issues particularly within rural health centers where retention problems are the greatest. CAPACITY will also continue to provide TA in long-term work force strategic forecasting and planning to the Permanent Secretary of the MOH and its staff. These activities will be coordinated through the Health Cluster, which is an official coordinating body in Rwanda grouping key donors in the health sector, including the GTZ, BTC, DfID, and others. While other donors in the Health Cluster are contributing to a basket fund to address HR issues, the EP is providing targeted support through CAPACITY and PBF strategies to augment low salaries of health workers based on performance standards and outputs. In addition, the EP will complement investments made by USAID with CSH funds to strengthen systems and ensure capacity building of local institutions.

The direct outputs of this activity are to build the organizational capacity of the MOH and the human resource capacity of 30 individuals.

These activities reflect the ideas presented in the Rwanda EP five-year strategy and support the GOR's national strategy of human resources and organizational capacity building

Continued Associated Activity Information

Activity ID:	2776
USG Agency:	U.S. Agency for International Development
Prime Partner:	IntraHealth International, Inc
Mechanism:	Capacity
Funding Source:	GHAI
Planned Funds:	$ 200,000.00

Emphasis Areas	**% Of Effort**
Human Resources	51 - 100
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	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	30	☐
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
Other MOH staff (excluding NACP staff and health care workers described below)
Other Health Care Worker
Implementing organizations (not listed above)

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: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 7211
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY 2006 -- NO NEW FUNDING IN FY 2007] 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.

Continued Associated Activity Information

Activity ID: 4780
USG Agency: U.S. Agency for International Development
Prime Partner: Macro International
Mechanism: Measure DHS
Funding Source: GHAI
Planned Funds: $ 160,000.00

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:	HIV/AIDS Performance Based Financing
Prime Partner:	Management Sciences for Health
USG Agency:	U.S. Agency for International Development
Funding Source:	GHAI
Program Area:	Other/Policy Analysis and System Strengthening
Budget Code:	OHPS
Program Area Code:	14
Activity ID:	7218
Planned Funds:	$ 0.00

Activity Narrative: [CONTINUING ACTIVITY FROM FY 2006 -- NO NEW FUNDING IN FY 2007] See related Activities: HVCT (2812), MTCT (2814), HBHC (2815), HTXS (2798, 4003), HVTB (4001), 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.
****PLUS-UP****
$600,000 - PBF will develop performance contracts with district supervisors to integrate HIV/AIDS indicators into their site visits to assure quality and efficiency of HIV/AIDS care. PBF will define and field test 10 indicators related to quality of HIV care for use in performance based contracting. PBF will develop national materials to guide districts in implementation of collaborative approach to achieve performance targets. These funds will be used to support national and district activities to integrate quality indicators into Performance-based contracting of HIV/AIDS services. Examples of quality indictors for possible use in PBC include: score > 70% on check lists from random medical record review for compliance with national protocols for: new PMTCT regimen, ARV prescribing, counseling for patients with positive HIV tests; score for percent of patients diagnosed with HIV from PIT, and score > 70% of checklist for adherence to supervision protocols. Rwanda has developed a national policy for quality improvement to serve as a basis for performance-based contracting. Continuing quality assurance through national implementation of the PBF is a top GOR priority and key activity to achieve sustainability in the Rwanda EP five-year strategy. Targeted DHTs will receive additional skill enhancement in monitoring the performance of health centers and hospitals in their districts to provide high quality, cost effective HIV services.

Continued Associated Activity Information

Activity ID: 2813
USG Agency: U.S. Agency for International Development
Prime Partner: Management Sciences for Health
Mechanism: HIV/AIDS Performance Based Financing
Funding Source: GHAI
Planned Funds: $ 1,053,432.00

Emphasis Areas	% Of Effort
Health Care Financing	10 - 50
Human Resources	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	☐

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: Health Policy Initiative
Prime Partner: The Futures Group International
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 7236
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY 2006 -- NO NEW FUNDING IN FY 2007] This activity is related to activities ARVS (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).

Continued Associated Activity Information

Activity ID: 4781
USG Agency: U.S. Agency for International Development
Prime Partner: The Futures Group International
Mechanism: PDI
Funding Source: GHAI
Planned Funds: $ 480,000.00

Emphasis Areas

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

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: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 7243
Planned Funds: $ 0.00
Activity Narrative: [CONTINUING ACTIVITY FROM FY 2006 -- NO NEW FUNDING IN FY 2007] ***PLUS-UP ADDITION: The Treatment and Research AIDS Center complex in Kigali takes in the TRAC ART clinic and VCT service, the National Reference Laboratory, the National Center for Blood Transfusion, and offices for central-level personnel working in the domain of clinical HIV/AIDS prevention, care and treatment. These funds will support the expansion and renovation of the complex to improve the quality of HIV services and ensure sufficient and appropriate working space for TRAC, NRL and CNTS staff. TRAC's mandate has recently been expanded to include coordination of MOH efforts in TB and malaria. The renovation will increase office space and meeting room capacity while freeing up space for the operations of the overcrowded TRAC clinic, which serves more than 2,500 ART patients. Improvements will leverage previous EP investment in office and ICT infrastructure, as well as technical capacity building at TRAC. This activity directly enhances EP partnerships with the NRL and CNTS, which are co-located with TRAC. This activity is consistent with the Rwanda EP five-year strategic goal of sustainable capacity building at national-level coordinating institutions.

Given that there is currently no isolation capacity in Rwanda for multi-drug resistant TB, these funds will also support the renovation of two isolation wards. One of these is located in Kigali Central Hospital and another in Butare at the University Hospital.***

Continued Associated Activity Information

Activity ID: 2742
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Treatment and Research AIDS Center
Mechanism: TRAC Cooperative Agreement
Funding Source: GHAI
Planned Funds: $ 280,000.00

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: UTAP
Prime Partner: Tulane University
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 7247
Planned Funds: $ 400,000.00

Activity Narrative: This activity relates to HVSI (7248).

