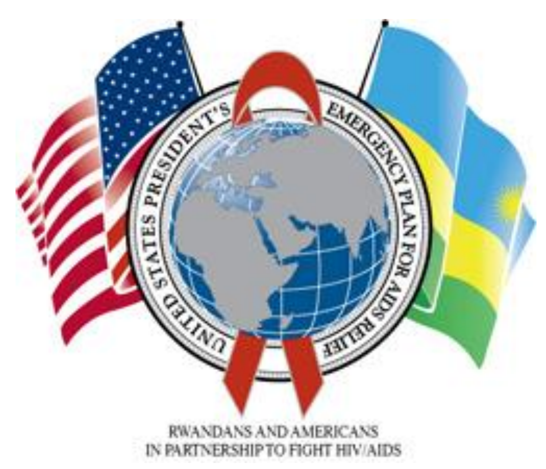

Partnership Framework for Cooperation
In the Response to the HIV / AIDS Epidemic in Rwanda
2009 – 2012

Between

The Government of the United States of America

And

The Government of Rwanda

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Purpose

This Partnership Framework is a coordinated strategic framework between the Government of the United States of America (USG) and the Government of Rwanda (GOR) to sustain and strengthen the national response to Rwanda's HIV/AIDS epidemic. Through the GOR's leadership, commitment, and collaboration with donor partners, civil society, and the private sector, Rwanda is uniquely positioned to simultaneously reduce HIV/AIDS incidence while reinforcing comprehensive and integrated health services to benefit all Rwandans. Over the past five years, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has supported the national capacity to plan, lead, manage, and deliver quality health services across Rwanda. This Partnership Framework outlines key objectives to build on this strong foundation of national management and coordination. Through this Partnership Framework, PEPFAR intends to continue to support the GOR's commitment to national ownership, data-driven approaches, quality service delivery, implementation of evidence-based policies, institutional capacity building, and a coordinated financial response.

The Partnership Framework places an emphasis on sustainability of HIV/AIDS activities to enable a strong Rwandan health system. Multiple aspects of sustainability are addressed, including: (i) technical sustainability: the ability to provide sound, high quality technical services; (ii) management sustainability: the ability to plan and manage all areas of the HIV/AIDS response; (iii) financial sustainability: the ability to independently finance programs without reliance on external support; and (iv) political sustainability: the ability to maintain the involvement of key decision-makers at all levels.[1] The USG supports the process of transitioning the technical leadership, program management, coordination, and increasing financial responsibility for HIV/AIDS prevention, impact mitigation, care and treatment services to local entities (governmental and non-governmental). Through the Partnership Framework, the USG intends to invest in key areas that will enhance sustainability of programs in the medium- and long-term. In addition, there are other critical infrastructure needs at the central level to improve institutional functioning.

Some of the key areas of transition over the next five years include:

- Increasingly transition financial and programmatic management of activities to GOR institutions and local civil society organizations;
- Transition PEPFAR Track 1.0 clinical care and treatment activities to local entities;
- Reinforce decentralization of the health sector through an emphasis on strengthening the district level capacity to plan, manage, implement, and finance HIV/AIDS programs; and
- Identify key, realistic benchmarks to monitor and evaluate technical, managerial, financial, and political sustainability of all programs.

The timing of this Partnership Framework is in line with the recently completed national Health Sector Strategic Plan 2009 – 2012 (HSSP II), and the HIV/AIDS National Strategic Plan 2009 – 2012 (NSP). In order to align with future strategic planning exercises, the Partnership Framework is aligned with this same timeframe (2009 – 2012). Rwanda is the

[1] Kotellos K, Amon J, Benazerga W. Capacity Building in HIV/AIDS Prevention Programs. AIDS 1998, 12 (suppl 2): S109-S117.

only country to receive approval on their HIV National Strategy Application (NSA) through the Global Fund for AIDS, TB and Malaria. These coinciding efforts have provided a unique opportunity for all partners in the national response to HIV/AIDS to engage in the participatory development of the Partnership Framework, NSP, HSSP II, and NSA. Partners have included multiple sectors of the GOR, civil society, private sector, bilateral and multilateral donors, and international organizations. Most importantly, the participatory national planning process has enabled the USG and Global Fund for AIDS, TB and Malaria (GFATM), the two largest GOR partners in HIV/AIDS, to align the Partnership Framework and the NSA.

The Partnership Framework represents the results of a transparent and participatory planning process and collaborative response to the HIV/AIDS epidemic in Rwanda, and provides a strategic approach for all PEPFAR-supported activities in Rwanda. The detailed objectives, expected contributions, and targets for the Partnership Framework are described in a separate Partnership Framework Implementation Plan. In future years, PEPFAR Country Operational Plan (COP) development should use the Partnership Framework and Implementation Plan as guiding documents. The USG and the GOR resources are limited. Therefore, all investments are subject to the availability of funds. The achievement of the Partnership Framework goals requires resources beyond the ability of any one partner, and therefore, a decrease in available funding from either participant or from other key partners could lead to a review and revision of goals.

Through the leadership of the GOR and the collaborative support of all HIV/AIDS partners, at the end of the Partnership Framework, Rwanda is expected to have improved outcomes in the prevention, impact mitigation, care and treatment of HIV/AIDS, and the health sector should be better positioned to reduce morbidity and mortality over the long term.

Guiding Principles

Country ownership

A key objective of the Partnership Framework is to ensure that Rwandans are at the center of decision-making, leadership, and management of the national HIV/AIDS program and are well-positioned to ensure long-term sustainability of their programs. Close collaboration with the Government of Rwanda, civil society organizations and the private sector is needed in order to achieve this objective.

Alignment and harmonization

All health sector donors, including the USG, closely adhere to the GOR priorities defined in the Rwanda Vision 2020 strategy, the 2008-2012 Economic Development and Poverty Reduction Strategy (EDPRS), the Millennium Development Goals, the Health Sector Strategic Plan II (2009-2012), the UNAIDS Global “Three Ones” framework (one HIV/AIDS action framework, one national AIDS coordinating authority, and one country-level monitoring and evaluation system), and the principles of the Monterrey Accords and Paris Declaration. The Partnership Framework also aligns with the priorities outlined in the 2009-2012 National HIV/AIDS Strategy (NSP) (a sub-sector strategic plan of the HSSP II) and the 2009 Civil Society Situation Analysis on HIV/AIDS in Rwanda. Finally, the Rwandan health sector operates under the core values of a sector-wide approach (SWAp). The USG is a

signatory to the Memorandum of Understanding of the SWAp but does not provide pooled funding.

USG interagency collaboration

The development of this Partnership Framework was an interagency effort of all the USG agencies under the leadership of the U.S. Ambassador to Rwanda. The Partnership Framework seeks to achieve synergies with other relevant health and development efforts, in particular, other USG programs including the President's Malaria Initiative (PMI), tuberculosis, influenza, reproductive health, maternal and child health, education, food and nutrition, agriculture, economic strengthening, and others as appropriate. Finally, the Millennium Challenge Corporation (MCC) Threshold Program seeks to reinforce the Partnership Framework objectives to strengthen citizen voices in local policy making, including strengthening civil society and local government capacity to support the delivery of health services.

Engagement and participation

The approach to development, implementation, and monitoring of this Partnership Framework is based on multi-sectoral partnership. The Partnership Framework utilized the participatory process led by the GOR to develop the HSSP II and NSP, and included various GOR ministries, civil society, private sector, bilateral and multilateral donors, and international organizations engaged in the fight against HIV/AIDS. The process also coincided with the development of the National Strategy Application for GFATM, which allowed for coordinated planning of financial contributions to implement the NSP.

Key national partners include: Ministry of Health (MOH), the National AIDS Control Commission (CNLS), Ministries of Defense, Education, Finance and Economic Planning, Gender and Family Promotion, Justice, Local Government, and Youth. Civil society partners include local and international non-governmental organizations, faith-based organizations, associations of PLWHA, and HIV/AIDS umbrella organizations. Key multilateral, bilateral, and other partners include: GFATM; United Nations agencies (UNDP, UNFPA, UNHCR, UNICEF, UNAIDS, UNIFEM, World Health Organization); the Great Lakes Initiative on HIV/AIDS; the private sector; the Belgium Technical Cooperation (BTC); European Union; German Society for Technical Cooperation (GTZ); Netherlands Embassy; Lux-Development; Swedish International Development Agency (SIDA); United Kingdom Department For International Development (DFID); and, Clinton Foundation.

Progress towards policy development and implementation

Robust policy development and implementation are essential to an effective response to the HIV/AIDS epidemic. Policy development and implementation are important to the achievement of the goals of the Partnership Framework, including Human Resources for Health (HRH), service delivery, access to services, and programs focused on gender, most-at-risk populations (MARPs), orphans and vulnerable children, stigma and discrimination.

In particular, key policies on the quality of care, integration of family planning with other services, basic care, task shifting, reproductive health and finger-prick testing are currently under development. The Partnership Framework focuses on implementing plans for these

key policies, and identifying additional policy changes that are necessary to facilitate achievement of national goals.

Increased financial accountability

The GOR has a strong record of financial controls and accountability. As part of the Partnership Framework, there should be continued emphasis on coordination of financial resources to avoid duplication, and increase financial and/or in-kind contributions of the GOR to the HIV/AIDS program over time.

The GOR recently finalized a cost estimation of the prevention, impact mitigation, care and treatment goals of the national HIV/AIDS strategy. While the Partnership Framework includes a greater emphasis on overall health systems strengthening and technical assistance, this costing is a useful tool for both the Partnership Framework and GFATM NSA. The Ministry of Health also recently launched a database to track all financial commitments in the health sector as a planning tool. Expenditures are tracked through national reporting to the Ministry of Finance, National Health Accounts (NHA), and National AIDS Spending Assessments (NASA).

Throughout the Partnership Framework, with both PEPFAR and other resources, the USG intends to continue to support financial planning, management, and accountability in the health sector. This includes support for the rational use of available health resources, and strengthened national capacity for cost reduction, revenue generation, and cost-sharing.

Finally, in accordance with the Paris Declaration, the USG and the GOR intend to partner to ensure that the USG health sector support is reflected in the GOR budget.[2]

Joint accountability for results

The USG and the GOR should be jointly accountable for achieving the results outlined in the Partnership Framework.

Indicators, targets, and benchmarks for measuring progress towards achieving the Partnership Framework goals and objectives are specified for all partners in the Partnership Framework Implementation Plan. Partners intend to monitor the implementation of the Partnership Framework annually to assess progress towards targets, meeting of expected contributions, approving and implementing key policies, achieving cost efficiencies through coordinated financing, and increasing program ownership by the GOR. Both the NSP and the HSSP II should be evaluated at mid-term, and final evaluations conducted in 2012. The findings of the mid-term evaluations should influence mid-course corrections to ensure achievement of jointly adopted goals.