In FY 2005, the EP, through Tulane UTAP, established the RHPIF program to build the program planning and M&E capacity of young professionals. The fellowship includes multiple components: training, mentoring, on-the-job experience and two-year paid internships with local public or not-for-profit agencies. Program costs, such as stipends, are managed directly by the NUR/SPH. In addition, the program also trains the host agencies - both public and private sector institutions – to design and implement HIV/AIDS programs. The RHPIF is a multi-sector HIV/AIDS intervention and recruits individuals from a cross-section of academic disciplines such as sociology, architecture, history, administration, finance and law. The RHPIF is a competitive program, receiving over 300 applications for the 15 fellows recruited in FY 2006.

Tulane UTAP works with NUR/SPH as a sub-grantee. Over the first two years of the program, Tulane UTAP gradually transferred responsibilities in technical, financial and managerial matters to NUR/SPH. The majority of the money allocated for this program is in the NUR/SPH sub-contract. Tulane UTAP provides administrative and financial oversight, as well as TA in planning, monitoring, logistics and training. In FY 2006, Tulane is successfully converting this training program into a university-recognized and accredited certificate course. As stipulated by the GOR, the investment in the RHPIF must have an impact beyond the 15 fellows and their designated supervisors who are participating in the FY 2006 program. Therefore, Tulane is training nearly an additional 50 national HIV/AIDS focal points in computer skills and in basic HIV/AIDS program areas, ranging from behavioral change topics to administration and financial management.

In FY 2006, the RHPIF is providing professional development support and leadership to alumni as they complete their two year fellowship. The program is also increasing the geographic distribution of fellows to agencies outside of Kigali. Because there is limited understanding of the role of fellows that sometime led to inadequate mentoring at some agencies, Tulane UTAP is focused on sensitizing the public & not-for-profit sectors about the contributions from these public interest fellows. In a parallel process, Tulane is also working with host institutions to strengthen mentoring skills and ensure appropriate professional development for fellows & their supervisors during their training period. As the program has matured, public sector institutions began to recognize the benefit of the fellows and offered some Fellows full-time employment suggesting that Rwandan NGOs working in the field of HIV/AIDS continue to have a significant need for skilled public health managers.

In FY 2007, Tulane will help the NUR/SPH increase the number of public interest fellows and their host agencies to 18. While the funding level for the program will decrease in FY 2007, Tulane will help the NUR/SPH trim costs without sacrificing the quality of the program with measures such as mobilizing external resources for the HIV/AIDS focal point training component, using the 1st & 2nd cohorts' laptops for subsequent cohorts. The fellowship components will continue to include training, mentoring, on-the-job experience and two-year paid internships with local public or not-for-profit agencies. Program costs, such as stipends, are managed directly by the NUR/SPH in FY 2006 and Tulane will continue to build this institution's capacity with the goal of being able to directly receive funds from donors for the RHPIF program. Tulane will also help the NUR/SPH further develop its marketing of the RHPIF to expand the number of participating host-institutions, future employers and future funding agencies – which are all important components to advance the sustainability of the RHPIF. In FY 2007, Tulane estimates that 15-20% of the total cost of the RHPIF will be used by Tulane UTAP directly while the other 80-85% will go to the NUR/SPH under a sub-contract that this GOR institution will manage on its own. The direct output of this activity is the training of 18 fellows.

These activities reflect the ideas presented in the Rwanda EP five-year strategy and support the GOR's national strategy of human resources and organizational capacity building.

Continued Associated Activity Information

Activity ID: 2746
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: Tulane University
Mechanism: UTAP
Funding Source: GHAI
Planned Funds: $ 500,000.00

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	15	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	30	☐
Number of individuals trained in HIV-related policy development	0	☐
Number of individuals trained in HIV-related institutional capacity building	30	☐
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

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism:	Tulane bilateral
Prime Partner:	Tulane University
USG Agency:	U.S. Agency for International Development
Funding Source:	GHAI
Program Area:	Other/Policy Analysis and System Strengthening
Budget Code:	OHPS
Program Area Code:	14
Activity ID:	7249
Planned Funds:	$ 812,000.00

Activity Narrative: These activities relate to OHPS (7247).

There are three components to this activity with the goal to strengthen both organizational and human resource capacity in Rwanda and to ensure that the NUR/SPH will become a self-sustaining institution that can limit its reliance on external funding and support. One component is a continuation of a FY 2006 activity while the other two components are new.

In the first component, the EP will continue to support the Executive MPH program through Tulane at the NUR/SPH and, in FY 2007, expand the number of public health practitioners, especially those working at decentralized health facilities. The two-year Executive MPH program targets GOR staff and individuals who are actively involved in EP-supported HIV services implementation. The MPH program provides intensive, graduate-level training that emphasizes applied skills through a combination of classroom participation and field assignments, focusing on strategic, data driven decision making. In FY 2006, ten MPH candidates are completing four modules in year one of the program. In FY 2007, these ten will complete their degrees with support from the EP. In addition to the ten participants from FY 2006, an additional ten participants will begin the Executive MPH program in FY 2007. The anticipated funding level of this activity is $400,000.

In the second component, the EP will advance the quality of palliative care by training social workers. As more people are living healthily on ART, Rwanda has an increasing need for HIV service providers to be trained in client-centered social work concepts. The GOR TWG on palliative care identified social work training as a priority for FY 2007 since it will strengthen the continuum of care and services for PLWHA. Given its human capacity development experience with the RHPIF and its work at the NUR/SPH, Tulane is well positioned to build the palliative care capacity of service providers and develop a social work certificate training program.

In collaboration with NUR/SPH faculty, Tulane will adapt two graduate level courses from its School of Social Work. The courses will target 20 students who are graduates from the NUR program in social work or are from the Free University of Kigali's program in social sciences. The certificate program will provide intensive, in-class instruction, hands-on experience and practical experience with an emphasis on developing counseling skills and techniques.

In addition, Tulane will adapt social work modules and convert them into a distance education format that can be accessed on the NUR website. The modules will also be translated into both French and English for greater accessibility. This activity will contribute to EP goals by strengthening Rwandans who are essential for linking PLWHAs between the clinical and community level. The direct output of these two activities is the training of 20 social workers. This second activity is budgeted at $262,000.