The indicators have been selected among the nationally agreed indicators of the NSP and the HSPP II 2009-2012, as well as the PEPFAR Next Generation Indicators. The Partnership Framework process emphasizes national target-setting and transitioning PEPFAR-specific reporting systems to national, country-owned and performance-oriented information systems.

[2] Funds are considered 'on budget' if they support the government sector, are in line with National Plans, use government procurement procedure and are in the control of the host government.

Collaborative and not contractual

This Partnership Framework is a non-legally binding joint strategic planning document that outlines the goals and objectives to be achieved, and the expected roles and contributions of all participating Partnership Framework members. The Partnership Framework is intended to facilitate communication and collaboration among partners, including ensuring that programs are more stable and integrated. The Partnership Framework does not alter existing USG or GOR rules, regulations, cooperative agreements or contracts.

Strategic Overview

With an estimated 3% of the adult population infected with HIV, Rwanda has a lower burden of disease compared to other countries in the region. Nonetheless, HIV transmission continues in an environment of rapid urbanization and burgeoning economic growth. HIV prevalence is higher among women than men, and urban residents have much higher infection levels than rural residents. In addition, most-at-risk populations (MARPs) are key epidemic drivers. Although an impressive 70% of those in need are already receiving anti-retroviral therapy, the social, economic and health burden of HIV and AIDS on those affected remains a challenge.

Over the past year, the GOR has facilitated a participatory process of all of the actors involved in fighting HIV/AIDS in Rwanda to develop the Rwanda HIV/AIDS National Strategic Plan 2009 – 2012 (NSP). This included in-depth research and analysis of the epidemiology of HIV/AIDS in Rwanda; the achievements of the response to date and the challenges faced today; the capacities of the wide range of partners and implementation systems involved in the response; and the most promising evidence-based interventions from Rwanda and beyond. The resulting NSP comprehensively identifies overarching goals for addressing the HIV/AIDS epidemic for communities, civil society organizations, national ministries and all development partners.

As part of the development of the Partnership Framework, the USG team requested that all implementing partners respond to the following questions:

- Which local entity is the “ideal” entity to take over activities currently covered by USG implementing partners?
- What are the reasons that the “ideal” entity is not currently implementing the activity, and how can these barriers be addressed by USG and USG implementing partners?
- How can activities be sustained in a manner that maintains quality and maximizes cost efficiency?

The Partnership Framework Implementation Plan incorporates the consensus perspectives around these questions.

The Partnership Framework outlines the USG’s expected contribution to achieving Rwanda’s goals, with an emphasis on health systems strengthening and national ownership. In alignment with the EDPRS, HSSP II and the NSP, the Partnership Framework has adopted four overall strategic goals. These goals have been taken directly from the NSP and HSSP II.

1. **The incidence of HIV in the general population is halved by 2012**

2. **Morbidity and mortality among people living with HIV/AIDS are significantly reduced**
3. **People infected and affected by HIV/AIDS have the same opportunities as the general population**
4. **The human and institutional capacity of the public health system to plan, manage, and implement sustainable health programs is strengthened at all levels**

While the USG has adopted these national goals to promote national ownership and harmonization, the overall scope of activities and summary of key contributions by each partner are described below (Table 1), and the Partnership Framework Implementation Plan further outlines the specific USG expected contribution to achieve these goals.

Goals

1. The incidence of HIV in the general population is halved by 2012

According to the 2005 Rwanda Demographic and Health Survey (DHS), HIV prevalence in the Rwandan population, ages 15-49 years, is 3%. HIV prevalence is higher among women than men in both urban and rural areas. Urban residents have much higher infection levels than rural residents (7.3% vs. 2.2%). Women are infected at younger ages than men, possibly resulting from cross-generational sex. HIV prevalence is higher among individuals who have had multiple lifetime sexual partners. For women, prevalence increases from 3.0 percent for those who have had one sexual partner during their life to 12.1 percent to those who have had 3-4 partners. HIV prevalence is also markedly higher among those who reported they already had a sexually transmitted infection (STI) or symptoms of an STI. For example, for men who reported having an STI or symptoms of an STI in the past 12 months, prevalence is 9.9 percent versus 3.0 percent for those who have not had an STI or symptoms of an infection.

In response to these epidemiologic data, the Partnership Framework has adopted the goal to reduce incidence of HIV by half in the general population from the Rwanda NSP. Achievement of this goal is to be accomplished through pursuit of the following three objectives, related to each of the three modes of transmission of HIV:

- **Objective 1.1. Reduction of sexual transmission of HIV/AIDS**
- **Objective 1.2. Reduction of Mother-to-Child Transmission of HIV/AIDS**
- **Objective 1.3. Maintenance of low levels of blood-borne transmission of HIV/AIDS**

Table 1 outlines the overarching contributions supported by each partner to achieve these outcomes. Effective HIV prevention is the key to reversing the continued spread of HIV, and providing a sustainable response to the enormous and growing need for care and treatment. Success depends on the extent to which effective interventions reach people at high risk of contracting the virus. Through the Partnership Framework, the USG plans to support targeted prevention interventions and continue to build the capacity of local organizations and national institutions to sustain these efforts. The USG also intends to continue to support the Government of Rwanda in their efforts to increase gender equity and reduce gender based violence. This is already an important part of all GOR programs, both in health and more

broadly. The USG plans to continue to emphasize the need for a gender focus in HIV/AIDS programs.

Key national policies to achieve these goals include: finger-prick testing, task shifting for male circumcision, policy and guidelines for STI treatment, implementation of couples-testing guidance, rational blood use policy, and guidelines for hemovigilance.

1.1. Reduction of sexual transmission of HIV/AIDS

Epidemic monitoring and modeling suggest that sexual transmission is responsible for the majority of new HIV infections in Rwanda. Intermediate outcomes that seek to contribute to reduced sexual transmission include:

- Reduction of risky sexual intercourse;
- Reduction of susceptibility to infection through increased male circumcision; and
- Reduction of susceptibility to infection through increased correct treatment of sexually transmitted infections (STI).

Through the Framework, the USG plans to support the GOR in reducing sexual transmission risk at the population level by targeting the key drivers of the epidemic. According to the PEPFAR-sponsored 2008 Rwanda HIV data triangulation exercise, these key drivers include: commercial sex work/transactional sex; HIV-negative partners in serodiscordant couples; and uncircumcised men. In addition, PEPFAR intends to support the GOR in extending intensified prevention interventions for People Living with HIV/AIDS (PLWHA). The Partnership Framework endeavors to employ evidence-based interventions with improved targeting, selection, and delivery of prevention interventions coordinated by the National AIDS Control Commission (CNLS). Evidence-based programming and rational allocation of resources should ensure emphasis on HIV prevention programs in higher prevalence urban and border areas, while preventing new infections in rural and other areas that currently exhibit low prevalence.

Risky sexual intercourse can also be addressed through counseling and testing. The Rwandan program has demonstrated impressive achievements in HIV Counseling and Testing (CT), through the provision of 964,966 CT sessions in 2008 for example, but challenges remain. According to 2005 Rwanda Demographic and Health Survey (RDHS), 56 percent of men and 64 percent of women who tested seropositive at the time of the survey had never undergone an HIV test previously. Although much progress has been realized in this program area since 2005, CT programs do not adequately reach MARPs. Under the Partnership Framework, the USG plans to target its support for GOR CT initiatives aimed at reaching people with HIV infection who have not yet been tested, including innovative ways to make HIV testing more accessible to MARPs. Mobile CT to CSW and their clients, mobile populations and uniformed corps expect to be used in addition to supporting CT services in clinical settings. The Partnership Framework should also intensify CT prevention effectiveness by intensifying HIV counseling for high risk negatives. The high incidence among serodiscordant cohabitating couples highlights a tremendous opportunity to prevent new HIV infections through partner/couple counseling and testing, identifying discordant couples and follow-up interventions through prevention with PLWHA. It is anticipated that provider-initiated testing will be used to reach people accessing health facilities, and the standard finger-prick approach for CT testing will be adopted.

High coverage of male circumcision has been shown to be effective in reducing heterosexual transmission of HIV infection. In Rwanda, only 12 percent of men age 15-59 have been circumcised (I-DHS, 2007). The USG has been actively involved in the development of a comprehensive package of male circumcision services for the military population. Through support from the Ministry of Health and the GFATM, it is intended that male circumcision services be extended to the police, adolescent and adult men, and newborns. The USG intends to contribute to this support through the training of trainers, development of guidelines, monitoring and evaluation of the program.

In the 2005 Rwanda DHS, 5% of women and 2.7% of men reported having a sexually transmitted infection (STI), abnormal genital discharge, or genital sore or ulcer in the past 12 months. Of those who reported symptoms or an STI, 12% of women and 14% of men sought advice or treatment from a health professional. However, STI treatment services are not available in all health facilities. Through the Partnership Framework, the USG endeavors to support the role of the revised STI treatment guidelines and diagnostic capacity with an emphasis on reaching young people. In support of reducing HIV incidence in high risk and vulnerable populations, USG expects to complement the efforts of MOH through the GFATM by providing a comprehensive preventive package aimed at youth, men who have sex with men (MSM), truck drivers, commercial sex workers (CSW), uniformed personnel, and prisoners. Special attention was given to PLWHA, maximizing the opportunity for prevention when HIV-infected people access care and treatment settings. Prevention with PLWHA should be established as a standard of care for care and treatment programs. Finally, the USG intends to join with MOH and GFATM to support sensitization and structural interventions aimed at reducing immoderate alcohol use, gender-based violence (GBV), and HIV risk-taking behaviors.

1.2. Reduction of Mother-to-Child Transmission of HIV/AIDS

The Rwandan program has achieved excellent results in the prevention of mother-to-child transmission of HIV (PMTCT). In 2008, 304,232 women attended antenatal clinic (ANC) services. Among them, 97% accepted to be tested for HIV. Of the tested women, 99.3 % received their results. HIV prevalence among pregnant women in ANC settings was 2.9% in 2008. Among the HIV-infected pregnant women attending ANC, 82% received efficacious antiretroviral (ARV) prophylaxis. Seventy-six percent of HIV-infected women gave birth in a health facility, and 91% of infants expected to receive ARV prophylaxis were documented to have received it. By December 2008, 75% of health facilities were offering PMTCT services. However, challenges remain. The HIV infection rate at 6 weeks postpartum stands at 3.2%. This drops to 2.8 % at 5 months, but unfortunately rises to 6.9% at 18 months, demonstrating the role of HIV transmission through breastfeeding. PMTCT programs emphasize education in this area, but these programs are not currently available in every health center in Rwanda.

During the initial years of the Partnership Framework, the USG intends to support the development of guidelines and provide the necessary infrastructure to contribute to the GOR’s goal to provide PMTCT to all health facilities in Rwanda. Family planning services, a key component of preventing vertical transmission of HIV, should be strengthened through the Partnership Framework by supporting the four pillars of PMTCT: prevention of HIV in women, especially young women; prevention of unintended pregnancies in young women at risk of acquiring HIV, and HIV-infected women; prevention of transmission from an HIV-infected woman to her infant; and holistic support to the mother and family.

When women deliver in health facilities, they have ready access to PMTCT and emergency obstetric services before and during childbirth. Rwanda has made remarkable progress in promoting this practice. The number of deliveries occurring in health facilities increased from 28%, according to the 2005 Rwanda DHS, to 45% according to Interim DHS 2007. This progress can be attributed to many efforts, including the roll-out of community health insurance schemes throughout the country, and robust political will to reduce maternal mortality. The USG expects to work with other partners, such as the MOH, UNICEF and UNFPA to promote an increase in the proportion of mothers with access to PMTCT services at childbirth with the institutionalization of provider-initiated HIV testing during labor as a component of the strategy. In addition, the USG plans to support strategies to reduce HIV transmission through breastfeeding in accordance with GOR guidance. Finally, the USG intends to support the necessary referral systems and infrastructural and capacity development of referral hospitals and laboratories to provide early infant diagnosis in a timely fashion to all HIV-exposed infants in Rwanda.

1.3. Maintenance of low levels of blood-borne transmission of HIV/AIDS

HIV transmission through blood transfusion is not believed to account for many new infections in Rwanda (NSP HIV), as 100% of blood donations are systematically screened for HIV, as well as Hepatitis B, Hepatitis C and syphilis. In a continued effort to sustain low blood-borne transmission, the USG plans to provide technical assistance, commodities, organizational strengthening, and capacity building in the rational use of blood, blood products, and injections at all levels. The USG intends to continue to support the development and implementation of the GOR's donor notification policy. Finally, the USG seeks to continue to support programs on safe injections and the correct disposal of medical waste. Programs for post-exposure prophylaxis should also be supported.

2. Morbidity and mortality among people living with HIV/AIDS are significantly reduced

The GOR, in collaboration with international donors and implementing partners, has launched an ambitious response to the HIV/AIDS epidemic. A key element of this response has been the rapid scale-up of HIV care and treatment services. According to the HIV/AIDS Unit in TRACPlus, over 63,000 PLWHA were receiving antiretroviral treatment (ART) at the end of 2008. It is estimated that roughly 73,500 patients will be receiving ART at the end of 2009; taking the upper 97.5% confidence interval for the number of patients estimated to be eligible for ART (based on the <350 cells/µL criterion), this amounts to a national coverage of 76% (2009 HIV Epidemic Update, TRACPlus and CNLS). Only two middle income countries in sub-Saharan Africa (Botswana and Namibia) have achieved higher ART coverage, and they both use a lower CD4 eligibility threshold. As of the end of 2008, 5,635 Rwandan children were receiving ART. Similarly, the number of health facilities providing ART increased from 171 to 217 during 2008. Given that only 1% of ART patients are currently on second-line treatment, the USG intends to support the GOR efforts to increase detection of first-line treatment failure.

Partners plan to achieve this goal through the following three objectives:

- **Objective 2.1. People living with HIV/AIDS systematically receive opportunistic infection prophylaxis, treatment and other co-infection treatment according to national guidelines**
- **Objective 2.2. People living with HIV/AIDS eligible for ART receive it**
- **Objective 2.3. People living with HIV/AIDS receive care and support according to needs**

The following key policies have been developed in partnership with the Government of Rwanda and are planned to be implemented during the Partnership Framework to facilitate the achievement of these objectives: ART guidelines for adults and adolescents; ART guidelines for children; cotrimoxazole prophylaxis guidelines; isoniazid preventive therapy (IPT) guidelines; task shifting for ART; opioid pain management policy; community health worker (CHW) policy; retention and adherence promotion; and, facility-community linkage policy.

A comprehensive transition plan is in development which should define technical, financial, and logistic aspects of a transition process throughout the Partnership Framework timeframe, particularly for Track 1.0 clinical partners, Columbia University and AIDSRelief. These should be the first clinical partners to begin the transition. Robust monitoring and evaluation is expected to play a critical role in demonstrating the long-term sustainability of these programs, and should include a combination of routine data collection, on-going quality improvement, and special studies. Transition of financing and management of some clinical partner activities to the MOH is projected to commence in 2010.

2.1. People living with HIV/AIDS systematically receive opportunistic infection prophylaxis, treatment and other co-infection treatment according to national guidelines

After ART, cotrimoxazole (CTX) is considered the most important clinical intervention for PLWHA, demonstrated to reduced morbidity and mortality among both pre-ART and ART patients. The MOH/TRACPlus changed the national CTX guidelines in 2008; the USG intends to support the dissemination of the revised guidelines promoting universal CTX eligibility for all HIV-infected individuals. Other key priorities include supporting national data collection regarding CTX prophylaxis among PLWHA and prevention, diagnosis, and treatment of other non-tuberculosis (TB) OIs, such as cryptococcal disease.

According to TRACPlus, in 2008, 96% of TB patients were tested for HIV; 34% were HIV-positive. CTX was administered to 87% of TB-HIV co-infected patients. Overall, routine data regarding TB screening of HIV-infected patients are incomplete and suggest variable performance. A survey performed in 2008 indicated that overall, PEPFAR-supported sites were screening the majority of patients at the time of enrolment into HIV care and treatment services (TRACPlus, unpublished), however follow-up screening needs to be improved. The objective of TB-HIV collaborative activities is the establishment and expansion of “one stop services” where patients have access to a complete package of services for both HIV/AIDS and TB diagnosis and treatment. USG support includes initial infrastructure development (labs and referral systems), mentoring and supervision to clinical staff, expansion and improvement in screening and diagnosis of TB for HIV-infected adults and children, improved and integrated monitoring and evaluation, and improved TB case detection rates.

2.2. People living with HIV/AIDS eligible for ART receive it

In 2008, the MOH revised the clinical guidelines for ART for adults and adolescents including a transition to tenofovir (TDF)-containing first-line regimens. This new guideline is now being implemented.

In 2009, a USG-sponsored health economist performed an ARV costing analysis. Findings from this analysis suggest that increasing the rate of "switch to second-line regimens" may be more expensive overall than the transition to "preferred TDF-containing first-line ART". Appropriate "switch to second-line regimens" is currently hampered by the lack of identification of treatment failure and/or the lack of familiarity and comfort with protease inhibitor-containing regimens. The USG intends to continue to support the GOR in addressing these critical aspects of quality treatment during the Partnership Framework. In addition, the USG seeks to continue to focus on ensuring robust monitoring and evaluation of the impact of these routine changes to clinical guidelines.

Finally, the USG continues to promote patient retention in care (both before and after enrolling in ART) and adherence to ART, CTX, and other health-sustaining interventions through regular assessment and counseling. A key strategy is the development of linkage models between health facilities and community-based organizations, including PLWHA associations, volunteer groups, and community health workers. These linkages help to ensure the timely tracing of patients who miss appointments and thus maintain elevated rates of retention and adherence in HIV care and treatment programs.

2.3. People living with HIV/AIDS receive care and support according to needs

The USG has supported and intends to continue to support access to a broad range of basic care and support services, including clinical and non-clinical (prevention, psychological, spiritual, and social care services) interventions at both the facility and community level. Currently, the majority of prevention, care, and treatment services for PLWHA are provided in the health facility setting. Most USG-supported clinical partners have developed linkage models with community organizations to ensure promotion of retention and adherence. With the development of a national community health worker policy, the type and range of basic care and support interventions addressed at the community level has expanded. For example, some clinical partners have used their linkage models to ensure that key clinical interventions, such as TB screening, are addressed. Overall, provision of cotrimoxazole (CTX) for eligible adults and exposed infants (according to revised national guidelines which now define CTX eligibility for all HIV-infected individuals), adherence counseling, nutritional assessment and support, prevention counseling, including prevention for PLWHA, and referrals to facility-based care and support services, are promoted to varying degrees by these linkage models and other CHW programs. While social care services have been primarily provided through community-based activities, some clinical partners also provide patients with health *mutuelles* (a basic type of health insurance), transportation support, income generation through PLWHA associations, and linkages to food support.

Community health workers are coordinated from the health facility by a social worker that provides the technical background to link the beneficiaries with the services available. Prevention, psychological, social, and spiritual services in the community are provided through various Rwandan faith- and community-based organizations, and hundreds of PLWHA associations in 23 districts (out of 30). These services include home-based care for

eligible PLWHA, psychological support, spiritual support through church leaders and volunteers, advocacy and mobilization support to PLWHA associations, access to *mutuelles*, OVC services, access to legal services, and income-generating activities (IGAs). The USG also supports training and support of caregivers in communities, with special attention to the needs of women and older girls, as they are often the ones providing care. The USG supports a number of wrap-around programs with the President's Malaria Initiative (PMI), for provision of long-lasting insecticide treated bed-nets, Title II, and other programs in health, economic growth and democracy and governance in order to provide a broad package of services to PLWHA. Generally, a family-centered approach is encouraged for provision of all care and support services at every service-delivery level.

From the health facilities, teams of community health workers constitute the link between the health providers and the patients. The monitoring and evaluation (M&E) system used by the USG implementing partners facilitates an accurate and updated record of the patients who are expected to access HIV services for their regular follow up visits. This mechanism enables the community health workers to conduct tracing of treatment defaulters and optimize the patients' follow up and adherence to ART. During the period of the Partnership Framework, a central focus of clinical M&E systems is harmonization and integration, as described below in the Strategic Information section.

3. People infected and affected by HIV/AIDS have the same opportunities as the general population

According to the Rwanda 2008 Epidemic Update, the total estimated number of people living with HIV in Rwanda was approximately 149,000, including around 17,000 children. According to the 2005 Rwanda DHS, 28.6% of children under 18 in Rwanda are either orphans or made vulnerable due to illness among adult household members. It is estimated that nearly a fifth of these orphans and vulnerable children are infected or affected by HIV/AIDS.