For the third component, the EP will promote the sustainability of NUR/SPH. As the only public health program in Rwanda, the NUR/SPH serves a critical role in building the public health workforce that addresses HIV treatment, care and services. Currently, the NUR, like most universities worldwide, requires that all of its teachers hold doctoral degrees. However, after the 1994 genocide, Rwanda has an acute shortage of both trained service providers and academics. As a consequence, the EP will bolster its support in public health research, training and practice.

The GOR recently shifted the emphasis of EP support to pre-service training from in-service training. As a result, the EP will support five students from NUR/SPH to complete their doctorate degrees. These five graduate students, who are close to finishing their PhD, currently serve as faculty but are not allowed to teach because they do not hold doctoral degrees. This EP support in long-term training would allow these individuals to travel to Tulane University and defend their dissertation, which is the final step to result in their doctorate degrees. In accordance with EP guidelines and current MOH policies on educational training and human capacity development, these individuals will commit to working at NUR/SPH for three or more years of time in exchange for this support. This strategy will build sustainability at NUR/SPH because these individuals will assume full teaching responsibilities and significantly reduce both EP funding and Tulane's long-term TA to NUR/SPH. Over the next few years, the NUR/SPH will graduate additional

public health academics with doctorate degrees with the goal of becoming self-sustaining. The direct output of this activity is that five individuals will receive their terminal degrees, and the NUR will be staffed with locally qualified public health academics simultaneously advancing the EP human resources capacity development and organizational capacity development strategies. This third activity would be budgeted at $150,000.

These activities reflect the ideas presented in the Rwanda EP five-year strategy and support the GOR's national strategy of human resources and organizational capacity building.

Continued Associated Activity Information

Activity ID: 2816
USG Agency: U.S. Agency for International Development
Prime Partner: Tulane University
Mechanism: Tulane bilateral
Funding Source: GHAI
Planned Funds: $ 400,000.00

Emphasis Areas	% Of Effort
Human Resources	51 - 100
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	0	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	0	☐
Number of individuals trained in HIV-related policy development	0	☐
Number of individuals trained in HIV-related institutional capacity building	59	☐
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

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: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 7258
Planned Funds: $ 200,000.00
Activity Narrative: USAID/Rwanda has been providing local and international TA to GOR institutions and limited direct grants to local NGOs since FY 2004.

In FY 2007, the EP will expand this to further build local capacity for five institutions. 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 FY 2005 and FY 2006 for such activities. USAID anticipates continuing this financial and technical support role in FY 2007. USAID will also support direct TA to GOR agencies as needed, in particular CNLS.

In addition, the EP will continue to utilize the expertise and resources of the USAID Energy team to help the EP clinical partners to better gauge the energy needs of their facilities. This will help ensure that facility upgrades are able to accommodate all necessary equipment and activities. Assistance will include further assessment of energy needs at health centers, district hospitals, and pharmacies; energy demand profiles and guidelines for partners; review of the capacity of Rwandan companies to maintain renewable and hybrid energy systems; train EP partners and health care staff on renewable energy systems; and recommend methods for partners to self-finance replacement parts to ensure sustainability of the energy systems.

The direct output is TA to five institutions that are directly providing HIV care. This activity reflects the ideas presented in the Rwanda EP five-year strategy and supports the GOR's national strategy of organizational capacity building.

Continued Associated Activity Information

Activity ID: 4973
USG Agency: U.S. Agency for International Development
Prime Partner: US Agency for International Development
Mechanism: USAID Rwanda Mission
Funding Source: GHAI
Planned Funds: $ 140,000.00

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		☑

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: Health Systems 20/20
Prime Partner: ABT Associates
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 8090
Planned Funds: $ 100,000.00
Activity Narrative: This activity relates to OHPS (7218).

NHA are the systematic, comprehensive assessment of resource needs and available resources in Rwanda's health system. These accounts are designed to facilitate the successful implementation of the GOR health system goals. A national health system should incorporate the inputs of donors and government budgets to facilitate the provision of an optimal package of goods and services to maintain and enhance the health of the population. NHA tries to estimate total needs within the Rwandan health system and attempts to trace, for any given year, all the resources that flow through the health system and where they end up. NHA is often the only information about national spending levels in health and is a standard management tool for situation analysis, planning, monitoring and evaluation purposes. NHA address four basic sets of questions: where do resources come from, where do they go, what kinds of services and goods do they purchase and whom do they benefit. The state of data availability for policy planning in the Rwanda remains limited and tables have not been updated since 2003.

Over the last few years, the GOR has made a significant effort to revitalize the NHA initiative which began with assistance from the US Government in the late 1990s. As more funds flow into the country from multiple donors, the inability of the GOR to understand the resource flows hampers its ability to their own resources and to understand the impact of initiatives like the EP, PMI, GFATM, etc. Given the size of the annual EP budget in Rwanda and the large proportion of HIV activities in the health budget, it is appropriate that HIV programs contribute to the overall effort to understand and quantify health system finances.

In FY 2007, the EP will assist the GOR to update the estimates of funding requirements for Rwanda's health system, and to update the NHA tables with the latest available data. This activity will help ensure that the EP resource flows are properly attributed within the overall GOR budget. The EP support will be coordinated with GOR and other donor funding to develop an up-to-date set of NHA.

The direct outputs from this activity will include an updated set of accounts including USG inputs which will increase the GOR capacity to plan and manage the health sector.

This activity reflects the ideas presented in the Rwanda EP five-year strategy and the Health Strategic Plan by directly contributing to Rwanda's efforts to improve sustainability.

Emphasis Areas	**% Of Effort**
Health Care Financing	51 - 100
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 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		☑

Target Populations:

National AIDS control program staff

Policy makers

Other MOH staff (excluding NACP staff and health care workers described below)

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: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 8179
Planned Funds: $ 0.00
Activity Narrative: N/A

Emphasis Areas	% Of Effort
Health Care Financing	10 - 50
Human Resources	10 - 50
Policy and Guidelines	51 - 100
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	0	☐
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
Country coordinating mechanisms
Doctors
Nurses
Pharmacists
Host country government workers
Laboratory workers
Other Health Care Worker
Doctors
Laboratory workers
Nurses
Pharmacists

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: Land
Prime Partner: Associates in Rural Development
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 8181
Planned Funds: $ 200,000.00
Activity Narrative: This activity relates to HBHC (7187) and MTCT (7208).