A recent study[3] showed that around 20% of people living with HIV of either sex are unemployed and not working at all. 37.2% of respondents reported that they had been refused employment opportunities as a result of HIV status. According to the same study, over 40% of people living with HIV have been excluded from a social gathering in the past year, over 50% have been insulted or threatened, and over 20% have been physically assaulted. In each case, HIV status was perceived as being the cause of discrimination or abuse by the majority of respondents. In addition, 24% of respondents reported that their HIV status had caused their family to be discriminated against.

Rights violations can occur in the context of access to health services for people living with HIV. For instance, 13.8% reported that ART had been provided conditional on the use of certain forms of contraception. People living with HIV are particularly burdened by the costs of health care, with individual spending on out of pocket expenses related to healthcare averaging 20% higher among people living with HIV than among the general population[4]. The 2005 Rwanda DHS highlighted the inability of households with orphans to meet the costs of schooling. Children living in child-headed households were experiencing the greatest difficulties.

[3] HIV stigma index – preliminary findings

[4] Cited in: National AIDS Commission (Republic of Rwanda). *UNGASS Country Progress Report Period 2006-2007* (2008)

The impact mitigation goal is to ensure that persons infected and/or affected by HIV and AIDS have the same access to services as the rest of the community, and that being infected and/or affected by HIV/AIDS does not constitute a social, economic, or psychosocial barrier to accessing services. Impact mitigation targets people who are HIV positive, the families of PLWHA and also those who may not be HIV positive but who are affected by the virus, particularly orphans and other vulnerable children (OVC).

To achieve this goal, the Partnership Framework has directly adopted the goal of the NSP. The following objectives contribute to the achievement of this goal:

- **Objective 3.1. People infected/affected by HIV/AIDS have improved economic opportunities and social protection**
- **Objective 3.2: Promote nutrition and food security for HIV affected households**
- **Objective 3.3. Social and economic protection are ensured for orphans and vulnerable children**
- **Objective 3.4. Reduction of stigma and discrimination of PLWHA and OVC in the community**

3.1. People infected/affected by HIV/AIDS have improved economic opportunities and social protection

A key component of efforts to promote economic opportunities for associations of people living with HIV/AIDS is to increase their access to business support services (market information, accounting, financial management, business planning, inputs, technical production support and development). Over the past five years, the USG has assisted with the establishment and strengthening of associations of PLWHA. Through the Partnership Framework, the focus is expected to shift to assisting with the transition of these associations to the status of cooperatives. Similarly, the USG support provided to people infected and affected by HIV to engage in income generating activities (IGA) should now be directed to ensuring existing IGAs are competitive and sustainable.

3.2. Promote nutrition and food security for HIV affected households

Adequate dietary intake is critical to the health and well-being of PLWHA. Quantity and quality of food has an impact on vulnerability to opportunistic infections, nutritional status, and overall quality of life.[5] Within an agriculture-dependent country, climatic shocks have even greater impact on PLWHA. Chronic and transitory food insecurity prevents PLWHA from securing an agricultural livelihood, leading to moderate and severe malnutrition. The USG plans to support good nutrition practices through education and counseling in both clinical and community settings and provide training in improved agriculture techniques, and kitchen gardens, to promote food security in the target groups.

3.3. Social and economic protection are ensured for orphans and vulnerable children

The USG supports the GOR to ensure OVC are assisted to reach their full potential and have the same opportunities as all other children to active and valued participation in home and

[5] The World Bank, *HIV/AIDS, Nutrition, Food Security: What Can We Do. A Synthesis of International Guidance*, 2007

community life. As of March 2009, the USG assistance had reached an estimated 68,000 OVC with a minimum package of services, according to need.

In Rwanda, the Ministry of Gender and Family Promotion (MIGEPROF) is responsible for OVC support and for coordination with other ministries. The USG has been supporting a full-time position at MIGEPROF to assist in the coordination of the OVC program. This support is expected to be renewed with revised terms of reference to allow the activities undertaken by this officer to be transitioned to the MIGEPROF. The USG intends to also support strategies to strengthen districts in the identification of OVC, management of the OVC database, and monitoring of community OVC activities.

3.4. Reduction of stigma and discrimination of PLWHA and OVC in the community

Rwanda has conducted a stigma index survey which has been used to inform policy development and program planning. In addition, laws exist to protect individuals from discrimination for any reason. The PEPFAR program has supported OVC through implementing partners who directly provide a minimum package of services including community- and facility-based psychosocial support. Under the Partnership Framework, strategies should be put in place to ensure that responsibility for provision of services are transitioned to extended families, civil society organizations and the Government of Rwanda. The role of the USG is to build capacity for ongoing quality assurance and improvement to ensure services make a measurable difference in the lives of OVC. Complementary to the minimum basic package of services, the USG plans to support policy reform to guarantee the rights of OVC and PLWHA.

4. The human and institutional capacity of the public health system to plan, manage, and implement sustainable health programs is strengthened at all levels

A well-functioning health system provides the foundation for quality, sustainable HIV prevention, care and treatment services. While the Rwandan MOH demonstrates strong leadership, there is a continued need to strengthen the health system to sustain the response to HIV/AIDS. Through the Partnership Framework, the USG plans to support the health system strengthening goals outlined in the HSSP II. These goals also align with the World Health Organization's six building blocks for health systems: strategic information and research; human resources; financing and governance; infrastructure and geographical accessibility; health commodities; and quality of care. The Partnership Framework proposes to use recognized strategies to address the most critical system constraints in order to achieve programmatic goals and objectives, and complement the efforts of the GOR and other donors.

The following objectives of the fourth Partnership Framework goal are aligned with the HSSP II:

- **Objective 4.1. Evidence-based policies and plans developed, updated, monitored and evaluated, and a culture of research is promoted and inculcated**
- **Objective 4.2. The availability, quality and rational use of HRH is improved for better health outcomes**
- **Objective 4.3. The Rwandan health sector is sustainably and equitably financed, and managed efficiently and transparently**

- **Objective 4.4. Geographical accessibility of the population to health services is improved**
- **Objective 4.5. The (universal) availability and rational use at all levels of quality drugs, vaccines and consumables is ensured**
- **Objective 4.6. The highest attainable quality of health services at all levels is ensured**

4.1. Evidence-based policies and plans developed, updated, monitored and evaluated, and a culture of research is promoted and inculcated

Rwanda is at the forefront of many e-Health activities in East Africa. These achievements notwithstanding, the performance of Rwanda's national health information system remains constrained by an excessive number of routine health indicators, data of uneven quality, multiple electronic information systems, and the lack of use of information in decision-making, particularly at district and health facility levels. Further investments in data management infrastructure are needed to achieve a transition from a paper-based to an electronic health information system. The current health information system is also undermined by the weak capacity of human resources dedicated to monitoring and evaluation. Moreover, health information system development efforts need to be better coordinated and strengthened. Policy gaps to be addressed by the Partnership Framework include the lack of policy and guidelines on data sharing, confidentiality and security, and a policy and strategy on health research to be further outlined in the Partnership Framework Implementation Plan.

In a draft M&E policy and strategy, the MOH recognizes that the ultimate goal of the national health information system is to facilitate and ensure the effective use of information in order to improve the health system's performance and health outcomes. The promotion of evidence-based and results-oriented decision making in the health sector is crucial for improving the capacity of the GOR to respond to the HIV epidemic in an efficient manner. The development of a cadre of highly skilled M&E professionals and biostatisticians for the health sector is a priority in the national strategy. The USG is strongly supportive of these efforts while being mindful of the importance of addressing organizational and behavioral determinants of information use, in addition to technical ones.

The reliance of the GOR on community health workers to increase the population's access to health services highlights the need to strengthen the structure and performance of the newly designed community-based component of the M&E system. In the provision of technical and financial assistance to the implementation of the national e-Health strategy, the USG should endeavor to minimize the gap between the requirements of IT systems and the realities on the ground.

The effectiveness of the national response to the HIV epidemic may also be improved by expanding the evidence base for planning through clinical, behavioral and operational research. However, local capacity to undertake research is limited by a dearth of skilled investigators in the health sector. The GOR's intention is to facilitate an atmosphere conducive to research by implementing a number of strategic interventions, including the establishment of a national coordinating body for health research within the MOH and the development of an HIV research agenda focused on national priorities. The USG is dedicated to assisting the GOR in building local capacity to review, evaluate, and implement research.

4.2. The availability, quality and rational use of human resources for health (HRH) is improved for better health outcomes

Human resources for health have been declared the priority for the next five years for both PEPFAR and the Ministry of Health in Rwanda. Successful transition of the USG-supported activities from USG implementing partners to the Ministry of Health depends upon the availability of sufficient numbers of skilled and trained health professionals within the GOR. Increased investment in people, processes, institutions and technologies is necessary to secure quality service delivery in a sustainable health system. The Human Resources for Health Strategic Plan (2010-12) was recently developed to provide a comprehensive plan to address the HRH objectives.[6] Through the Partnership Framework, the USG intends to address key identified bottlenecks, complementing the activities of the GOR and other donors.

Health workers in Rwanda are predominantly employed in the public sector. The GOR currently provides salary support for approximately 62% of these health workers (External Evaluation 2008). Regardless of the source of salary support, all health workers are accountable to the GOR and managed through the MOH mechanisms.

According to the *Ministerial Decree Governing the Functioning of and Working Relationship of Health Services in Districts* (October 2006), each district hospital should have four medical doctors and at least 20 nurses and other technical staff. Each health center should have one visiting doctor, seven nurses, one lab assistant, one social worker, and one *mutuelle* (community health insurance) representative. Currently, health worker performance assessments and evaluations are not systematically conducted and not all health professionals have clear job descriptions. The goal of the MOH is to post five specialists in each district: an obstetrician/gynecologist, pediatrician, surgeon, anesthesiologist and internal medicine specialist.

Critical specialists, such as public health nurses, dietetics and nutritionists, medical records administrators, and health system managers are currently trained outside the country. The Faculty of Medicine at the National University of Rwanda was only designed to train 30 students per year. Currently, over 100 students per year use the inadequate facilities. Nurse training has experienced major reforms in recent years, resulting in six recognized nursing schools and the introduction of a single, modular curriculum in 2007. Currently, most of the nurses in the health system are classified as A2 or A3, and thus have the lowest level of training. Since 2006, there has been an emphasis on upgrading nurse training to produce A0 and A1 nurses.

Currently, 80% of health care is provided in rural facilities, which are staffed by only 37% of the health professionals. A two-year bonding system currently exists to encourage newly graduated health professionals to consider rural posts, but there remains an imbalance between rural and urban deployment and retention. To increase geographic accessibility of healthcare the MOH finalized the *National Community Health Policy* in March 2007. The policy defines three types of volunteer community health workers (CHWs): *Agent de Sante Binome* (male and female community health worker), *Animatrice de Sante Maternelle* (traditional birth attendant), and *Agent de Sante Communautaire* (community health worker

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[6] With major restructuring of the Ministry of Health underway, including the proposed establishment of an integrated Medical and Health Sciences body, revisions to the strategic plan are anticipated.

specializing in HIV/AIDS and other care). The MOH recently completed training of 60,000 CHWs to serve within all 30 districts.

Through the Partnership Framework, the USG plans to support the HRH Strategic Plan goals. This support seeks to include the collection, analysis and use of information for GOR planning related to training needs, compensation packages, and staff deployment initiatives. These studies should complement the planned WHO forecasting study and seek to address the current lack of information required for human resources planning and management. Concurrently, professional associations should be strengthened to ensure that staff has clear job descriptions against which their performance can be evaluated and training needs identified, support the development of health care and workplace policies, and provide recommendations for improved working conditions and other retention strategies.

The USG intends to support key educational institutions to provide quality pre-service training in nursing, medicine, social work, public health management, field epidemiology and strategic information including strengthening regional linkages. In addition, innovative strategies for retention and attraction of trained health professionals from the Rwandan Diaspora should be co-developed with the MOH and Ministry of Education. In order to avoid the disruption of in-service training, the USG seeks to emphasize incorporation of modules into the pre-service curricula. Specific strategies to support educational institutions should be clarified more fully in the Partnership Framework Implementation Plan.

The USG intends to also support the MOH Human Resources Management Information System (HRMIS) to support data availability and use, and ensure that routine appraisal/evaluations are linked with performance based financing and the national Health Management Information System.

4.3. The Rwandan health sector is sustainably and equitably financed, and managed efficiently and transparently

The Rwandan health sector operates under the principles outlined in the Sector Wide Approach (SWAp); the USG has signed the SWAp but does not provide pooled funding. An increasing proportion of USG health funds are considered ‘on budget’[7] and all program activities are in line with the national plans. The Partnership Framework emphasizes this continuing trend. Financial reporting and accountability are an important component of a fully functioning health system. The provision of technical assistance proposed in the Partnership Framework to the financial units at central and decentralized levels are intended to assist the MOH to increase its ability to attract and manage direct donor and USG funding.

The percentage of the total GOR budget for health has increased from 8.2% in 2005 to 9.1% in 2007 (PER 2006-2007), translating to a rise of per capita government health expenditure from USD 6 to USD 11. Total health expenditure per capita had risen from USD 17 in 2003 to USD 34 in 2006.[8] The Ministry of Health is committed to redressing an imbalance favoring tertiary hospitals over rural centers and redirecting the focus from curative to preventive service delivery. The USG has provided funding and technical assistance for the National Health Accounts and National AIDS Spending Assessments which furnish the necessary expenditure data to support budgetary decision-making. In the next four years, the

[7] Funds are considered ‘on budget’ if they support the government sector, are in line with National Plans, use government procurement procedure and are in the control of the host government.
[8] NHA 2006

USG intends to provide the necessary assistance to strengthen the capacity of Rwandan nationals to conduct these financial reviews and assessments.

A social health insurance scheme (*mutuelles*) covers 68% of the population (I-DHS 2007.) Facility-based Performance Based Financing (PBF) was introduced nationally in 2006. PBF has since been extended to district hospitals and the central level Ministry of Health. PBF is a mechanism to pay for performance using set indicators and adjusted for quality of services. Since the introduction of PBF there has been a marked increase in both the quantity and quality of health care services delivered. Community-based PBF to benefit Community Health Workers is currently under development. The expansion of both mutuelles and PBF has coincided with an increased per capita utilization of curative care services from 0.54 in 2006 to 0.86 in 2008 and average general emergency referrals from 8 to 16 per month[9]. A system of identifying the poorest categories of individuals and families for selected services has been implemented nationwide. Through the Partnership Framework, support in planning, development of guidelines and training is proposed to complement other donor support to ensure robust sustainable systems. In addition, the mechanisms for financing the HIV indicators should be reviewed to allow increased government control.

4.4. Geographical accessibility of the population to health services is improved

Currently, 60% of the population lives within 5 km of a health facility and 85% live within 10 km (RDHS-III, 2005). The goal of the MOH is for everyone to have access to a health facility within one hour (walking) and for all health facilities to have access to electricity and safe water by 2012 (EDPRS). To achieve this goal, the GOR continues to invest in construction and rehabilitation. Since 2005, three new district hospitals and 14 new health centers have been constructed or rehabilitated along with district offices as part of the decentralized approach to health care management. The GOR through the MOH is planning to construct a National Public Health Laboratory that should adequately handle the ever increasing medical diagnostic demands of the country. While there is need for supporting construction of new health facilities, the USG plans to focus on the renovation of selected existing sites currently supported by the USG to allow for provision of HIV services including patient monitoring to ensure facilities meet the criteria developed for transition from partner support to the MOH management. Similarly the procurement and installation of equipment to meet basic standards of HIV care are expected to continue in the USG supported sites to pave the way for transition of these services. Transport capacity has already improved as 71 ambulances and 570 motorcycles have been distributed to the health facilities. To complement infrastructure development, the MOH has engaged in the recruitment and training of community health workers nationwide. Insufficient funding is a major challenge recognized in the HSSP II in improving geographical access (infrastructure, equipment and transportation). In addition, there are critical infrastructure development needs at the central level to improve institutional functioning.

While the majority of the USG-supported clinical sites have access to safe water and electricity, those that do not should be upgraded to ensure access to these essential resources. The exact number and support is intended to be further outlined in the Partnership Framework Implementation Plan. The GOR has secured pledges worth over $90 million in support of electrification of an additional 6% of households and all public buildings including health facilities. The parastatal electricity and water company plans to connect all health

[9] MoH, 2008. Annual report 2007 – Performance-based Financing in the Rwandan Health Sector.

facilities within 5 km of the grid, and Belgium Technical Corporation (BTC) intends to provide solar energy to 50 health facilities falling outside this radius. The USG intends to contribute to this joint initiative. Working closely with the MOH, BTC and GTZ, the USG also plans to support a sustainable maintenance strategy that includes innovative public-private partnerships. Once electrified, the potential for electronic health initiatives, including telemedicine, to address data collection and human resource challenges should be enhanced.

4.5. The (universal) availability and rational use at all levels of quality drugs, vaccines and consumables is ensured

In Rwanda, the quantification, forecasting, procurement and distribution of all HIV-related commodities are managed through the Coordinated Procurement and Distribution System (CPDS). This entity was established by the GOR with support of its partners to maximize the purchasing power of donor funds and ensure quality products through a centralized supply of ARVs and OI drugs. Within the CPDS, international donors, local and international implementing partners, and representatives of the GOR form the Resource Management Committee (RMC), to provide the highest level of decision making. The CPDS also includes committees for quantification and implementation.

The Partnership Framework aims to support GOR in its efforts to ensure availability and rational use at all levels of quality drugs, vaccines and consumables. To achieve this, USG's primary focus should be to strengthen coordination in the pharmaceutical sector through policy development, organizational framework development and central level capacity building. Emphasis should be placed on strengthening the procurement, distribution and storage of health commodities. USG further intends to build the capacity of district pharmacies and the decentralized laboratory network. The laboratory interests focus on injection safety, quality assurance and accreditation for the National Reference Laboratory. The Partnership Framework should assist the National Reference Laboratory to decentralize laboratory services to district hospitals and local health centers and to oversee the quality of laboratory services in the country. The NRL plans to expand the ability of laboratories to provide diagnostic testing for opportunistic infections, sexually transmitted infections and surveillance to support epidemiological investigations. Additional efforts in the Partnership Framework are to assist the NRL to build capacity for senior-level management of laboratory services to provide strategic leadership and ownership of laboratory programs. The pharmaceutical supply chain capacities should be addressed through support of district pharmacies, incorporating active distribution and establishment of the logistics management information system. The CPDS plan to be strengthened through technical support from implementing partners and management support by the GOR.

4.6. The highest attainable quality of health services at all levels is ensured

The Partnership Framework endeavors to emphasize quality of care. The Ministry of Health is engaged in the development of a number of strategies, including development of quality norms and standards, quality management (quality improvement, performance based financing and mutuelles), an accreditation process and a supervisory framework. The USG continues to support quality services through implementing partners, who conduct supervisory visits and mentor and coach health facility teams. During the Partnership Framework, the USG emphasis is intended to shift towards integrated supervision of health facilities. Furthermore, the USG plans to support the MOH in the development and implementation of a harmonized Rwandan model of quality improvement at the district and

central levels. The model should bring together core elements and best practices of current quality improvement models and be harmonized with existing quality and supervision initiatives (PBF, accreditation, supervisory framework and mutuelles). Inclusion of quality indicators in the routine HMIS and PBF systems is a key goal.

The MOH recognizes that community participation is an important aspect of quality assurance as it guarantees that patients' opinions are heard and that patient satisfaction with services is prioritized. The MOH seeks to ensure that community members are included in health facility quality councils, a patients' rights charter plans to be produced and regular satisfaction surveys are expected to be conducted. In turn, community involvement in quality management models should be at the forefront of the USG-supported approach. For long-term sustainability, the USG intends to support the inclusion of quality management modules in pre-service training for relevant health professionals.

Partners: Roles and Contributions

The Partnership Framework capitalizes on the GOR's exceptionally high level of health system ownership and determination to control HIV/AIDS. The CNLS is the national coordinating agency responsible for ensuring that all HIV/AIDS interventions in Rwanda are harmonized and aligned with national priorities and strategies. TRACPlus/Centers for Infectious Disease Control is responsible for the development of clinical HIV/AIDS treatment policies, guidelines, and research. As the Ministry of Health internally restructures these entities into the Rwanda Biomedical Center, these institutions may change names, but plan to continue to be at the forefront of developing policies and strategies as well as coordinating resources and activities. During the Partnership Framework, PEPFAR intends to strengthen the management capacity of the Ministry of Health to oversee and implement programs currently undertaken by PEPFAR-funded partners, and based on the MOH capacity and readiness, should transition discrete PEPFAR program activities to the GOR. PEPFAR also continues to partner with other Ministries that support HIV/AIDS including the Ministries of Education, Defense, Finance, Local Government, Youth, Justice, and Gender and Family Promotion.