Women's land rights are of special concern in Rwanda where most agricultural activities, including both cultivation and marketing, are conducted by women and where 33.9% of households are female-headed (2005 RDHS-III). Women's rights to land are precarious and complicated by such factors as customary practices as to land management, land "ownership," the predominance of informal marriages or consensual unions, and polygamy. Despite a relatively progressive inheritance law, customary patrilineal inheritance patterns continue in Rwanda. These practices, in conjunction with the acute land shortage, translate to fewer land parcels passing to women. Women who do have access to land through their household sometimes lose their access to that land in the event of the breakdown of the household (by way of widowhood, abuse, abandonment, banishment, and polygamy). When women are diagnosed with HIV/AIDS, they are sometimes put off of the land by the spouse or other family members. When women lose their access and rights to land, whether because of HIV/AIDS or because of breakdown of the household, these women frequently are forced to turn to higher-risk behaviors that may increase the incidence of HIV/AIDS. According to the 2005 RDHS-III, 33.2% of widowed women reported being dispossessed of property.

On their faces, Rwanda's 2003 Constitution, recent Land Policy, 2005 Organic Land Law, and Inheritance Law all promote and establish land-related legal rights for women and prohibit gender discrimination. However, the difficulties and challenges inherent in clarifying and implementing any law, along with the customary and informal realities that govern gender relations in large part in Rwanda, make it a challenge to achieve the goals set out in the Constitution and underlying laws. The EP will provide support to this USAID-funded land reform activity to include short-term technical specialist on gender and land to incorporate gender-specific provisions within the new land laws, decrees, and regulations. That person will also help to amend existing laws to: reflect and attempt to accommodate the slowly changing reality of customary and informal practices; improve the likelihood that women can retain land when household events, such as HIV-infection or death due to AIDS, occur that might otherwise divest them of their land; provide for more universal land titling to women, including those living in informal consensual unions; better provide for women to obtain land by way of market transactions. Taken together, this assistance will improve women's ability to access and retain needed productive land resources and viable sources of livelihoods, and to lower the need to engage in high-risk behavior as a survival strategy (and thereby reduce the incidence of HIV infection among Rwandans).

The direct output of this activity is to facilitate the passage of legislation that would advance gender equity for PLWHA.

This activity addresses the key legislative issue of gender. This activity reflects the Rwanda EP five-year strategy by improving the quality of life for all PLWHA, especially HIV+ women.

Emphasis Areas	% Of Effort
Linkages with Other Sectors and Initiatives	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	1	☐
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:

Women (including women of reproductive age)

Widows/widowers

Key Legislative Issues

Increasing women's access to income and productive resources

Increasing women's legal rights

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: Peace Corps
Prime Partner: US Peace Corps
USG Agency: Peace Corps
Funding Source: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 8671
Planned Funds: $ 200,000.00
Activity Narrative: Peace Corps left Rwanda in 1994 with the outbreak of civil war and genocide. Over the last 12 years, Rwanda has seen an enormous economic recovery and development, but the country still suffers from the lingering effects of the fighting. Peace Corps believes that now is an opportune time to begin discussing a return to Rwanda in FY 2008. Rwanda continues to experience a significant shortage of trained health workers and teachers. To help build human resource capacity, Peace Corps proposes working in the areas of education and Health, particularly in HIV/AIDS. Peace Corps Volunteers would develop and manage effective community-based activities for the prevention of HIV/AIDS and for the care of infected- and affected-families. These efforts would contribute to the on-going EP efforts to prevent and mitigate the impact of HIV/AIDS in Rwanda. Peace Corps Volunteers would work closely with other EP-funded partners to increase referrals between clinical and community health and HIV/AIDS services as well as to address stigma and discrimination in their communities.

With an initial $200,000 in EP funding, Peace Corps will travel to Rwanda to begin discussions with the GOR – MOH, MINEDUC, MIGEPROF, and MINALOC – Voluntary Service Overseas, and the other USG agencies and partners. This funding will be used to conduct an initial country assessment.

The direct output of this activity is a comprehensive assessment to re-establish the Peace Corps program in Rwanda.

These activities address the key legislative issue of volunteers. Peace Corps plans to begin a full program in FY2008 in Rwanda pending successful consultation with the GOR and future congressional funding. This activity reflects the Rwanda EP five-year strategy by coordinating among USG agencies and encouraging volunteer activities.

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		☑

Key Legislative Issues

Volunteers

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: Transport Corridor Initiative
Prime Partner: Family Health International
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 8744
Planned Funds: $ 25,000.00
Activity Narrative: This activity relates to ROADS activities under HVAB (7199), HVOP (7199), HVCT (7201), HKID (8727), and HBHC (8142).

The overall goal of the ROADS Project is to stem HIV transmission and mitigate the consequences of HIV/AIDS on vulnerable populations along major East African transport corridors. This multi-sectoral project will target high-risk mobile populations--drivers and their assistants, CSWs, members of the uniformed services and stop-over site communities--with regionally coordinated SafeTStop messages. It will also link these target populations with new or improved HIV/AIDS services and care tailored to meet their needs. Innovative elements of the SafeTStop model include essential HIV-related programming on alcohol, gender-based violence, food security and economic empowerment. The ROADS Project works in Kenya, Uganda, Djibouti, Southern Sudan, Rwanda, Burundi and the DRC.

Over the last year, the ROADS Project focused on three sites in Rwanda: Kigali-ville, Gatuna on the Uganda border and Cyangugu on the DRC border. FHI launched the SafeTStop campaign in November 2005 with participation from the three major transport associations in Rwanda (Truck drivers, Mini-bus drivers and Motorcycle Taximen) as well as from the Association of Truckers' Wives, the CNLS and the Ministry of Labor. ROADS has trained 132 peer educators from the associations who in turn reached more than 3,400 individuals with ABC messages, information on STIs, and VCT referral. In FY 2006, ROADS completed an assessment on alcohol and HIV as part of a three-country study requested by the ECSA Ministers. ROADS will finalize rapid assessments in all three SafeTStop sites to identify programming needs. ROADS will continue to train peer educators to convey HIV prevention messages including the risks associated with cross-generational sex and prevention for positives. The peer educators will be out-of-school youth, truck drivers, commercial sex workers, and other community members. ROADS will work in partnership with PSI and health facilities to provide mobile VCT services.