The GOR actively fosters a system of shared strategic planning and implementation among its development partners. Health sector donors have signed a memorandum of understanding to align and harmonize their own planning, performance monitoring and review of activities in the health sector as part of a GOR strategy called the Sector-Wide Approach. While PEPFAR and GFATM are the largest donors in the health sector, other donors and multilateral institutions play important roles in combating HIV/AIDS and addressing other health needs. Over the next five years, the main donors and multilateral institutions contributing to the Rwanda health sector are expected to include: the Belgium Technical Cooperation; European Union; GTZ; DED; Netherlands Embassy; Lux-Development; SIDA; DFID; USG; Canadian Embassy; Embassy of China; GFATM, UNDP; UNFPA; UNHCR; UNICEF; UNAIDS; WFP; and WHO.

PEPFAR plans to continue to support the GOR's goal to extend ownership and empowerment to additional stakeholder groups, including provincial and local government agencies, non-governmental organizations, faith-based organizations, PLWHA networks, and the private sector. Civil society organizations should be important actors for the implementation of new strategies. The eight civil society umbrella organizations in Rwanda facilitate the

coordinated planning of HIV/AIDS interventions of their members in order to ensure a good coverage of the population by those interventions while avoiding duplication of efforts.

While there is a history of strong partnership to address HIV/AIDS in Rwanda, the Partnership Framework institutionalizes coordination surrounding PEPFAR funds and ensures sustainability of HIV/AIDS activities through enabling a strong Rwandan health system.

The following table (Table 1) specifies the high-level contributions anticipated from partners to achieve the Partnership Framework goals.

Table 1: Goals and Expected Contributions to the Partnership Framework

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
1. The incidence of HIV in the general population is halved by 2012					
1.1. Reduction of sexual transmission of HIV/AIDS					
1.1.1 Reduction of risky sexual intercourse	Coordinate and harmonize all prevention activities in Rwanda, including leadership of functional Technical Working Groups	Support comprehensive prevention in the general population	RCC: IEC/BCC activities targeting farmers and handicraft associations GF6: Expand and improve prevention and care of HIV/AIDS; training of clinic staff	Outreach to general population by comprehensive prevention programs	UNFPA: Provide technical and financial support to CNLS UNAIDS: Provide joint technical and financial support to World AIDS Day campaign at national and district level (Umuganda) FXB: Personnel and provision of HIV prevention sessions
	Reinforce HIV preventive activities among youth through youth-friendly centers	Support evidence based intervention in youth ages 15-24 (in and out of school)	GF6: BCC mass media and community outreach in schools and associations of PLWHA in 10 districts		KfW: Peer education IPC, supervision, BCC special events at youth centers
	Develop strategic plan for behavior change communication among youth		GF7: Peer education IPC, supervision, BCC special events at youth centers; training of peer educators at youth centers BCC mass media and community outreach by CHW		UNICEF: Provide technical and financial assistant to CNLS, MoH, TRAC Plus, NCDC, Vision Jeunesse Nouvelle, FBOs, CSO, Handicap International for youth prevention

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
			14 Youth friendly services and 4 centers for gender based violence victims		
	Target prevention interventions for military, CSW, truck drivers, MSM, police	Support targeted prevention intervention to most at risk populations (men in uniform, commercial sex workers, truck drivers and MSM)		Outreach to CSW and other vulnerable and most at risk populations	
	Plan and coordinate collection, analysis and use of HIV/AIDS data	Support data driven comprehensive prevention programs targeting emerging most at-risk populations		Coordination of Civil Society Umbrella Organizations	
	Expand couples CT nationally	Support couples CT		Promote awareness campaigns and facilitate linkages between NGO/CBO/FBO and health centers for couples CT	
	Expand prevention activities for people living with HIV/AIDS	Support interventions for prevention in PLWHA	GF6: BCC mass media and community outreach in schools and associations of PLWHA in 10 districts	Provide prevention services to people living with HIV including sero-discordant cohabitating couples	Lux Development: Funding for national expert to RRP+ program; training RRP+
	Support prevention interventions and follow-up for discordant couples	Support prevention intervention for discordant couples		Provide prevention services to PLWHA including discordant couples	
	Increase correct and consistent condom use in most at risk populations as well as the general population	Support interventions for increasing correct and consistent condom use in most at risk populations as well as the general population	GF6: Distribute condom kits; train CHWs and public sector providers on correct and consistent condom use	Promote the use of male and female condoms making them accessible for all populations	UNFPA: Condom procurement
		Procure and promote correct and consistent condom use	GF7: Procure, sell, and create national "guerilla" marketing campaign		

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
	Targeted CT for most at risk populations/youth	Target CT for most at risk populations/youth, including the mobile CT for difficult to reach/most at risk populations		Promote awareness campaign and referral for MARPs to health centers	UNICEF: Support national youth council for 3 youth friendly centers
	Implement finger prick technique in all testing programs	Support innovative testing approaches			
	Coordinate a response to gender, socioeconomic status, male norms, family communication, and violence	Support sensitization interventions communicating the link between alcohol use, GBV, and HIV exposure Support interventions that address gender norms, education opportunities for girls, and property and legal rights for women	BCC mass media and community outreach by CHW 14 Youth friendly services and 4 centers for gender based violence victims	Prevent HIV infections resulting from sexual or gender-based violence	
1.1.2 Reduction of susceptibility to infection through increased male circumcision	RDF continues military MC program, including TOTs, TOPs, community outreach, and M&E of program	Support male circumcision programs in the military and police		Community outreach M&E programs and sensitization for general population	
	Expand access to medically-safe male circumcision following WHO guidelines	Technical assistance to MoH for MC in the general population, including TOTs, guideline development, M&E of program	Sensitization for MC to general population through HCC		WHO: Support MoH in development of Rwanda-specific guidelines UNICEF: Provide technical and financial support for MC

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
	Provide funding for MC infrastructure, including equipment, and renovation and rehabilitation of health facilities	Provide funding for MC infrastructure, including equipment, and renovation and rehabilitation of health facilities			
		Support integration of male reproductive health services into MC program	GF7: Integration of reproductive health and HIV services in 182 health facilities supported by GFATM	Promote linkages of health centers and community for MC through awareness campaigns	Lux Development: Financial support to RH counseling
1.1.3 Reduction of susceptibility to infection through increased correct treatment of sexually transmitted infections (STI)	Implement policy and guidelines for STI screening and treatment	Support integrated HIV testing and STI screening and treatment		Promote the syndromic approach in diagnosis and quality treatment of STI	
		Support STI management in most at risk populations to prevent HIV transmission		Train MARPs in STI prevention	
		Support provision of youth-friendly STI screening and referral services			
1.2. Reduction of mother-to-child transmission of HIV/AIDS					
1.2.1 Transmission of HIV during pregnancy, childbirth and breastfeeding is reduced	Implement task shifting for nurses to provide triple therapy in PMTCT	Support integration of PMTCT services in health facilities in PEPFAR-supported districts	Extend PMTCT services to all non-PEPFAR-supported health facilities in the country		UNICEF: Provide technical and financial support for PMTCT services to TRAC, Districts, 8 PMTCT sites, Imbuto Foundation and 5 health centers
	Support activities aimed at reducing transmission of HIV during pregnancy, childbirth	Support activities aimed at reducing transmission of HIV during pregnancy, childbirth		Advocate for integration of PMTCT services in all health facilities not yet covered	Clinton Foundation: Support to Imbuto Foundation for family package program

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
	and breastfeeding nationally	and breastfeeding in all PEPFAR-supported facilities		Promote institutional deliveries to facilitate PMTCT programs Promote community-based follow-up of infants born to HIV-positive mothers	UNICEF: Provide technical and financial support to TRAC Provide HIV commodities through strengthening UNITAID support (UNTAID ends Dec 2010)
	Implement early infant diagnosis (EID) nationally	Support EID implementation in the NRL/CHUB and at PEPFAR-supported PMTCT sites			
1.2.2 HIV-positive women are empowered to take informed reproductive health decisions	Support HIV infected women with family planning services to prevent unintended pregnancies	Support family planning integration into HIV services to reduce unintended pregnancies in HIV-positive women	RCC: 101 health facilities GF6: 146 HF GF 7: Integration of PMTCT and reproductive health services NSA: Target: 500 health facilities (cover remaining gap) GF7: Integration of reproductive health and HIV services in 182 health facilities supported by GFATM	Integrate family planning program for HIV-positive pregnant women in PMTCT package	Millennium Village Project: Improving maternal and child health Lux Development: Financial support to RH counseling UNICEF: Provide technical and financial support for family planning services and empowerment
1.3. Maintenance of low levels of blood-borne transmission of HIV/AIDS					

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
1.3.1 Blood-borne HIV transmission in clinical environments is reduced	Build and maintain infrastructure (health facilities, labs etc)	Provide TA, commodities, organizational strengthening, and capacity building in the rational use of blood and blood products and rational use of injections at all levels		Promote the continued blood HIV transmission safety	Lux Development: Training and integration; International expert counseling
	Establish a rational blood use policy, guidelines for hemovigilance, and policy for Hepatitis B vaccine for all health care workers				
1.3.2 All Blood donated for transfusion is screened for HIV	Establish transfusion committees at all health facilities	Support the GOR's donor notification policy development and implementation		Promote the continued blood HIV transmission safety	
1.3.3 Blood-borne HIV transmission outside clinical environments is reduced		Provide infrastructure support for waste management			
2. Morbidity and mortality among people living with HIV/AIDS are significantly reduced					
2.1. PLWHA systematically receive OI prophylaxis, treatment and other co-infection treatment according to	Provide access (financial, geographical and social) to OI (particularly TB), STI and other co-infections prophylaxis and treatment according to need	Provide technical, capacity building, financial and logistical support for diagnosis, treatment, prophylaxis and monitoring of OIs	RCC: 101 health facilities GF6: 20 health facilities; TB case finding in 182 HF GF7: 121 health facilities and 58 TB treatment centers		

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
national guidelines			NSA: target :500 health facilities (cover remaining gap)		
2.2. People living with HIV/AIDS eligible for ART receive it	Provide universal testing of all age groups of the population	Support the provision of quality HIV testing and ART services at USG supported sites for all age groups	RCC: 101 health facilities GF6: 20 health facilities GF7: 121 health facilities and 58 TB treatment centers		
		Ensures quality follow up to maintain optimal levels of adherence to ART through regular updates of ART guidelines, defaulters tracing and initiatives to reduce the loss to follow up of ART patients	NSA: target :500 health facilities (cover remaining gap)		
	Increase the coverage and maintain the standards for quality of ART services	Provide resources for drop in centers and MARPS friendly services in USG supported districts			
2.3. People living with HIV/AIDS receive care and support according to needs	Provide psychosocial support including care and nutrition to PLWHA	Provide psychosocial support including palliative care and nutrition to PLWHA in USG supported districts	RCC: Home based care and community nutritional support through PLWHA associations linked to 101 HF	Provide psychosocial support to PLWHA including basic care	BTC: Psychosocial support/mental support
		Promotes linkages between HIV services and other care and support providers	GF6: Home based care through PLWHA associations and CHW linked to 20 HF		

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
		including supplemental food, legal assistance, access to mosquito nets, IGA, etc	GF7: IGA for PLWHA associations for better income and nutrition; support to CHW and linkage between HF and community for 182 health facilities NSA: Target: Nutritional and psychosocial support provided in 500 HF (cover remaining gap)		
3. People infected and affected by HIV have the same opportunities as the general population					
3.1. People infected/affected by HIV/AIDS have improved economic opportunities and social protection	Create a guarantee fund for cooperatives formed by people infected and affected by HIV	Support capacity building of people infected and affected by HIV		Develop entrepreneurship among people infected and affected by HIV	UNAIDS: Provide capacity development through technical and financial assistance of organizations of PLWHA and CBOs to program, implement, monitor and evaluate interventions
	Create partnership and alliances of cooperatives with financial institutions	Support the associations of PLHA to transition to cooperatives		Build the capacity of people infected and affected by HIV	
	Create links between industry and people infected and affected by HIV to access markets	Support IGAs of people infected and affected by HIV to become more competitive and sustainable			FAO: Provide training and TA to CBOs for development and implementation of IGAs for PLWHA
3.2. Promote nutrition and	Improve food production for PLWHA	Promote food security by supporting training in			FAO: Supply agriculture inputs to reinforce food

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
food security for HIV affected households	Increase agricultural skills	improved agricultural production and kitchen gardens for HIV affected households			security of PLWHA
	Create community nutrition programs based on the concept of positive deviance	Support good nutrition practices among people infected and affected HIV through education and counseling		Raise awareness of good nutritional practices among PLWHA	LUX-Development: Provide nutritional and social care to OVC and families WFP: [Provide goats to discharged PWLHA to improve nutritional status
3.3. Social and economic protection are ensured for orphans and vulnerable children	Improve management and coordination of the OVC program	Support a full-time position at MIGEPROF to assist in the coordination of the OVC program; Support districts in OVC identification, database management, and monitoring of community OVC activities	Provide technical support to MIGEPROF for community-based OVC planning and service delivery to enhance appropriate targeting and sustainability	Improve OVC identification and coordination	UNICEF: TA and financial support to district authorities to coordinate the OVC minimum package and National Plan of Action
	Develop guidelines to operationalize the OVC minimum package of services	Support the provision of sustainable and age-appropriate services to OVC	Expand access of OVC to education and vocational training, health insurance, and Early Childhood Education (ECD) in 10 districts	Provide a menu of essential services to OVC	UNICEF: Support 3 CBOs to model the implementation of the minimum package of services
	Coordinate the development and implementation of OVC quality standards	Support quality assurance and improvement to ensure services make a measurable difference in the lives of OVC		Mainstream quality standards in OVC service delivery	UNICEF: TA and financial support to PLHA organizations and CBOs for training interventions focusing on children
3.4. Reduction of stigma and discrimination of PLWHA and	Review existing laws to ensure the rights of OVC and PLWHA	Support policy reform to guarantee the rights of OVC and PLWHA		Advocate for adoption and enforcement of laws to protect the rights of OVC and PLWHA	

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
OVC in the community	Ensure the accessibility of legal aid services to people infected and affected by HIV	Support capacity building of community and facility-based providers of psychosocial support		Raise public awareness of the rights of OVC and PLWHA Provide social support to OVC and PLWHA	
4. The human and institutional capacity of the public health system to plan, manage, and implement sustainable health programs is strengthened at all levels					
4.1. Evidence-based policies and plans developed, updated, monitored and evaluated, and a culture of research is promoted and inculcated					
4.1.1 Develop and adopt a standardized planning and M&E framework and tools for national and district levels	Lead and coordinate the development and adoption process	Provide technical and financial support for the strengthening and harmonization of the health management information system at all levels	Support to the strengthening of the M&E system (RCC, Rounds 6 and 7) Cover funding gap for M&E component of NSP (NSA)	Collect and report data on CSO activities	
	Gradually assume the responsibility for funding salaries of data managers	Fund data managers at USG-supported health facilities	Fund Data Managers at GF supported health facilities		
4.1.2 Implement the national e-Health strategy	Lead and oversee the implementation process	Provide technical and financial support for the development of some electronic health information systems			
4.1.3 Develop and apply a data sharing policy	Lead the development and application of the policy	Participate in policy development		Participate in policy development	

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
4.1.4 Develop a national data center that links to health data warehouse	Lead the development process and maintain data warehouse	Provide technical and financial support for the development of data warehouse	Provide financial support for the development of national data center		
4.1.5 Develop and maintain a community-based information system and link it to the facility-based information system	Steer the development process	Provide technical and financial support for system development and roll-out		Maintain the information system	
	Maintain the information system				
4.1.6 Build appropriate health information and communication infrastructure nationwide	Specify needs and coordinate support	Support the improvement of IT infrastructure at MOH, TRAC Plus, CNLS and health facilities		Maintain the information system	
4.1.7 Develop and apply data quality assurance mechanisms	Provide stewardship and coordinate efforts of stakeholders	Provide technical and financial support for these processes			
4.1.8 Establish an M&E Unit and a documentation center for OVC activities	Provide office space	Provide technical and financial support for the establishment of an M&E Unit for the monitoring of OVC activities		Strengthen civil society umbrella organizations M&E and documentation of OVC activities	

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
	Integrate M&E staff into MIGEPROF structure after two years	Support the establishment of a documentation centre for OVC related activities at the national level			
4.1. 9 Develop and implement a national plan for the promotion of data use in decision making	Lead the development process, carry out planned activities and monitor implementation	Provide technical and financial support for these processes		Participate in monitoring and evaluation of the HIV/AIDS response and the PF	
	Strengthen linkages with PBF, Quality Improvement and Supervision within MOH	Support efforts to improve the capacity of central and local governments, and of umbrellas to manage data and use it for decision making		Hold GOR and development partners accountable	
4.1.10 Develop and implement a policy and strategy to support health research	Lead the development and application of the policy and strategy	Participate in policy and strategy development		Participate in policy and strategy development	
	Organize annual national conferences to disseminate research findings	Provide technical and financial assistance for implementation			
4.1.11 Establish and support a national coordinating body for health research within MOH/Rwanda Biomedical Center	Establish national coordinating body			Participate on the national coordinating body for health research	
	Provide technical and management support for protocol development, study coordination, research ethics, statistical support, data collection and analysis, and research writing				

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
4.1.12 Build capacity of national health institutions in scientific research, and conduct research	Conduct studies, surveys, and clinical research	Build capacity of TRAC Plus, NRL, MOH and any other appropriate GOR body to train investigators who meet international standards	RCC: Support operational research at TRAC Plus on different preventive and curative interventions (CT, PIT, PMTCT, STI treatment, ART adherence and outcomes)		
		Train Rwandan institutions and investigators in scientific and operational research methodologies	GF7: Operational research on integration of HIV and reproductive health services		
		Support national-level studies, surveys, and targeted clinical and/or operational research in health	NSA: Operational research on innovative intervention strategies for MARPs, for discordant couples, for male circumcision, and other new approaches developed in NSP		
		Build capacity of Rwandan investigators and institutions in the preparation of scientific reports, abstracts, presentations, and manuscripts for submission to peer-reviewed journals and national and international conferences	NSA: Support the development of a national research agenda and cover gaps to ensure implementation of research priorities and utilization of results		
		Train Rwandan institutions and investigators in international standards for research ethics and human subject protections			

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
		Mentor Rwandan investigators and institutions to improve technical and ethical review processes for scientific protocols			
4.1.13 A culture of research is promoted	Abide by international standards of research ethics, data sharing, and publication	Abide by national and international standards of research ethics, data sharing, and publication			
	Provide an enabling environment for clinical and operational research and survey activities, including timely research administration and approval processes, development of a national research agenda, setting of research priorities, and use of research results to inform program decisions				
	Develop national standards of research ethics, data sharing, and publications				
	Create a supportive environment for clinical and operational research and survey activities				

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
	Establish and support a national coordinating body for health research within MOH/Rwanda Biomedical Center				
	Establish dedicated Research units within MOH and RBC for adequate technical and management support at central and decentralized levels, including protocol development, study coordination, research ethics, statistical support, data collection, and analysis, and research writing				
	Develop a policy and strategic to support effective, ongoing health research				
4.2. The availability, quality and rational use of HRH is improved for better health outcomes					
	Support 62% of health worker salaries	Support assessments and surveys in training needs, health worker labor markets, workplace policies and working conditions	RCC: Support key positions in central coordination bodies (TRAC+, NRL, UPDC, CNLS, RRP+) and health care workers positions in 101 supported HF	Advocate for capacity building in various areas of organizational development	Kfw, SDC, DFID: CDPF support
	Manage health human resources recruitment and deployment				Kfw: Staff salaries
					PIH: Staff salaries, CHW incentives
	Organize performance appraisals for all health professionals	Support development of policies through professional associations			BTC: Performance policy
					Lux: HR management training

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
	Continue to redress the imbalance in health workers between rural and urban health facilities Provide pre-service training for all cadres of health worker	Support development of HIV workplace policies Improve working conditions for health personnel			Save the Children UK: district health team training AIDS Healthcare foundation: salary support WWHPs: salary support WHO: nursing code of conduct IRH: staff salaries GTZ: support to HR TWG Columbia: HR mgmt training UNAIDS: Policy dissemination
			Round 6: Additional staff for CT/PMTCT services in 60 HF and for ART services in 20 HF	Participate in the review of the HRH plan	
		Support key educational institutions (including infrastructure) to provide pre-service training in nursing, medicine, social work, public health management, field epidemiology and strategic information Support innovative strategies for retention of graduates Support the inclusion of in-service training modules into pre service curricular, conducting a review of	Round 7: Additional staff for HIV services (CT, PMTCT, ART and reproductive health services) to ensure comprehensive services in 121 HF	Advocate for CSOs and FBO health facilities in management tools for HRH	GTZ: training in general nursing, health informatics, general surgery, ultrasonagraphy, anesthesiology, surgical nursing, health facility management and accounting, training of nurses in GBV, Mental health WWHPs: medical trainings, CHW trainings CAHO and UK Friends: scholarships World Vision: CHW training