With FY 2007 funding, ROADS will continue building the capacity of the local transport associations while expanding to work with new local partners. ROADS plans to create sub-agreements with different CBOs, PLWHA associations, women's groups and OVC groups to implement the HIV prevention and care activities. Through the regional LifeWorks Partnership, ROADS will work with the private sector to identify and support small business enterprises for women and older OVC. ROADS will provide TA in M&E and in community mobilization and advocacy to an estimated 25 different local CBOs. At least one person from each organization will receive training in HIV-related institutional capacity building.

The direct output of this activity is to build the capacity of 25 local organizations and 25 individuals.

These activities reflect the Rwanda EP five-year strategy and support the GOR's national strategy of human resources and organizational capacity building

Emphasis Areas	**% Of Effort**
Local Organization Capacity Development	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	25	☐
Number of individuals trained in HIV-related policy development	0	☐
Number of individuals trained in HIV-related institutional capacity building	25	☐
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:

Community-based organizations
Faith-based organizations
Non-governmental organizations/private voluntary organizations
Volunteers
Host country government workers

Coverage Areas

North

Gicumbi

West

Rusizi

Kigali

Gasabo

Kicukiro

Table 3.3.14: 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: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 9388
Planned Funds: $ 0.00
Activity Narrative: Reprogramming 8/07: This activity has been abandoned.

This activity also relates to HBHC (8139, 8716) and HLAB (7224).

The overall goal of this activity is to support a regional training program for pathologists to better diagnose OIs.

This is a new activity for 2007. The diagnosis of OIs frequently requires the examination of human tissue, either in the form of thin sections or fine needle aspirations. Preparation and examination of such samples requires specialized technical training that is currently unavailable in Rwanda. In the August 2006 meeting, the Association of Pathologists from Eastern, Southern, and Central Africa resolved that the lack of quality OI diagnoses is the major impediment to quality OI treatment. The consensus of this group, which was comprised of about 100 pathologists, is that the most significant challenge to providing accurate OI diagnoses is the lack of trained personnel. No one country has sufficient facilities or senior faculty to provide comprehensive training in Rwanda, Kenya, Tanzania, Malawi, and Uganda, which are all EP focus countries. Collectively, these nations have agreed to each contribute $75,000 towards a joint regional program that could support the training of one MD pathologist and two pathology technicians for each country. These staff members are equally important for their role in obtaining and reading fine needle aspirations from tuberculosis lymphadenitis among PLWHA.

In FY 2007, this activity will train one pathologist and two pathology technicians to identify and properly diagnose OIs in the laboratory. Currently, Rwanda has only 2 pathologists. Each of them does approximately 450 exams per year; in comparison, each pathologist does about 4,000 exams in the US. This activity, therefore, will work towards increasing skill levels in the overall health system and will address the acute shortage of pathologists. Trainees will rotate through clinical centers in Eastern and Central Africa and the training will emphasize the diagnosis of HIV-related diseases.

The direct output of this activity is the training of one pathologist and two lab technicians with the goal of improving the quality of pathology services in Rwanda.

This activity reflects the ideas presented in the Rwanda EP five-year strategy and the National Prevention Plan by strengthening human resource capacity.

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	0	☐
Number of individuals trained in HIV-related policy development		☑
Number of individuals trained in HIV-related institutional capacity building	0	☐
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:	RPM+
Prime Partner:	Management Sciences for Health
USG Agency:	U.S. Agency for International Development
Funding Source:	GHAI
Program Area:	Other/Policy Analysis and System Strengthening
Budget Code:	OHPS
Program Area Code:	14
Activity ID:	9638
Planned Funds:	$ 660,000.00

Activity Narrative: Reprogramming 8/07: With these reprogrammed funds RPM+ in collaboration with PMI, TRAC and APHAR will provide TA to the Ministry of Health for a small scale program of passive surveillance of adverse events related to ARVs and OI drugs. RPM+ will coordinate short term TA from African countries who have experience in pharmacovigilance as well as short training to Rwandan professionnals for routine monitoring reporting, and interepretation of use of data on adverse events resulting from ARV and OI druds use.This activity will contribute to the quality of HIV services in Rwanda.

In FY 2006, the EP, through RPM-Plus, is beginning to support the NDA, which has recently been approved as an official entity by the MOH. The NDA is responsible for certifying and monitoring the quality of drugs that are domestically manufactured and imported from other countries. RPM-Plus is seconding a technical staff to the NDA to assist in establishing a new government agency. A major accomplishment is the training of staff in drug registration file management.

In FY 2007, the EP will scale up its support to the NDA by focusing on three components.

First, the EP will provide technical and management support to the NDA. RPM-Plus will help develop two plans: one for implementation and another for strategic planning. The implementation plan will delineate and define the roles and responsibilities of a pharmaceutical regulatory authority. This plan will identify, define and prioritize a mix of technical activities to support the Rwanda's regulatory system; assess the conditions and resources necessary for a comprehensive pharmaceutical system; assist the NDA through regional collaboration and training on financial, technical and human resources topics. RPM-Plus will recommend priorities for the NDA, including the scope of product coverage; gaps in human, technical, financial, legal, and information technology resources; and the role of NDA within the MOH structure. RPM-Plus will develop a second plan on strategic planning. This plan will establish activities for a drug registration system; create nationwide QA in testing, inspection, and monitoring; support policies and procedures for drug regulation. Additionally, RPM-Plus will help to develop a fee structure for commercial registration of drugs, including pricing policy and plans for financial audits.

Second, the EP will assist the GOR in establishing a pharmacovigilance system at the central and district level. This will be coordinated with APHAR, PFSCM and other partners as necessary. RPM-Plus will work with the NDA to create the procedures and forms to be completed by health providers. A regulatory team will compile and analyze information and oversee any adverse events due to HIV/AIDS drugs.

Third, the EP will focus on building the capacity of pharmacists. RPM-Plus will support the institutional strengthening of APHAR by providing materials and training of pharmacists. RPM-Plus will also support the University of Butare's School of Pharmacy to integrate HIV/AIDS pharmaceutical management into its pre-service curriculum.