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
		curricula as appropriate Support the inclusion of English language and IT training for teaching staff and students			Millennium village: capacity building
		Support to the MOH, to use HRMIS to improve HR management Support the development of modules on data analysis and use, and quality management for pre-service training institutions of health professionals	NSA: target: comprehensive HIV services in 500 HF; provide additional staff for remaining gap	Develop an appropriate compensation package for HRH	
4.3. The Rwandan health sector is sustainably and equitably financed, and managed efficiently and transparently					
	Allocate US assistance within MTEF to increase the portion of USG assistance on budget (Funds are considered 'on budget' if they support the government sector, are in line with National Plans, use government procurement procedure and are in the control of the host government)	Ensure that all program activities are aligned with GOR National Plans Increase proportion of funding channeling through GOR and civil society structures Increase proportion of funding under direct control of GOR and civil society Increase proportion of funding using government procurement mechanisms			GTZ: Support to coordination of SBS and donor coordination, Joint Action Forum

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
		Support development of improved and innovative mechanisms for districts to generate, plan, manage and be accountable for funds Support strengthened financial systems, including improved planning, budgeting, and equitable, efficient use of financial resources at both the central and district levels Build capacity for MOH to conduct its own NHA and NASA	RCC: Support PMU staff for project management Round6: PBF for health care workers in 182 HF supported by GF	Design motivation strategies to avoid staff turn-over	Columbia/Earth institute: training in financial management and accounting GTZ: Training in management and accounting WWHPS: Management systems and processes UNAIDS: support for NASA
	Complete the Mutuelles Strategic Plan Use the supply channel to ensure that the poor are subsidized to access Quality of Care and avoid stigma and discrimination	Support completion of the Mutuelles Strategic Plan Conduct activities for community sensitization for need to pay Mutuelles by revenue categories Strengthen the link between health sector and ubudehe categories for Mutuelle premiums Conduct Mutuelles training for management staff in the capitation payment system	Round 5: Access to Mutuelles health insurance for vulnerable PLWHA and OVC	Provide input into the Mutuelles strategic plan	PIH: mutuelles support Gtz: Support to Fond Equite at hospital level, Mutuelle support at district level Save the Children UK: identifying financial and non financial barriers to health care, Mutuelles TWG and staff training CAHO: poor fund, indigent care ILO: support to computerization of mutuelles ubudehe

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
	Purchase non HIV indicators	Develop pre-service training modules for PBF for all relevant health professionals Co-design and reach consensus on a strategy to use civil society for counter verification of PBF evaluation	Round 7: PBF for HF manager and for CHW NSA: Ensure comprehensive PBF system for all HIV related activities in health sector		Gtz: Technical support to TWG PBF and CAAC, PBF Ruhengeri Rockefeller: PBF in districts study Lux: ACM PBF support
	Develop and approve a financial policy for MOH	Strengthen MOH capacity for cost reduction, revenue generation, and cost-sharing for services			SDC: TA to strengthen district JAWPs Save the Children UK: district team training GTZ: DSS , support to decentralization, medical library SDC: decentralized SWAP
4.4. Geographical accessibility of the population to health services is improved					
		Provide support to infrastructure development efforts in key areas: e.g. for scale up for male circumcision; expansion of training institutes for health professionals; infrastructure for medical waste management; coordination of central level planning; and improvement of central-level institutional functioning	RCC: rehabilitation of 101 HF for provision of comprehensive HIV services and 22 district pharmacies Round 6: rehabilitation of 60 HF for CT/PMTCT and 20 HF for ART services Round 7: rehabilitation of 121 HF for provision of comprehensive HIV services		Kfw: vehicle and equipment PIH: health facility construction, repair and running costs, patient transport fees, vehicle repair BTC: Rehabilitation of offices in Kigali Lux Dev: building and construction

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
			NSA: target: comprehensive HIV services in 500 HF Rehabilitation of existing HF not yet covered and contribution to building of 50 new health centers (proportion linked to HIV= 60%)		Save the Children: construct maternity blocks (Kirambo, Ntaruka, Gicumbi, furniture and health center/ post construction Rubaya) Millennium Village: construction of 3 health posts
		Support the development of specifications for all Health facility equipment, including energy equipment			BTC: TA in biomedical maintenance PIH: health facility communication, office equipment and computers and running costs UNICEF: rehabilitation and equipment for district hospitals MCH activities, NRL for EID Gtz: infrastructure and equipment support to health facilities (name) WWHPS: Facility renovation and equipment supplies DGIS-US$ 30m for on grid development ADB: $50 m towards energy distribution including health facilities and public buildings BTC: Solar electricity for 65 health facilities

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
					EU: Energy to public institutions through hydro power plants ($10m)
		Collaborate with MOH and other donors to establish a sustainable maintenance strategy for medical, laboratory and energy in all health facilities to include public-- private partnerships; Provide training in energy management for district managers; Provide energy to USG supported facilities not covered by other national programmes in line with national policy			Lux Dev: International hospital maintenance expert, logistic support and training to ACM, Spare parts ACM, maintenance tools, district hospital workshop, inventory of facilities equipment and infrastructure Gtz: training in handling of biomedical equipment, ACM biomedical maintenance capacity building, hospital generators; Biogas installation, Energy and water support Columbia /Earth: connecting 11 HC to water supply, tanks to store water
	Coordinate ambulance system management through SAMU Ensure effective emergency transportation of referral patients from the community and between health facilities			Support villagers in accessing services through door to door service delivery and referral/transport (stretchers) to the health facility	
4.5. The (universal) availability and rational use at all levels of quality drugs, vaccines and consumables is ensured					

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
	Strengthen coordination in the pharmaceutical sector through policy development, organizational framework development and central level capacity building	Support the mobilization of Active Distribution through technical support to the central medical stores, district pharmacies and health facilities	RCC: ART and laboratory consumables for 42,890 patients Support active distribution system (rehabilitation, equipment, staff and revolving fund for district pharmacies)		
	Strengthen procurement, distribution and storage of health commodities through finalization of procurement policies, plans and procedures for district and central level, including active distribution, local production of drugs and infrastructural upgrades	Support for district pharmacies Support implementation team for distribution in support of the Active Distribution initiative	Round 6: ART and laboratory consumables for 10,000 patients		
	Operationalize quality assurance for health commodities through registration systems for drugs and supplies, regular inspections and establishment of a quality control laboratory	Training and technical support in quantification, forecasting, supply planning and procurement of equipment, diagnostics and lab commodities; The purchasing of ARVs, OIs, rapid test kits and lab commodities Strengthen laboratory supply chain system	Round 7: ART and laboratory consumables for 24,000 patients Improve central storage at CAMERWA and train district pharmacists NSA: target: 116,100 patients under ART (91% of total need) Cover remaining gap for ART		
	Ensure rational use of health commodities through provision of tools for rational drug use, national pharmacovigilance system, and promoting rational drug use at community level	Support the establishment of National Pharmaceutical Quality Laboratory Technical support to the CPDS Support in establishing a			

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
	Operationalize LMIS of health commodities Promote use of secure and effective traditional medicines through policy development, documentation of good practices and capacity building for traditional healers	national pharmacovigilance system, and tools to assess the rational use of commodities Support drug safety and rational use of medicines Support for LMIS, including computerized LMIS and a Logistics Management Unit			
4.6. The highest attainable quality of health services at all levels is ensured					
	Development and implementation of a harmonized quality improvement strategy including quality norms and standards, quality management (quality improvement, performance based financing and mutuelles), an accreditation process and the supervisory framework	Support the development and national role out of one Rwandan QI model using best practices and core elements of existing models Support the role out of the QI model in all health facilities including community feedback component Technical assistance in the development of the accreditation system and ensures health facilities in USG supported districts adhere to the norms and standards	GF7: supervision of districts by central level RCC: Support central coordination bodies (TRAC+, LNR, CNLS, CAMERWA, UPDC, PMU) to strengthen their quality assurance system GF7: Strengthening QA system with addition of management staff at HF level and improving HIMS NSA: Ensure establishment of a comprehensive QA system covering preventive, curative and social mitigation		BTC: Provision of QA mechanisms in health in Kigali Gtz: support for laboratory standards and SOPs for laboratory services

Objectives & Sub-Objectives	Expected Contributions				
	National	USG	GFATM	Civil Society	Other Donors
		Support for development of the harmonized QM plan and integration of quality measures in the routine HMIS	interventions at health facility and community levels (cover remaining gap)		
		Assistance in publishing patients charter in USG supported sites (including IT development for soft copies), and continue to implement successful community approaches in quality improvement (e.g. PAQ)			
		Develop core modules and trains a core group of trainers (10) and district staff incorporating muddles into pre-service curricula of health professionals to include leadership and management modules			
		Support in conducting a baseline evaluation to monitor quality of care			

Management and Communication

The successful implementation of this partnership depends on effective joint governance, informed by collaboration and mutual respect. The governance system to manage the Framework builds on existing structures established for oversight of the national HIV response (PEPFAR Steering Committee).

Technical Oversight

To develop the Partnership Framework and Partnership Framework Implementation Plan, the PEPFAR Steering Committee (chaired by CNLS and co-chaired by the USG) convened national technical working groups (TWGs) in Prevention, Care and Treatment, Social Mitigation, Strategic Information, and Health Systems Strengthening. These TWGs included representatives of the GOR, the USG, civil society, and USG implementing partners. It is anticipated that these TWGs may be integrated into restructured Technical Working Groups that report to the Health Sector Cluster Group (HSCG). In addition, a smaller group of senior representatives from the USG, international donors, GFATM, Civil Society, and Ministries of Health, Education, Finance and Economic Planning, Youth, Justice, and Local Government was convened to review the draft Partnership Framework and discuss any final clarifications.

Annual reviews of the Partnership Framework and its supporting Implementation Plan are intended to be incorporated into national reviews, such as the 'Big Lines' meeting and the Joint Health Sector Review. In addition, the USG and the GOR anticipate conducting regular joint field visits.

Strategic Oversight

Strategic oversight is expected to be provided by the PEPFAR-GOR Steering Committee, with regular updates provided to the HSCG to ensure harmonization of USG activities with those of GFATM and other development partners.

Communication

A clear communication strategy needs to be developed to outline roles and responsibilities of the partners under this Framework. This includes responsibilities for internal and external coordination, e.g. communication within and between the GOR institutions and units, the USG agencies, implementing partners, and other stakeholders. Communication channels between the USG and the MOH should be described in greater detail in the Partnership Framework Implementation Plan.

Signatures

Minister of Health
Honorable Dr. Richard SEZIBERA
Chair of Social Cluster of the Government of Rwanda

19 June 2010
Date

i.o. Joseph GUMUYIRE

Mrs. Béatrice KAGOYIRE
President of the Network of People Living with HIV (RRP+)

19/06/2010
Date

U.S. Global AIDS Coordinator
Ambassador Eric Goosby
U.S. State Department

19 June 2010
Date