The direct output will be capacity building on policy development for three organizations and eight people under this activity, as well as institutional capacity building for four organizations and 14 people.

This activity reflects the Rwanda EP five-year strategy and supports the GOR's national strategy of human resources and organizational capacity building

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

Targets

Target	Target Value	Not Applicable
Number of local organizations provided with technical assistance for HIV-related policy development	3	☐
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	4	☐
Number of individuals trained in HIV-related policy development	8	☐
Number of individuals trained in HIV-related institutional capacity building	14	☐
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:

Pharmacists
Policy makers
Laboratory staff
Host country government workers
Other MOH staff (excluding NACP staff and health care workers described below)

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: Leg (formerly TBD)
Prime Partner: Associates in Rural Development
USG Agency: U.S. Agency for International Development
Funding Source: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 12302
Planned Funds: $ 400,000.00
Activity Narrative: As emphasis on HIV programs grows in Rwanda due to increased funding from the US Government as well as significant funding from GFATM, there is a significant need to ensure that there is a conducive policy and legislative environment in place to facilitate programs and ensure maximum impact. Incorporation of gender and gender based violence considerations, land tenure and inheritance rights for people living with HIV – particularly women, issues around stigma and discrimination for those living with HIV, regulations surrounding testing, integration of HIV education in school curricula are but a few of the many issues facing the Rwandan parliament and Ministry of Justice. EP funding for this activity will support several TDYs by legislative drafting experts for two objectives. Firstly, a review of all pertinent legislation currently "on the books" in Rwanda will identify an inventory of problems and legislative gaps or out of date regulations which will need to be addressed.
Secondly, the consultants will work with the parliament and the MOJ to train local staff on good drafting principles generally, incorporation of gender and HIV principles into legislation as a routine consideration, and specifically develop an agenda for HIV-specific legislation over the next year.

Emphasis Areas	% Of Effort
Local Organization Capacity Development	10 - 50

Coverage Areas:

National

Table 3.3.14: Activities by Funding Mechanism

Mechanism: TBD--TBD GBV
Prime Partner: Catholic Relief Services
USG Agency: HHS/Centers for Disease Control & Prevention
Funding Source: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 12303
Planned Funds: $ 150,000.00
Activity Narrative: "The Office of the Global AIDS Coordinator recently funded an initiative on gender-based violence (GBV) and HIV. The goal of this initiative is to increase access for survivors of sexual violence to comprehensive treatment services including HIV post-exposure prophylaxis (PEP). The initiative has at least two specific objectives that will be undertaken by implementing partners that OGAC will select centrally."

The first objective of the initiative is to implement and evaluate sexual violence service delivery models building upon existing services in Rwanda. To achieve this objective, the initiative will attempt to establish and strengthen connections between health, law enforcement, legal, and community services for delivery of a coordinated response to sexual violence survivors. In addition, the GBV initiative will attempt to strengthen the capacity of local partners and institutions to deliver quality health care services to survivors of sexual violence.

"The second objective of the initiative is to foster South-South exchange of programmatic experience, protocols, and tools through linkages with a network of partners implementing similar service delivery models in Zambia, Kenya, and South Africa and smaller sexual violence projects in Zimbabwe, Malawi, and Ethiopia. The GBV initiative will establish a network of communication and exchange among countries participating in the initiative. Currently, the OGAC gender technical working group has proposed to undertake the GBV initiative in Rwanda, Uganda, and South Africa and the USG country team in Rwanda will receive limited central funding for it. Consequently, the USG country team would like to supplement OGAC's central funds for this GBV initiative with $150,000."

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: GHAI
Program Area: Other/Policy Analysis and System Strengthening
Budget Code: OHPS
Program Area Code: 14
Activity ID: 12309
Planned Funds: $ 0.00
Activity Narrative: In FY06, the Emergency Plan supported a range of activities in pharmaceutical management in Rwanda. These include capacity building of district pharmacists with MSH RPM+, renovation of district hospital pharmacies with the district support block grant, and central level support (SOP's, improved stock management, etc) with SCMS and CAMERWA. As the EP extends its geographic coverage in the country (22 out of 30 districts will receive direct EP support by the end of 2007), and in response to the GOR decision to reorient WB MAP support to other priority sectors, facilities demand for HIV commodities will increasingly strain the existing passive drug distribution system.

To date, all health facilities offering ART are required to place orders for and collect commodities from Kigali. In FY 2007, the EP will support the national medical stores medium term objective of establishing an semi-active commodity distribution system by providing technical and financial assistance to upgrade existing 2 district pharmacies into regional pharmacies, which will have additional warehousing space, cold chain etc to stock sufficient commodities for all sites offering ART in their respective provinces.

MSH/RPM +, in collaboration with CAMERWA, MOH and SCMS, will strategically select the pharmacies to be upgraded. It is expected that these regional facilities will serve as warehouses and as regional medical stores for health facilities in their respective geographic areas, thereby reducing strain on the central level warehouse, and sharply cutting down on costs for re-stocking of drugs and other commodities. MSH/RPM+ will also support the adaptation of information systems for stock-management at regional pharmacy level. This information will improve the data for forecasting demand of ARV's and related commodities, and provide stronger data on site level consumption patterns. This activity supports the EP five-year strategy for national scale-up and sustainability, and the Rwandan Government administrative and ART decentralization plan by strengthening capacity of districts and sub-national institutions.

Emphasis Areas	**% Of Effort**
Infrastructure	51 - 100

Coverage Areas

South

West

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: $ 5,730,000.00

Program Area Context:

The EP in Rwanda, under the leadership of the Ambassador, works through an integrated interagency team. The EP team uses a consultative process for planning and implementing the program, with weekly standing USG meetings to discuss issues and resolve problems of implementation, and monthly standing meetings with GOR and other stakeholders in the PEPFAR Steering Committee. Frequent ad hoc meetings within and outside USG focus on implementation issues as they arise. The steering committee is the primary coordinating mechanism for technical working groups, and is the key management mechanism for COP development. The GOR has publicly and privately expressed considerable satisfaction with the FY 2007 COP development process and with this resultant document. Both the GOR and the EP team concur that FY 2007 COP 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. We jointly operate under the principle of "co-management", responding to both GOR and USG requirements. Moreover, staffing includes five continuing cross-agency positions: an SI liaison, an SI assistant, an HMIS coordinator, a public relations coordinator and an outreach coordinator.

The Rwanda EP team has been advised that program management staff should spend at least 20% of their time in the field to ensure quality program implementation. Due to inadequate staffing in FY 2006, the EP team has been unable to devote as much time to field visits as they would like. DOS has decided not to fill an administrative coordination position identified in previous COPs, and has eliminated that position from the staffing matrix. Neither USAID nor DOD anticipates adding positions in FY 2007. In COP06, the 12 LES who comprise the MVCT team were described in narratives but mistakenly excluded from the COP06 staffing matrix. The correction of this error in COP07 makes it appear as if there is a large jump in CDC staff. In actuality, only two new CDC positions are proposed, both LES to be embedded at the Ministry of Education.

A recent (August 2006) staffing review by senior USAID and CDC management documented staff shortages that result in excessive local workloads and inability to adequately address key functions such as field visits and fiscal accountability. This has been documented in the "Staffing for Success" report previously submitted to OGAC. It is difficult to answer "yes" to the question asked in COP Guidance for this program area, "Are you fully staffed?" The need for additional staff must be balanced against external limitations such as the DOS rightsizing initiative, agency restrictions, and the physical limitations of new embassy complex. Creative solutions are already being pursued, such as embedding LES and contractual employees in GOR ministries or with other partners.

Recruitment and retention of highly qualified local and international staff continues to be challenging, with three dynamics at play: 1) the local pool of appropriately-trained Rwandans is very limited and most are already employed with other agencies; 2) the USG salary structure for local technical staff has not been competitive with other donors and international NGOs (however, the mission is attempting to address this disparity with a proposed salary increase expected in early FY 2007); and 3) recruitment of international staff is difficult due to continuing misperceptions of post-genocidal instability in Rwanda. Staff turnover has been relatively high, with positions often open for relatively long periods because of extended recruitment.

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: GHAI
Program Area: Management and Staffing
Budget Code: HVMS
Program Area Code: 15
Activity ID: 7252
Planned Funds: $ 3,300,000.00
Activity Narrative: The 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 COP06, with no additions planned in COP07. 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. ICASS charges are estimated at $225,000 for the 15 people employed full time on the EP. The USAID IRM tax is estimated at $65,000, a non-discretionary charge for information technology services (including intranet) provided by USAID/W.

Continued Associated Activity Information

Activity ID: 2785
USG Agency: U.S. Agency for International Development
Prime Partner: US Agency for International Development
Mechanism: USAID Rwanda Mission
Funding Source: GHAI
Planned Funds: $ 2,070,000.00

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: GAP
Program Area: Management and Staffing
Budget Code: HVMS
Program Area Code: 15
Activity ID: 7259
Planned Funds: $ 1,135,000.00
Activity Narrative: This activity relates to HVMS (7260). In FY 2006 staffing increased substantially to address activities described in various program areas. In addition, the office secured administrative staff to better support the technical work of directly implementing USG EP activities. Specifically, the office recruited a senior budget and administrative specialist, a logistics coordinator, and a receptionist. As well, CDC recruited a new Chief of Party and also filled the Deputy Director position. In addition to personnel costs, this activity includes equipment and services to support general office function. The office has projected ICASS expenditures greater than in FY 2006. In addition to ICASS, this budget will support charges for Capital Security Cost Sharing tax. ICASS charges are estimated at $310,000 for the 36 people employed full time on the EP, with another $391,000 Capital Security Cost Sharing.

Continued Associated Activity Information

Activity ID: 2791
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: US Centers for Disease Control and Prevention
Mechanism: CDC Country Office GAP/TA

Funding Source: GAP
Planned Funds: $ 1,135,000.00

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: GHAI
Program Area: Management and Staffing
Budget Code: HVMS
Program Area Code: 15
Activity ID: 7260
Planned Funds: $ 1,165,000.00
Activity Narrative: This activity relates to HVMS (7259). CDC Rwanda requests early funding in the amount of $600,000 to finance the implementation of technical activities in the first quarter of FY 2007. This is a stop-gap measure which will allow CDC to continue its program uninterrupted while awaiting the approval of regular FY 2007 EP funds (CDC functions according to the USG fiscal year, and therefore was required to spend all FY 2006 funds by September 30, 2006). The early funding requested will finance national CT policy revision (to include separate norms and guidelines for PIT and VCT), site surveys for different program areas and purchases of test kits for the MVCT program. Administrative support funds for programmatic activities, including technical staff salaries, considerable international technical assistance costs, equipment and other office costs are included.

In COP06, the 12 LES who comprise the MVCT team were described in narratives but mistakenly excluded from the COP06 staffing matrix. The correction of this error in COP07 makes it appear as if there is a large jump in CDC staff. In actuality, only two new CDC positions are proposed, both LES to be embedded at the Ministry of Education.

Continued Associated Activity Information

Activity ID: 2844
USG Agency: HHS/Centers for Disease Control & Prevention
Prime Partner: US Centers for Disease Control and Prevention
Mechanism: CDC Country Office GAP/TA
Funding Source: GHAI
Planned Funds: $ 383,851.00

Table 3.3.15: Activities by Funding Mechanism

Mechanism: DOD Rwanda Office
Prime Partner: US Department of Defense
USG Agency: Department of Defense
Funding Source: GHAI
Program Area: Management and Staffing
Budget Code: HVMS
Program Area Code: 15
Activity ID: 7267
Planned Funds: $ 100,000.00
Activity Narrative: The DOD Coordinator position began in FY 2006 and will continue throughout FY 2007. Responsibilities for the DOD Coordinator are broad and include management, coordination, and support of all DOD's EP activities in Rwanda. In addition, this funding supports costs for DOD technical assistance, which furthers development, monitoring and evaluation of new and existing programs. Additionally, these funds for the coordinator will support travel, training, workshops and equipment.

Continued Associated Activity Information

Activity ID: 2802
USG Agency: Department of Defense
Prime Partner: US Department of Defense
Mechanism: DOD Program Mgt
Funding Source: GHAI
Planned Funds: $ 30,000.00

Table 3.3.15: Activities by Funding Mechanism

Mechanism: Embassy Rwanda
Prime Partner: US Department of State
USG Agency: Department of State / African Affairs
Funding Source: GHAI
Program Area: Management and Staffing
Budget Code: HVMS
Program Area Code: 15
Activity ID: 7268
Planned Funds: $ 30,000.00
Activity Narrative: The US Embassy in Rwanda has overall responsibility for a broad range of activities, including coordination of DOD, HHS/CDC, and USAID EP activities. This activity includes miscellaneous equipment and services to support EP management particularly relating to public outreach and information management.

The US Embassy in Rwanda has decided to not fill the previously proposed PEPFAR coordinator position, principally because no added value is envisioned from the addition of an administrative layer when agencies on the ground are already functioning so effectively as an integrated team. Therefore, this position has been eliminated from the Staffing Matrix.

Continued Associated Activity Information

Activity ID: 2817
USG Agency: Department of State / African Affairs
Prime Partner: US Department of State
Mechanism: Embassy Rwanda
Funding Source: GHAI
Planned Funds: $ 0.00

Table 5: Planned Data Collection

Is an AIDS indicator Survey(AIS) planned for fiscal year 2007?	☐ 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 2007?	☐ 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 2007?	☑ Yes	☐ No
When will preliminary data be available?		
When will preliminary data be available?	6/15/2007	
Is an Anc Surveillance Study planned for fiscal year 2007?	☑ Yes	☐ No
if yes, approximately how many service delivery sites will it cover?	30	
When will preliminary data be available?	3/1/2008	
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 2007?	☐ Yes	☑ No

Other significant data collection activities

Name:
Impact of Rwanda's national ARV program

Brief description of the data collection activity:
In close collaboration with the OGAC treatment technical working group, a two-part protocol was developed in FY 2006 to evaluate the impact of Rwanda's national ARV program. Part 1 of the evaluation examines patient retention, weight, and CD4 outcomes at 6 and 12 months based on routinely available data abstracted from ART site medical records. Part 2 includes the evaluation of viral load suppression at 6 and 12 months based on RNA PCR determination performed on residual blood specimens from routine CD4 testing. This evaluation will be repeated annually to track program impact over time.

Preliminary data available:
February 28, 2007

Name:
Diagnosis review of smear negative and extra-pulmonary TB

Brief description of the data collection activity:
TB related mortality among PLWA is higher than among TB patients without HIV infection. The main reason is the late diagnosis of certain form of TB particularly smears negative and extra pulmonary TB. This evaluation aims at reviewing the process of diagnosing these types of TB in three selected hospitals in Rwanda in other to identify issues and gap in timely diagnosis and referral to treatment for TB.

Preliminary data available:

Name:

Prevalence of HIV infection and active TB diseases among HIV infected children

Brief description of the data collection activity:

The aim of this public health evaluation is to assess the prevalence of HIV infection and active TB diseases among HIV infected children and build capacity of HIV services providers in timely diagnosis and treatment of children infected with HIV and diagnosed with TB. Lung disease is the most common cause of morbidity among HIV-infected children and TB is an important opportunistic infection (OI) and cause of death among children living with HIV/AIDS. While WHO recommends that all people living with HIV/AIDS (PLWHA) should be screened for TB, there are no specific screening recommendations for children, which may differ from adults in important respects.
n
nInterventions to reduce TB related mortality rates in HIV infected children could include: 1) earlier case detection through screening of HIV-infected children for latent TB infection (LTBI); 2) early identification of active TB disease; and 3) timely and appropriate treatment of latent infection and disease. Additionally, there is a great need to operationalize the integration of HIV and TB programs at points of service for childhood health and HIV care and treatment. Models that effectively integrate HIV and TB care in various levels of health care systems and establish functional referral mechanisms are an important missing link in childhood and adult HIV disease.
n

Preliminary data available:

Name:

Performance- based financing evaluation

Brief description of the data collection activity:

The main objective of the external evaluation is to determine if the Rwanda EP PBF strategy is meeting the sustainability needs of the USG as well as the improved health system performance desired by the MOH. 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?

Preliminary data available:

December 14, 2007

Name:

CPDS evaluation

Brief description of the data collection activity:

The overall objective of the evaluation is to assess the efficiency, transparency and functioning of the CPDS and CAMERWA in relation to quantification, procurement, inventory management, distribution, and monitoring and reporting of ARVs at and between CAMERWA, District and site level between July 2005 and October 2006. A key expected outcome of the evaluation will be whether ARV drugs have been procured, stored and distributed in line with donor restrictions and financial contributions made to the CPDS, and in accordance with the CPDS framework.

Preliminary data available:

January 15, 2007

Name:

Models of care for HIV/AIDS service delivery

Brief description of the data collection activity:

This activity will begin in FY 2006 and continue in FY 2007. The overall goal of this evaluation is to improve palliative care services by determining what model of case management is best adapted to the Rwandan context. The EP funded 4 distinct models of case management through Columbia, CRS, CARE, and IntraHealth Capacity in FY 2004 through FY 2006 to advance EP goals of creating a continuum of care. It is presently undecided which of these models will be both affordable and consequently a viable option for the national program. Within the Rwandan context, case management appears to be viewed as an initiative that is unsustainable in a resource-constrained setting, but no data exists to support this hypothesis. However, literature from other countries suggests that a case management model can both advance positive health outcomes for PLWHAs and also be affordable. Accordingly, this evaluation is necessary to advance data-driven decisions for the USG Rwanda team and

to advance the EP palliative care strategy on establishing a strong continuum of care from the point of diagnosis.

Preliminary data available:

September 28, 2007

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, conducting incidence testing of specimens from 2005 and 2006 sentinel surveillance and analyzing and disseminating the results. This activity is planned but not scheduled because the BED assay performance is under review, and CDC is waiting for approval of this test before proceeding.

n

n

n

Preliminary data available:

September 27, 2007

Name:

ARV Drug Resistence

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. Protocol development has been completed and will be submitted to the National Ethical Committee and IRB review for approval.

Preliminary data available: