



IntraHealth International HIV/AIDS Clinical Services Program (HCSP) Gasabo, Gicumbi, Nyagatare and Rulindo Districts, Rwanda

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ACRONYMS

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral
CDC	Centers for Disease Control and Prevention
CDLS	district AIDS control committee
CITC	client initiated testing and counseling
COP	country operational plan
COP11	2011 country operational plan
CRS	Catholic Relief Services
CTX	cotrimoxazole
DBS	dried blood spot
DHSST	district health system strengthening team
DHU	district health unit
EmONC	emergency obstetric and neonatal care
FOG	fixed obligation grant
FP	family planning
GBV	gender-based violence
GOR	Government of Rwanda
HCSP	HIV/AIDS Clinical Services Program
HIV	human immunodeficiency virus
ICATT	Integrated management of childhood illness computerized adapted training tool
IGA	income generation activities
IHDPC	Institute of HIV/AIDS, Disease Prevention and Control
IMNCI	integrated management of neonatal and childhood illness
IUD	intrauterine device
MCH	maternal and child health
MOH	Ministry of Health
M&E	monitoring and evaluation
NRL	National Reference Laboratory
PBF	performance-based financing
PC	palliative care
PCR	polymerase chain reaction
PEP	post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	provider-initiated testing and counseling
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PSI	Population Services International
PwP	prevention with positives
RBC	Rwanda Biomedical Center
RH	reproductive health
SCMS	Supply Chain Management Systems
STI	sexually transmitted infection
TB	tuberculosis
TC	testing and counseling
TRAC Plus	Center for Treatment and Research on AIDS, Tuberculosis and Malaria
TWG	technical working group
USAID	United States Agency for International Development
USG	United States Government
WFP	World Food Program

INTRODUCTION

The IntraHealth International HIV/AIDS Clinical Services Program (HCSP) is a five-year, \$27.8 million program funded by the United States Agency for International Development (USAID) that reinforces Rwanda's health care system and expands access to HIV and AIDS clinical services in the Rwandan districts of Gasabo, Gicumbi, Nyagatare and Rulindo. IntraHealth implements this program in close partnership with the Center for Treatment and Research on AIDS, Tuberculosis and Malaria (TRAC Plus), the Institute of HIV/AIDS, Disease Prevention and Control (IHDPIC),¹ district health units (DHU), district AIDS control committees (CDLS), district hospital and health center staff, USAID, the Centers for Disease Control and Prevention (CDC), and other key stakeholders. During the period October-December 2011, we supported **93** subgrants designed to support health centers, hospitals and DHUs in achieving district and national objectives:

- **50** service delivery input subgrants: **41** to health centers; **1** to Miyove Prison; **4** to hospitals; and **4** to DHUs;
- **43** performance-based financing (PBF) fixed obligation grants (FOG): **40** to health centers; and **3** to hospitals.

An HIV and AIDS clinical services project by name, our work is strengthened by our commitment to palliative care (PC) and service integration, as well as the cross-cutting fields of reproductive health (RH) and family planning (FP), maternal and child health (MCH), nutrition, and gender, particularly services associated with gender-based violence (GBV). We collaborate directly with the sites we support to plan, implement, monitor and evaluate their activities.

Our technical and management staff participate in several technical working groups (TWG) of the Rwandan Ministry of Health (MOH), including the TWGs for HIV prevention, HIV care and treatment, tuberculosis (TB)/HIV integration, PC, FP, MCH, nutrition, gender and GBV, PBF, laboratory, community health, monitoring and evaluation (M&E) and strategic information, as well as the Steering Committee for Research in HIV/AIDS, the Children and HIV Steering Committee, the PBF Extended Team, the Quantification Committee and district-level Joint Action Development Forums. Such participation provides a forum for the HCSP to share lessons we have learned as well as learn from others. It also enhances our partnership with the MOH and aligns our work with Rwandan priorities.

¹ Formerly the National AIDS Control Commission

Table 1: Facilities and Services Supported by Subgrants and Fixed Obligation Grants

		Number of subgrants	PBF	Number of sites by service supported							
				TC	PMTCT	DBS	ART	PC	TB/HIV	FP/HIV	GBV
Gasabo District	Health Center	5	5	5	5	5	4	5	5	5	5
	Hospital	1	1	1	1	1	1	1	1	1	1
	DHU	1	-	-	-	-	-	-	-	-	-
Gicumbi District	Health Center/ Prison	16	16	14	14	14	7	13	13	16	16
	Hospital	1	1	1	-	-	1	1	1	1	1
	DHU	1	-	-	-	-	-	-	-	-	-
Nyagatare District	Health Center	12	10	9	10	10	6	12	12	12	12
	Hospital	1	1	-	-	1	1	1	1	1	1
	DHU	1	-	-	-	-	-	-	-	-	-
Rulindo District	Health Center	9	9	9	9	9	5	9	9	9	9
	Hospital	1	-	<i>District hospital support package only.</i>							1
	DHU	1	-	-	-	-	-	-	-	-	-
Total		50	43	39	39	40	25	42	42	44	46

PEPFAR PROGRAM AREAS

From October 1-December 31, 2011, the HCSP used funding from the President's Emergency Plan for AIDS Relief (PEPFAR) to support implementation of the 2011 Country Operational Plan (COP11) and assist the MOH to expand HIV and AIDS clinical service activities and capacity in TC, PMTCT, antiretroviral therapy (ART) services, clinical care, laboratory services, post-exposure prophylaxis (PEP) and prevention with positives (PwP). In this section, we present our clinical results as defined by PEPFAR II indicators.

Thanks to effective training coverage in previous years, our capacity building efforts concentrate on skills transfer and consolidation through refresher training, post-training follow-up and integrated supervision and mentorship. We conduct full training only when new service providers join the health facilities we support, or if we initiate support for new sites. Our achievement of certain training results may therefore appear low this quarter, but this does not reflect actual numbers of trained providers at the facility level.

Indeed, the HCSP works hand in hand with the sites we support. Our clinical services officers spend approximately 80% of their time alongside service providers and district supervisors, providing mentorship to ensure the transfer of skills and adherence to national protocols and guidelines. We use an integrated clinical checklist to strengthen

quality assurance and clinical service supervision that is consistent with Rwandan national guidelines and covers all program areas of the HCSP. This quarter, the HCSP senior technical advisor also began to develop a tool that communicates the most pressing clinical and data-oriented supportive supervision needs at a glance, for use by all program staff. Over the last few quarters we supported relevant TWGs to develop a standardized checklist for supportive supervision countrywide. We also contributed to the development of new TRAC Plus clinical mentorship guidelines that will be finalized in coming months.

The multidisciplinary team approach is another way in which we facilitate coordination, the application of best practices, and collaboration between our program, the sites we support and different services on-site. These teams have been successful in a number of health facilities, notably Kibagabaga Hospital, where members have developed a series of tools for interdepartmental and hospital-community referrals, and meet weekly to discuss how to ensure a holistic approach to care. Our technical staff participate in these meetings at other sites as well, and we will continue to support the few remaining facilities currently without multidisciplinary teams to establish them before project close.

Testing and Counseling

Table 2: Testing and Counseling Results

PEPFAR Indicator	Quarterly results				COP11 result to date	COP11 target	% of target achieved
	Oct – Dec 11	Jan – Mar 12	Apr – Jun 12	Jul – Sep 12			
Number of service outlets providing TC according to national and international standards	39				39	39	100%
Number of individuals who received TC for HIV and received their test results (including TB)*	35,619				35,619	134,900	26%
Number of persons trained in TC	26				26	78	33%

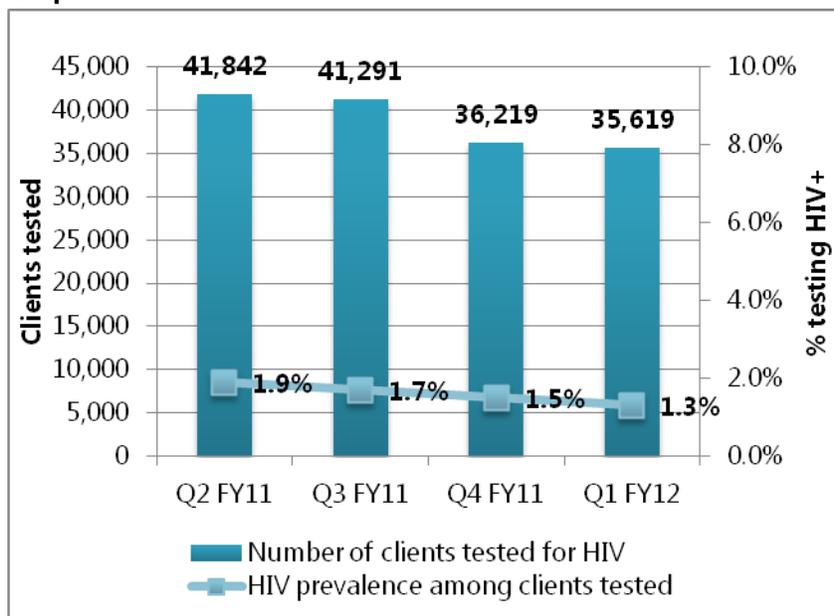
* Note that this figure does not include pregnant women tested in PMTCT.

TC is the entry point into care and treatment for people living with HIV (PLHIV). TC services on offer at HCSP-supported sites include pre- and post-test counseling; mobile TC; immediate referral of HIV-positive clients to the nearest treatment facility; TB screening; FP counseling; community sensitization; sensitization of PLHIV to encourage them to join PLHIV cooperatives and support groups; home visits to HIV-positive clients; and couples TC. Also, a family-oriented approach is necessary to test the whole family, especially children. While individuals aged 15 or older can either seek testing on their own or receive provider-initiated testing and counseling (PITC), testing children under

15 requires parental involvement. A family approach in all HCSP-supported sites ensures that parents or guardians who bring children for vaccinations or any other service are counseled and encouraged to consent to an HIV test for the child. And as is discussed below, all HIV-exposed infants are systematically tested for HIV.

Of **30,644** adults tested between October and December 2011, **410 (1.3%)** were found to be HIV-positive, while **54 (1.1%)** of **4,975** children tested were HIV-positive. All who tested positive were immediately referred and accompanied to care and treatment services in the same facility or, where ART services were unavailable, to the nearest ART service site.

Graph 1: TC and HIV Prevalence



Prenuptial consultation services are also available at the sites we support, including blood typing; sexually transmitted infection (STI) and HIV tests; physical exams; tetanus vaccines; and counseling on reproductive health, responsible parenting, gender equality and human rights. In November, **26** service providers received training to provide these services: 14 at Rubungo Health Center, which launched pre-nuptial consultation in December, and 12 at Jali Health Center. During this quarter, **1,016** couples received pre-nuptial TC services. Of these **2,032** individuals, **9 (0.4%)** tested HIV-positive. As well, **9 (0.9%)** couples were found to be sero-discordant and provided with additional counseling emphasizing the importance of condom use and family planning.

World AIDS Day on December 1 marked the first day of an annual three-month campaign against HIV/AIDS in Rwanda. We contributed financially to mobile TC services in the four districts we support, as well as through our subgrants for other campaign activities. A member of the national campaign steering committee, the HCSP helped to plan not only campaign events but also the launching ceremony on December 1 at National Amahoro Stadium. The slogan this year was: "Protecting oneself and others against HIV is everyone's responsibility. I choose to use condoms."

Since last quarter, the HCSP has participated in efforts led by the Rwanda Biomedical Center (RBC) to update trainer and service provider manuals with the latest information on finger prick HIV testing, and develop the national finger prick reference guide. We will remain involved until they are approved.

Next quarter the HCSP will continue to focus on supportive supervision; a family approach to HIV testing; PITC at all service entry points; community sensitization; and mobile TC services.

Prevention of Mother-to-child Transmission

Table 3: PMTCT Results

PEPFAR Indicator	Quarterly results				COP11 result to date	COP11 target	% of target achieved
	Oct – Dec 11	Jan – Mar 12	Apr – Jun 12	Jul – Sep 12			
Number of service outlets providing the minimum package of PMTCT services according to national and international standards	39				39	39	100%
Number of pregnant women with known HIV status, including women who were HIV-tested and received their results	5,872				5,872	28,028	21%
Number of HIV-positive pregnant women who received antiretroviral prophylaxis to reduce risk of mother-to-child transmission*	85				85	869	10%
Number of persons trained in PMTCT	16				16	78	21%

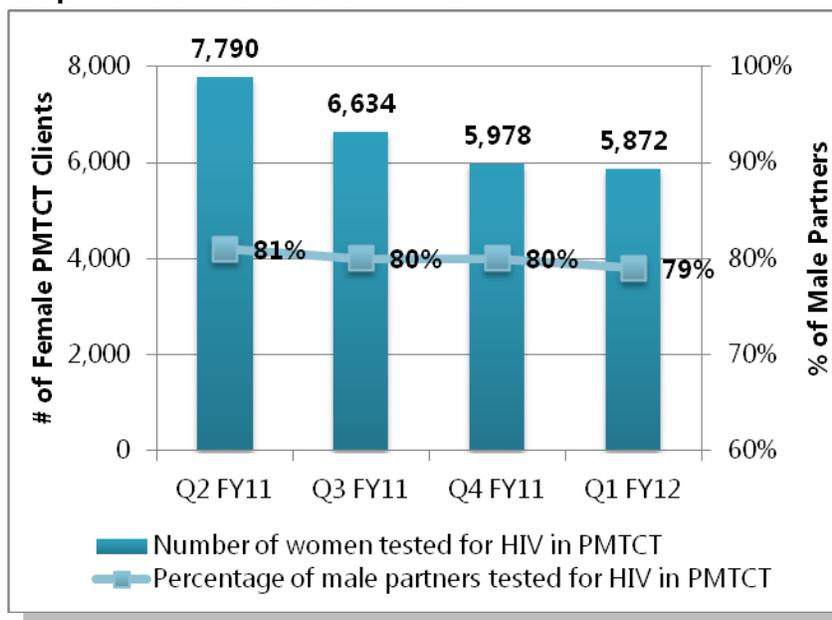
The prevention of HIV transmission from mother to child is a major focus of HCSP activities. We are committed to fortifying PMTCT activities at the sites we support and nationally with the aim to reduce not only mother-to-child transmission, but also morbidity and mortality among HIV-positive women and their partners. We continue to participate actively in the PMTCT subcommittee of the Prevention TWG, particularly in the review, revision and site implementation of national protocols, and development of targets and indicators for the national strategic plan to eliminate mother-to-child transmission.

All PMTCT sites that we support offer the full package of PMTCT services that consists of HIV TC; antenatal care (ANC); maternity and postnatal services; provision of antiretroviral (ARV) prophylaxis to infants and pregnant or breastfeeding women; FP counseling and

method provision; infant HIV testing and follow-up, including nutrition support; and home visits to women or exposed infants who missed their appointments.

When the new national PMTCT protocol took effect in November 2010, PMTCT stand-alone sites began to offer ARV prophylaxis and treatment to a much greater extent than they had before. The protocol calls for timely, effective treatment of pregnant women enrolled in PMTCT as well as their infants. To gauge success at the facilities we support, and move toward real-time monitoring of clients, this quarter we continued to refine our new PMTCT mother-infant tracking tools and database (further details are in the *Monitoring and Evaluation* section below).

Graph 2: Male Involvement in PMTCT



In total, we support **39** PMTCT sites. At these sites, **5,872** pregnant women knew their HIV status this quarter, including women who were tested and received their results in a focused ANC setting, which includes PMTCT. Of these women, **153 (2.6%)** were HIV-positive, counting 88 with previously known HIV-positive status. They received continuous counseling on infant feeding and were encouraged to breastfeed for 18 months.

Since the advent of the new PMTCT protocol, we have supported sites to phase out azidothymidine use in favor of triple therapy prophylaxis until weaning, or as lifelong treatment. This quarter, **85 (56%)** eligible HIV-positive pregnant women received triple ARV prophylaxis, and **68 (44%)** received triple ART for life. None received azidothymidine monotherapy.

This quarter, **146** HIV-positive pregnant women followed at the facilities we support delivered babies, with **139 (95%)** deliveries at an HCSP-supported site. Furthermore, **323** HIV-positive pregnant or lactating women received food and nutritional supplementation.

In collaboration with local authorities, PLHIV community volunteers, and the health facilities we support, we organized sensitization and education sessions for families of HIV-positive women enrolled in PMTCT services. The health facilities we support also encouraged routine testing of male partners of women receiving ANC or PMTCT services. This quarter, **4,630 (79%)** male partners of women receiving PMTCT services were tested for HIV. Of these men, **58 (1.3%)** were found to be HIV-positive, referred to treatment services and advised to join PLHIV cooperatives or support groups.

The HCSP will continue to ensure the correct application of the new national PMTCT protocol via joint supportive supervision and mentorship with the DHUs and district hospitals. While we have always stressed its importance, we are placing renewed emphasis on joint supervision with district supervisors as a means of transitioning supervision and mentorship responsibilities from the HCSP.

HIV Treatment and Antiretroviral Therapy Services

Table 4: HIV Treatment Results

PEPFAR Indicator	Quarterly results				COP11 result to date	COP11 target	% of target achieved
	Oct – Dec 11	Jan – Mar 12	Apr – Jun 12	Jul – Sep 12			
Number of service outlets providing ART	25				25	25	100%
Adults and children with advanced HIV infection newly initiating ART	188				188	1,460	13%
Adults	170				170	1,241	14%
Children	18				18	219	8%
Adults and children with advanced HIV infection receiving ART therapy	6,739				6,739	7,984	84%
Adults	5,988				5,988	6,786	88%
Children	751				751	1,198	63%
Adults and children with advanced HIV infection who ever started on ART	10,243				10,243	11,057	93%
Adults	9,013				9,013	9,399	96%
Children	1,230				1,230	1,658	74%
Adults and children known to be alive on ART 12 months after initiation of ART	279				279	1,435	19%
Adults	237				237	1,220	19%
Children	42				42	215	20%
Number of persons trained in ART	7				7	50	14%

The HCSP supports a total of **25** ART sites (3 hospitals, 22 health centers). Each of these sites offers a comprehensive ART package that includes HIV care and treatment, CD4

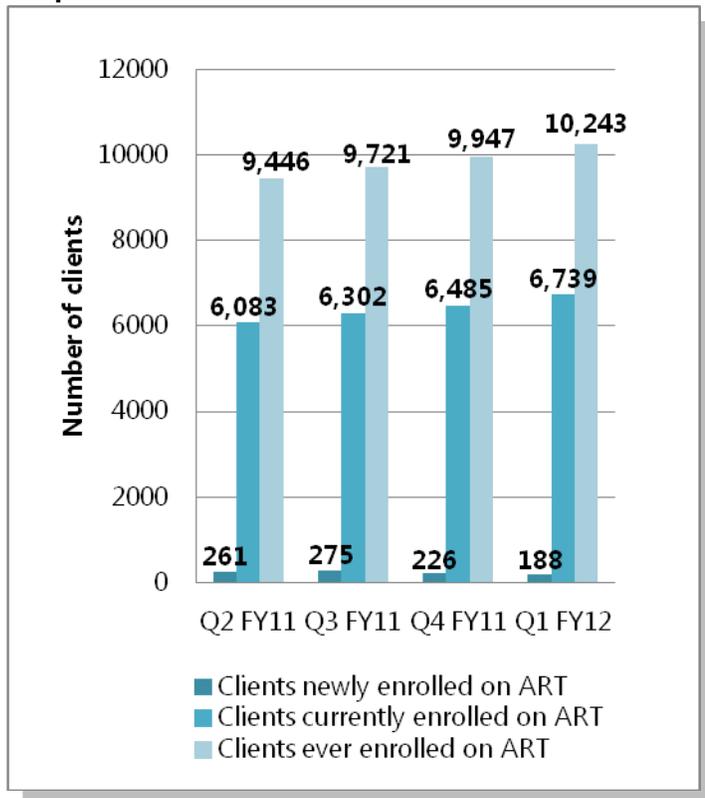
counts, clinical chemistry and hematology tests, clinical clearance testing and monitoring, and viral load tests at one year, while integrating TB, nutrition, PC, GBV, nutrition and FP services. This quarter, **7** service providers were trained in comprehensive care and treatment for PLHIV.

During this quarter, **170** adults and **18** children with advanced HIV infection newly initiated ART. At the end of this quarter, **5,988** adults and **751** children with advanced HIV infections were receiving ART. In total, **10,243** individuals have ever received ART at HCSP-supported sites, including **9,013 (88%)** adults and **1,230 (12%)** children under 15. Moreover, of the 316 clients who newly initiated ART from October-December 2010, **279** were still alive and on treatment this quarter at the sites we support. However, in calculating this figure, we are unable to determine how many new ART clients from quarter one in year four had since transferred to sites outside of our intervention zone.

The HCSP recognizes pediatric ARV treatment as a program priority. Currently, children constitute 11% of all clients on ARV at the facilities we support. While this is in line with national figures and the experiences of other partners in Rwanda, we wish to increase the number of HIV-positive children enrolled in treatment and encourage the return to care of more children lost to follow-up. With this aim, we emphasize PITC in pediatric and outpatient wards and all other service entry points, as well as family-centered services, peer support groups and collaboration with PLHIV cooperatives to sensitize communities on the services available to them.

In continuation of a series of mentorship visits begun last quarter, we also mentored physicians and ART nurses at each of the four district hospitals we support in care and treatment for adolescents living with HIV. Adolescence marks the transition from childhood to adulthood, and teenage clients have different needs and vulnerabilities than younger children or adults; it is also a time when they may initiate sexual activity.

Graph 3: ART Client Enrolment



Therefore, in our mentorship we emphasize the importance of TC for adolescents with unknown HIV status and a full package of RH/FP services integrated with adolescent care. MOH assessments have shown that it is common for HIV-positive adolescents to be unaware of their status even when they are on ART, signaling an extra challenge that service providers must overcome to offer quality care.

Next quarter we plan to examine the use of referral forms within and between the facilities we support. We are aware that frequent movement of HIV-positive clients between facilities creates documentation and monitoring challenges for service providers; it is particularly common for PMTCT clients to transfer from PMTCT stand alone sites to ART service sites. Our clinical and M&E staff will work together in supervision visits to ensure that referral forms are available, filled correctly, and utilized by service providers. As a result, we will not only ensure complete and accurate documentation of ART clients, but also strengthen referral systems at facility level.

Clinical Care

Table 5: Clinical Care Results

PEPFAR Indicator	Quarterly results				COP11 result to date	COP11 target	% of target achieved
	Oct – Dec 11	Jan – Mar 12	Apr – Jun 12	Jul – Sep 12			
Number of HIV-positive adults and children receiving a minimum of one clinical service	10,337				10,337	11,527	90%
Adults	9,437				9,437	9,698	97%
Children	900				900	1,829	49%
Number of HIV-positive persons receiving cotrimoxazole (CTX) prophylaxis	10,337				10,337	11,527	90%
Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	858				858	185	464%
Number of HIV-positive patients who were screened for TB in HIV care or treatment settings	10,337				10,337	11,527	90%
Number of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	34				34	185	18%
Number of infants—born to HIV-positive women—who received an HIV test within 12 months of birth	114				114	818	14%
Number of infants—born to HIV-positive women—who started CTX prophylaxis within two months of birth	128				128	818	16%

PEPFAR Indicator	Quarterly results				COP11 result to date	COP11 target	% of target achieved
	Oct – Dec 11	Jan – Mar 12	Apr – Jun 12	Jul – Sep 12			
Number of persons trained in any HIV service	33				33	90	37%

Clinical care includes not only ART services, but also other services such as integrated TB/HIV care; prevention and treatment of STIs and opportunistic infections, such as *Pneumocystis jiroveci* pneumonia; nutritional support and infant weaning; and care delivered by community volunteers to clients in their homes. During this quarter, **7** providers were trained in HIV-related clinical services.

Between October 1 and December 31, **10,491** HIV-positive adults (**36%** males and **64%** females) and **969** HIV-positive children (**48%** males and **52%** females) received a minimum of one clinical service at an HCSP-supported site. All of these adults and children received CTX prophylaxis.

A one-stop-service approach ensures that all clients co-infected with TB and HIV are able to receive both treatments in the same service area. During this quarter, **10,337** HIV-positive patients were screened for TB in HIV care and treatment settings, and **38 (0.4%)** tested positive for TB. Of these, **34 (89%)** initiated TB treatment. As well, **178** registered TB patients received HIV TC and results.

Last quarter, our field team leaders began intensive mentorship for hospital physicians in fine needle aspiration biopsy, a simpler, quicker alternative to open biopsy for the diagnosis of TB. At Byumba Hospital, **5** physicians and **1** laboratory technician were mentored in this technique this quarter, while **4** physicians and **2** nurses were mentored at Rutongo Hospital. Kibagabaga and Nyagatare hospital physicians were mentored in year four.

The HCSP does not collect data on the number of live births each quarter. Even so, as mentioned above, we know that **139** HIV-positive pregnant women followed at the sites we support also delivered at these sites. In total, **114 (82%)** HIV-exposed infants underwent dried blood spot (DBS) polymerase chain reaction (PCR) testing between four and eight weeks of age. Of those who received their results by the end of the quarter, **3 (2.6%)** tested HIV-positive and were referred for treatment and continuous follow-up. This quarter, **128 (92%)** infants were started on CTX prophylaxis at six weeks.

To enhance support to HIV-positive mothers and aid in tracking, testing and treating HIV-exposed infants, the HCSP supports health facilities to implement a community-based mother support program. Modeled after the work of the well-known South

African organization, Mothers2Mothers, our program engages HIV-positive mothers who received full PMTCT services in the past as lay counselors for other women, particularly new mothers receiving PMTCT services. In previous quarters, we trained 39 mother counselors to coordinate and manage peer support groups, adherence counseling, home visits, and the tracking of mothers or exposed infants lost to follow-up.

Palliative Care

PC is a key strategy to improve the quality of life of chronically ill patients and their families via a holistic care and treatment approach that addresses the physical as well as psychological, social and spiritual needs of a person. PC covers a range of services from pain management to bereavement support and, in this way, overlaps the clinical care and support care categories within PEPFAR II. With our partner Mildmay International, the HCSP ensured the provision of PC services to **11,475** PLHIV (**91%** adults and **9%** children) this quarter.

Our national-level PC activities advanced significantly this quarter. All district hospitals in the country have at least soft copies of the national policy documents, and all other health facilities we support have hard copies. We also hosted numerous meetings of the PC TWG and its specialized core group whose work this quarter concentrated on finalizing the national PC training curriculum and reference manual for service providers. In January, the MOH will base a training session for national PC trainers on these two documents. The HCSP will provide funding and technical support for this training session as well as for post-training mentorship, during which trainees are expected to begin integrating PC into the core services at their respective facilities: the five provincial hospitals, two hospitals at Rwinkwavu and Butaro supported by Partners In Health, and the university teaching hospitals of Kigali and Butare. Together, these 9 hospitals will take part in the first phase of integrating PC into all health services countrywide.

We also anticipate that next quarter a donor roundtable will be held to mobilize and commit resources for the two-year implementation plan, currently under review by the MOH.

This quarter the acting director of Kibagabaga Hospital, Dr. Ntizimira, successfully completed a course on PC at Harvard University. In recognition of the value Dr. Ntizimira's participation in this course contributes to national expertise in palliative care, the HCSP covered course tuition and travel costs. The course consisted of long-distance study with one week of classroom study at Harvard University in both April and November.

In December, the HCSP palliative care officer attended the International Conference on AIDS and STIs in Addis Ababa, Ethiopia, to present a poster showcasing impressive results achieved by the pediatric palliative care center at Kibagabaga Hospital during its first year. The poster documents a 148% enrolment increase between September 2009 and September 2010, as well as an increase in median CD4 count among clients from 784 (range: 45-2,129) to 929 (range: 335-2,703). In the same period, the number of malnourished children decreased from 7 to none, and the mean number of missed appointments in the preceding three months decreased from 1.9 to 0.6.

In light of its achievements, Kibagabaga Hospital mentors other health centers that we support, sharing best practices in PC and pediatric care. Last year, we stepped up our efforts to extend Kibagabaga's multidisciplinary, family-centered approach to all the ART service sites we support. We facilitated two-day mentorship visits by the Kibagabaga Hospital pediatric care officer, seconded by Mildmay, to other health facilities we support outside of Gasabo. She spent the first day at each facility working with managers and providers to establish multidisciplinary teams, support groups and pediatric wards or play spaces; strengthen home visits and family testing; and improve the tracking and referral of HIV-positive clients. She devoted the second day to training providers on status disclosure to HIV-positive children, role playing and questions. Our clinical services officers now follow up with these facilities to help them apply what they learned.

The HCSP also supported a number of psychosocial support events during the December festive season. Rubungo Health Center coordinated a weeklong holiday camp for HIV-positive children aged 7 to 16 where, in addition to enjoying games and dance, they gave each other peer support and shared personal experiences, guiding their service providers to maximize linkages between health facilities and schools. Kibagabaga Hospital organized two two-day camps for different groups of children aged 7 to 11, providing opportunity for peer support and a thorough check of their nutritional status. Through a partnership with an American organization, the children also received shoes and Christmas messages from American children the same age.

Adolescent HIV-positive clients at Kibagabaga Hospital aged 12 to 18 also benefitted from a week of training and exchange with members of the Kigali Hope Association/Young Positives, who passed on their skills in peer education and gave testimonials to the possibilities of success and good health while living with HIV. They also covered topics such as reproductive health, and protecting themselves and others.

On December 22, approximately 85 children and adolescents living with HIV from Rubungo, Rukozo and Muyanza health centers came with their families to join clients and families from Kibagabaga Hospital at La Palisse in Kigali for a Christmas celebration. The HCSP palliative care officer also liaised with key community organizations—the Kenya Commercial Bank, Christ’s Church Rwanda, and MTN—to arrange not only their attendance but their sponsorship of scholarships, *mutuelles* fees and other client needs. With Mildmay funds, we also contributed school materials to reward individual children for strong performance at school.

Nutrition Support

Proper nutrition is a central part of human health and greatly affects the health outcomes of PLHIV. For example, adequate nutrition is vital for PLHIV to both tolerate and fully benefit from ART. HCSP nutrition activities include developing service providers’ skills in nutritional counseling, providing materials needed for clients’ nutritional support, and even establishing kitchen gardens or IGA to benefit PLHIV cooperatives at our supported health facilities.

Among all HCSP-supported sites, **44** have established gardens, the one exception being Kibagabaga Hospital, which lacks suitable space to set up a garden. However, with HCSP financial and technical support, the hospital continues to implement a special nutrition education program that targets mothers enrolled in PMTCT services. Hospital staff also mentor health centers in establishing their own nutrition programs. In the long-term, Gasabo District and the hospital aim to extend the program to schools and other public institutions. In 2012, the other three districts we support will replicate this nutrition program.

As part of the Ibyiringiro Project led by Catholic Relief Services (CRS), the HCSP oversees complementary nutrition programs at **37** sites: **35** HCSP-supported PMTCT sites and **2** sites where PMTCT services are supported by the Global Fund (Rurenge and Matimba health centers). During this quarter, activities reached **641** HIV-exposed infants aged 6 to 18 months, as well as **149** pregnant and lactating women. In November, as part of Ibyiringiro activities, the HCSP nutrition officer participated in all steering committee meetings.

Safe water is also important to maintain good nutrition. While PSI leads water, sanitation and hygiene work, notably through the provision of SurEau, a water treatment product, the HCSP plays a role in sensitization, education and training. During nutrition education and PMTCT training sessions, we emphasized the importance of treating water with SurEau, and monitored health centers to ensure that they receive and use it in sufficient

quantities. We also emphasized good hygiene practices in the preparation and conservation of food as a means to prevent diarrhea, one of the main causes of malnutrition in Rwanda.

The HCSP provided financial support this quarter to IGA at **45** of the sites we support. Our nutrition officer also directly engaged with PLHIV cooperatives to support them not only in establishing gardens, but also in managing their IGA. Mushroom cultivation by the PLHIV cooperative at Karangazi Health Center enjoyed particular success this quarter following fungiculture training in October, organized with subagreement funds. For now cooperative members grow mushrooms as a food source, but they hope to expand into commercial sale soon; mushroom cultivation is new in the region and bears potential for success.

As of the end of this quarter, **8,679** PLHIV had kitchen gardens. All the gardens grow vegetables, and a small number have begun to produce pineapples and sugar cane. These activities have enabled PLHIV cooperatives at several HCSP-supported sites to open their own bank accounts, which have started to see increasing revenues. Thanks to their growing income, many PLHIV have begun to pay their own *mutuelles* fees.

In addition, we worked with the World Food Program (WFP) on the Food for ART program to provide support to malnourished adult and child ART patients. During this quarter, **836** ART patients were supported by Food for ART. Unfortunately, this was the final quarter of Food for ART, which was terminated by the WFP on December 31. The facilities we support are informed that there will be no further deliveries under this program.

We also concluded management and monitoring support to the **17** additional PLHIV cooperatives with whom we signed subagreements last year to implement nutrition-related IGA with funding from WFP. Twelve cooperatives completed their projects by the end of September, and the remaining five IGA ended in October.



The garden at Muhondo Health Center

Through our collaboration with other partners, such as CRS and the WFP, and our participation in national-level activities, the HCSP is at the forefront of the latest nutrition events in Rwanda. As part of our regular participation in the national nutrition TWG, we helped to plan the second national nutrition summit that took place November

22-23, and supervised during the national nutrition campaign from November 28-December 1. The HCSP nutrition officer was also certified as a national-level master trainer in the maternal, infant and young child nutrition counseling package, and will begin training district-level trainers in the four districts we support next quarter.

Laboratory

Table 6: Laboratory Services Results

PEPFAR Indicator	Quarterly results				COP11 result to date	COP11 target	% of target achieved
	Oct – Dec 11	Jan – Mar 12	Apr – Jun 12	Jul – Sep 12			
Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	45				45	45	100%
Number of lab personnel at HCSP-supported sites trained	0				0	45	0%

The HCSP supports laboratory services at the national, district and facility levels. Nationally, we participate in relevant TWGs and other groups to develop laboratory supervision tools and standard operating procedures, ensure training of national trainers, and assist the National Reference Laboratory (NRL) in other tasks. At the district level, we support laboratory trainings, orient district supervisors in the use of laboratory supervision tools and supervise them to ensure that the national protocol is followed. In the facilities we support, we provide supportive supervision to laboratory technicians to make certain that necessary skills, materials and equipment are in place, and that there is minimal turnaround time in receiving key laboratory test results.

In year four, to accelerate the procurement of essential laboratory equipment not yet available at certain facilities we support, we submitted to Supply Chain Management Systems (SCMS) a detailed list of all outstanding equipment, much of which had been requested in previous years. We have since been working with SCMS to facilitate procurement and install all equipment on site as it becomes available. In December, we installed hematology and biochemistry equipment at Bushara Health Center and provided special mentorship to their laboratory technicians in its use. All ART sites that we support now have biochemistry and hematology analyzers. We expect to receive more laboratory supplies next quarter.

In July, we received five 30 kva generators from Management Sciences for Health. This quarter we worked with the supplier, AZ Impex, to arrange for delivery and installation at Gisiza, Kigogo, Mukono and Kiyanza health centers. The fifth generator will be installed at Kabuga Health Center in January 2012.

In total, we support **45** laboratories with the capacity to perform clinical laboratory tests, including all tests necessary for HIV and AIDS clinical services. All facilities we support are trained to use the new HIV rapid testing algorithm, and all but one are trained in DBS collection for PCR.²

Our laboratory support officer trained **21** laboratory technicians and **17** nurses from Gatsibo District in post-vasectomy semen analysis at a one-week MOH-led session in Rwamagana and Gatsibo this quarter. Where vasectomy services are provided at facilities we support, 52 service providers are already trained in semen analysis. In turn next quarter, in collaboration with the MOH, we will train one laboratory technician and one nurse each in our supported Nyagatare and Gasabo facilities in semen analysis.

Also next quarter, we will coordinate the training of one laboratory technician per facility we support on biosafety and laboratory waste management, and sample transportation. Although we had planned to coordinate these training sessions this quarter, they unfortunately could not be arranged due to the unavailability of trainers.

Post-exposure Prophylaxis

Table 7: Post-exposure ARV Prophylaxis Results

PEPFAR Indicator	Quarterly results				COP11 result to date	COP11 target	% of target achieved
	Oct – Dec 11	Jan – Mar 12	Apr – Jun 12	Jul – Sep 12			
Number of persons provided with PEP	81				81	350	23%
Number of providers at HCSP-supported sites trained in PEP provision	7				7	90	8%

PEP is given when an HIV-negative individual is exposed to HIV, usually through occupational hazard or sexual contact. We ensure from the start that any new supported sites have the materials and skills necessary to administer PEP, and as a result all of the sites we support are currently able to do so. As PEP provision is integrated into our PMTCT, ART and GBV trainings, all unique individuals who received these trainings are also considered in our PEP reporting. During this quarter, **4** providers from HCSP-supported facilities were trained to provide PEP.

Between October and December 2011, **81** individuals were provided with PEP: **8** individuals were provided with PEP for occupational reasons and **73** for non-occupational reasons, including **40** survivors of sexual violence. Whereas the norm used

² Miyove Prison has not launched PMTCT services.

to be that health centers referred clients to district hospitals for PEP, HCSP-supported training on how to administer PEP has increased health center providers' comfort and skill in this area. Through sensitization, communities have also become more conscious of the need to seek PEP as soon as possible after exposure. With our technical assistance, the latest draft of national GBV service indicators includes a PEP indicator. As community awareness and health facility capacity grow, a greater number of HIV-exposed individuals receive this important prophylaxis.

Prevention with Positives

Table 8: Prevention with Positives Results

PEPFAR Indicator	Quarterly results				COP11 result to date	COP11 target	% of target achieved
	Oct – Dec 11	Jan – Mar 12	Apr – Jun 12	Jul – Sep 12			
Number of PLHIV reached with a minimum package of PwP interventions	10,337				10,337	15,425	67%
Number of service providers trained in PwP	7				7	90	8%

The HCSP undertook several PwP activities this quarter at all the health facilities we support such as risk reduction counseling; behavior change communication; monitoring and treatment of STIs; and testing and status notification of partners. All PwP beneficiaries, including partners in discordant couples, are documented in client registers on-site.

PwP interventions at Miyove Prison face a unique challenge: while VCT and TB screening services are offered onsite with possibility of referrals to access care and treatment, prisoners are not permitted to access FP services, including condom distribution, under government policy. This requires that service providers, with support from HCSP staff, be especially attentive in their counseling to HIV-positive prisoners' health risk behavior.

The number of service providers trained in PwP includes unique individuals trained in TC, PMTCT, ART and FP. This quarter, **7** service providers were trained to provide PwP services and **10,337** PLHIV were reached with a minimum package of PwP interventions.

OTHER PROGRAM AREAS

FP/HIV Integration and Maternal and Child Health

Table 9: FP and MCH Results

HCSP Key Indicator	Quarterly results				COP11 result to date	COP11 target	% of target achieved
	Oct – Dec 11	Jan – Mar 12	Apr – Jun 12	Jul – Sep 12			
HCSP-supported sites providing FP counseling and other services	45				45	45	100%
Number of women who attended their first ANC visit	5,754				5,754	28,028	21%
Number of deliveries attended by a skilled birth attendant	6,172				6,172	17,097	36%
Infants under 12 months who received DPT3 (Diphtheria, Pertussis, Tetanus) vaccinations	6,670				6,670	28,028	24%
Children under five who received Vitamin A	67,942				67,942	121,040	56%

In quarter one, we continued to provide technical, financial and logistical assistance to site-level FP trainers from Gasabo and Nyagatare—including facilities that do not receive our formal support—while they transferred FP skills to their colleagues through on-the-job training. In Nyagatare, **145** service providers were trained by site-level FP trainers, mentored by national trainers with assistance from the HCSP FP/MCH coordinator, and passed their final evaluations in December. All of these providers can offer short-term FP methods and insert Jadelle implants. In Gasabo, **95** service providers were trained by site-level FP trainers and will complete the practical component of their training in Jadelle and intrauterine device (IUD) insertion next quarter.

In light of evidence that clients throughout the country frequently have their Jadelle implants and IUDs removed prematurely, the MOH led a one-year retrospective assessment of long-term method use and motivational factors behind discontinued use. As requested by the MOH, we collected assessment data from 10 health facilities in Gasabo District in November.

The HCSP provided logistical and technical support to coordinate a one-day vasectomy sensitization campaign in Nyagatare District in December, after which the MOH led a training session for 12 physicians and nurses from Nyagatare, Kirehe and Kibungo hospitals. We printed and delivered training modules for this session.

Across each of the districts we support, **10,098** clients—including men having undergone vasectomy—used a modern FP method this quarter.

Community-based provision (CBP) is a key strategy to improve client access to FP counseling and methods, an important objective of the HCSP. Training in CBP began last quarter. Ultimately, trained community health workers will be able to provide a range of modern contraceptive methods, including birth control pills, injections, and male and female condoms.

In continuation of activities begun in Rulindo last quarter, **494** community health workers were trained in CBP of FP between October and December. In Gicumbi, we also oriented **21** site-level FP trainers on training manuals, supervision tools and data collection tools. An orientation meeting about CBP was held in October and attended by **75** local authorities, including the MOH community health supervisor, the director of Byumba Hospital, district personnel in charge of community health and many other representatives from the sector and facility levels. Shortly afterward in November, training for **630** community health workers began. Upon completion of the practical component of their training next quarter, successful community health workers will receive CBP kits from the MOH to facilitate service provision. Due to budgetary constraints, we will not conduct the same activities in Gasabo and Nyagatare districts, which are not included in the MOH CBP extension plan.

In November, we coordinated a 17-day training session for **16** service providers—5 from Gasabo, 4 from Gicumbi, 2 from Nyagatare and 5 from Rulindo—in comprehensive EmONC. These trainees, once certified next quarter, will qualify for consideration by their respective districts for further training to become district-level trainers. In the interest of sustainability, we plan to leave four EmONC trainers in place in each district we support before project close.

Also of note this quarter, our FP/MCH coordinator participated in a capacity building workshop hosted by the MOH and the World Health Organization in December, where she learned to use a computerized training tool known by its acronym, ICATT, which facilitates the adaptation of international guidelines on the integrated management of neonatal and childhood illness (IMNCI) for training. In addition to using ICATT to prepare future IMNCI training sessions, we will pass our knowledge of this tool to IMNCI service providers in the facilities we support.

Next quarter, we will collaborate with the MOH and national trainers to coordinate training in essential newborn care for service providers at all health facilities in Nyagatare. This training was completed in the three other districts last quarter, but was postponed in Nyagatare while on-the-job FP training was still ongoing.

Gender and Gender-based Violence

Table 10: Gender and GBV Results

HCSP Key Indicator	Quarterly results				COP11 result to date	COP11 target	% of target achieved
	Oct – Dec 11	Jan – Mar 12	Apr – Jun 12	Jul – Sep 12			
HCSP-supported sites providing GBV services	45				45	45	100%
GBV survivors who received care and support	287				287	450	64%
Health facility personnel trained in care and treatment of GBV survivors*	41				41	3,668	1%

* Note that results include service providers from facilities in our supported districts that do not receive direct HCSP support.

IntraHealth recognizes the importance of understanding the implications of gender in all our programs. In response to requests from our beneficiaries, we place particular emphasis on the care and treatment of GBV survivors. Our support for GBV activities can be categorized in four different ways: community sensitization; training and technical assistance to health service providers; strengthening service linkages between different institutions within the health and justice sectors, namely health facilities and the police; and national-level coordination in collaboration with the police, the MOH and the Ministry of Gender and Family Promotion.

Thanks to intensive training and supportive supervision, GBV services are well integrated into other clinical services at all **46** of the facilities we support, including even Rutongo Hospital, where we only provide a district support package, and Miyove Prison. All personnel at HCSP-supported facilities are trained to provide care to GBV survivors. Further training was held across all four districts this quarter for **41** health center personnel in charge of community health workers, who in turn began to train community health workers at their facilities in December.

Throughout quarter one, **287** GBV survivors received adequate care and support. Documentation of this care and support was facilitated by client registers with integrated GBV components at the sites we support.

In partnership with Nyagatare District, the HCSP supported the process of establishing a one-stop GBV service center at Nyagatare



Health center personnel in charge of community health workers who were trained in GBV

District Hospital. All staff are in place and trained. Equipment procurement and renovations concluded in October, after which time the center became operational. Four Nyagatare one-stop center staff (one physician, one psychologist, one nurse and one social worker) benefitted in October from an additional five-day training placement at Isange One-Stop Center.

After a protracted process, the MOH approved the contents of the national GBV kits in May. Once the kits are available at CAMERWA, we will obtain them for the sites we support. Furthermore, next quarter, we plan to print the information, education and communication materials developed as part of the PEPFAR Special Initiative on Sexual and Gender-based Violence, and recently revised by the GBV TWG, for dissemination among the facilities we support.

In addition, we provided technical and financial assistance to the anti-GBV committees in each of our supported districts to hold special coordination meetings to inform them about Nyagatare Hospital's new one-stop GBV services and their role in assisting GBV survivors to access them. We also worked with a total of 242 committee members to plan activities in honor of the 16 days of activism against GBV from November 25-December 10, such as general community sensitization and visits to homes that have been touched by GBV. We also participated in national 16 days of activism events, including providing logistical and financial support for the official closing ceremony that took place in Nyagatare District.

PERFORMANCE-BASED FINANCING

As of December 31, **43** PBF fixed-obligation grants were in force between the HCSP and the TC/PMTCT and ART sites we support: 17 grants in Gicumbi, 6 in Gasabo, 9 in Rulindo, and 11 in Nyagatare.

The HCSP continued to provide financial support to the DHUs in each of our four supported districts to facilitate coordination of PBF activities. In addition, we regularly participated in national-level PBF meetings such as those organized by the CAAC (*Cellule d'Appui à l'Approche Contractuelle*), the PBF extended team, the PBF TWG and district-level PBF steering committees. As a member of the PBF extended team, this quarter we contributed to the revision of community-level PBF indicators. Throughout this quarter, under the coordination of the district hospitals, we actively participated in the quantitative and qualitative evaluation of PBF indicators in each of the four districts we support, as well as hospitals at Ngarama, Kiziguro and Gahini. Evaluation results were

transmitted to the CAAC to prepare quarterly payments based on the quantity and quality of HIV services provided during this period.

Whereas payment for this quarter’s performance will not be made until February, last quarter’s performance scores are indicative of the latest performance trends. The lowest and highest quality scores per district are shown in Table 11.

Table 11: Most Recent PBF Performance Scores, July-September 2011

District	Lowest Quality Score (%)	Highest Quality Score (%)
Gasabo	77	97
Gicumbi	55	97
Rulindo	89	98
Nyagatare	78	90

Miyove Prison again received the lowest quality score in Gicumbi (55%) last quarter, but displayed considerable progress since the previous quarter when it was evaluated for PBF for the very first time and achieved 24%. At Rutare Health Center, we have provided focused support to the new health center director and worked closely with him and providers to address problems on-site, such as frequent staff turnover and a poor burn rate. There, the PBF score also improved, moving from 67% to 79%.

Nyagatare Health Center has made a conscientious effort to raise its quality scores in recent quarters, but remains with the lowest score in the district (78%). Nyagatare Hospital achieved a slightly better score (81%) last quarter. We have realized that part of the challenge lies in incomplete documentation of services provided. It is for the same reason, we believe, that Kibagabaga Hospital achieved the lowest score in Gasabo (77%) last quarter.

The highest scores last quarter were achieved by Kayanga Health Center in Gasabo (97%), Bwisige Health Center in Gicumbi (97%), Rukozo Health Center in Rulindo (98%) and Ntoma Health Center in Nyagatare (90%).

Whether an overall score is high or low, PBF evaluation data provide ample basis for open discussion with the facilities, and clearly identify areas needing improvement. They are an important source of information that we will continue to refer to in our final year as we strengthen our district-focused integrated supportive supervision and mentorship approach (further details are found in the *Sustainability* section of this report).

MONITORING AND EVALUATION

Since the end of August 2010, when TRAC Plus put in place new data collection tools and an upgraded TRACNet reporting system that incorporates TC/PMTCT data with ART data, we have intensified our training and support to data managers to ensure correct collection, management and reporting of service data. While we remain heavily involved in field activities such as post-training follow-up, troubleshooting and correcting reports with sites, we focus our mentorship on hospital data managers who, in turn, oversee and mentor their health center counterparts.

Our other efforts to minimize data management and reporting shortcomings include running error checks weekly on-site and monthly at the HCSP office, and reviewing data back-up files sent monthly from the health facilities. Also, since last quarter, our training database is fully functional. Variables captured include, but are not limited to: training dates and location; funding; program area; type of training (on-the-job, refresher or initial training); and trainer and participant identifiers such as name, sex, institution, occupation and telephone number.

We closely monitor facility-level clinical service data, ensuring their reliability and validity. Last quarter we identified the need to strengthen supportive supervision for M&E by integrating not only HCSP's clinical staff during routine M&E inspection, but also hospital supervisors, district supervisors and TRAC Plus. Responsibility shared among all stakeholders should improve the sustainability of best practices in data generation and management. We now ensure that M&E and clinical staff are together during all quality assurance and improvement visits to health facilities we support.

In year four, we began to address a specific challenge in monitoring PMTCT clients, both mothers and infants: health facilities report on cumulative numbers of clients receiving services rather than provide patient-level data linking mothers to infants—vital to monitor PMTCT service delivery and outcomes. Throughout this quarter, our M&E team worked with key program staff to finalize the HCSP's new PMTCT mother-infant tracking database that contains more than 30 patient-level data variables. New data collection tools were also developed. Variables captured include, but are not limited to: location; the mother's HIV serostatus, baseline CD4 count, and prophylaxis/treatment; and the infant's feeding method, prophylaxis, and HIV testing data. From January 2012, information will flow into the database directly from health facilities, via HCSP staff, to ensure real-time monitoring of clients.

Starting next quarter, the HCSP M&E team would like to coordinate sessions during district health system strengthening team (DHSST) meetings to orient DHSST members in how to take advantage of health service data in decision-making.

ENVIRONMENTAL MITIGATION AND MONITORING

The routine clinical activities supported by the HCSP produce an inevitable amount of waste, from biomedical waste to expired drugs and laboratory reagents. Last quarter, to limit our potential negative impact on the environment, we developed an environmental mitigation and monitoring plan and put it into immediate effect. The plan identifies activities to protect the environment, notably the proper disposal of biomedical waste, and training for health facility personnel on biosafety and waste management. We have integrated them into our overall year five work plan.

We also use a detailed safety and waste management checklist during supportive supervision visits at the sites we support. The checklist allows us to identify strengths and weaknesses at each health facility in mitigating environmental impact. At least two staff members from each of **45** health facilities we support are trained in waste management, and all facilities that we support have deep burial pits for biomedical waste. Throughout year five we will work with these facilities to ensure that all also have functional incinerators and a full stock of disinfectants, and follow timely procedures in the destruction of expired drugs.

In addition, as mentioned above, we will coordinate the training of one laboratory technician per facility we support on biosafety and laboratory waste management, as well as safe sample transportation.

OPERATIONS AND SUPPORT

Last year, we received a written request from the MOH to support four secondary health posts in Kicukiro District to provide modern FP methods. We agreed to allocate funds for the procurement of needed equipment and materials at the health posts. The procurement process began last quarter. Furniture was delivered in September, and medical equipment has been procured and should be delivered by the end of January.

The HCSP continues to see steady progress in the quality and accuracy of financial and grants management at site level. In reviewing facility reports each month, we notice improvement in compliance with administrative procedures such as procurement, and

only minimal errors. Our grants team collaborates with HCSP clinical services officers to provide supportive supervision in grants management.

SUSTAINABILITY

Throughout the life of the HCSP, IntraHealth has prioritized strengthening the clinical and management capacity of health workers as a means to enhance the quality of HIV and AIDS clinical services in the districts we support. Yet, as we begin the final year of the project, our capacity building efforts favor intensive mentorship over training in preparation for our eventual withdrawal from day-to-day oversight.

The HCSP transition team became operational with the start of year four. The team, composed of four clinical services officers and the field and transition team leader, is tasked with ensuring the smooth transfer of sites currently supported by the HCSP to the GOR. The exact process by which sites will be transferred has yet to be determined, and it is important that the GOR, USAID, IntraHealth and other USAID-funded clinical partners agree to a harmonized approach and common strategy.

In the meantime, we continued to strengthen our integrated supportive supervision and mentorship approach to build the capacity of district supervisors and ensure the sustainability of program activities. This quarter the HCSP technical team closely examined our supportive supervision planning processes and worked directly with district hospital supervisors to streamline planning and ensure joint supervision visits based on real needs as well as program priorities.

We are equally involved in planning and supporting activities with district-level institutions. For example, we participated in Joint Action Development Forum initiatives, including Gicumbi District's open day event on November 29-30. Moreover, our field and transition team leader serves as chairman of the Rulindo forum, whose open day will take place next quarter.

Indeed, the role of the district will be central to a successful transition. Last quarter, in line with the GOR decentralization policy and framework, the HCSP provided technical and financial assistance to each of the districts we support to launch their DHSSTs. Responsible for overall coordination of the district health system, each DHSST is composed of a core



The Rulindo DHSST meeting in November

team and an extended team. The core team includes the directors of the DHU, district hospital, district pharmacy and *mutuelles*, along with the CDLS technical assistant, one health center representative and two implementing partner representatives. The extended team includes the core team members as well as the vice-mayor in charge of social affairs, sector personnel in charge of social affairs, and all health center directors. DHSST meetings are held quarterly, and the districts are responsible to cover all costs. HCSP staff participated in each district's DHSST meeting this quarter. Going forward, the HCSP will work closely with each DHSST to strengthen district capacity in health system management.

HIGHLIGHTED CHALLENGES

In addition to the results and achievements described above, the HCSP and our partners managed some specific challenges during the quarter.

- **Delayed renovations at Gikomero Health Center after fire:** In collaboration with Gasabo District, this quarter we continued to address administrative formalities related to the renovation of Gikomero Health Center, which was partially destroyed in April 2010 during an accidental fire. Renovations began last year but were suspended after the company undertaking the work discovered significant underbudgeting by the district engineer. Last quarter, acknowledging the error, the district developed a new scope of work and new budget totaling Rwf 16,927,160. Because of the new, higher budget, we relaunched the tender process and, as of the end of this quarter, were still accepting bids from prospective contractors.



Current damage at Gikomero Health Center

- **Implementation of the national PC program:** Although our national-level PC activities are advancing well, the lack of a national PC coordinator still represents a major obstacle to supporting the MOH in operationalizing the national PC policy. This quarter, the MOH successfully recruited a candidate for the position. As of the end of December, we were awaiting ministerial approval for the candidate to assume the post.

- **Uncertainty over roles and responsibilities with regard to GBV one-stop centers:** The day before the launching ceremony of the one-stop GBV service center at Nyagatare Hospital, planned to coincide with the official close of the 16 days of activism against GBV, the Nyagatare district mayor postponed the inauguration until further notice. We understand that the delay is the result of a difference of opinion between the Rwandan National Police and the MOH regarding their respective roles and responsibilities in operating such centers. We will try to stay abreast of the latest news in this situation, as any subsequent decisions will influence our plans to establish a one-stop GBV service center at Byumba Hospital this year.

NOTABLE ACCOMPLISHMENTS

We achieved some significant accomplishments this quarter that merit special mention.

- **Improved data management and monitoring in PMTCT:** The HCSP's new PMTCT mother-infant tracking database represents a major systems improvement, the benefits of which should trickle down into clinical care. Tracking mother-infant pairs facilitates service delivery monitoring, which should reduce missed opportunities for treatment, ensure early initiation of prophylaxis and/or treatment, and improve morbidity among HIV-exposed infants. The system also facilitates tracing of patients as they enter and leave the continuum of care, including HIV-positive mothers who transfer in to seek care for their infants. Those who use the database will at any time access a current picture of PMTCT services being provided at facility-level, and will be able to follow-up as needed.
- **One-stop GBV service center at Nyagatare District Hospital open:** Following months of preparations—including equipment procurement, staffing, training and renovations—the one-stop GBV service center at Nyagatare Hospital became operational in October. To date, only three other such centers exist in Rwanda: the Isange One-Stop Center at Kacyiru Police Hospital, and the one-stop centers at Gihundwe Hospital in Rusizi District and Gisenyi Hospital in Rubavu District. We congratulate Nyagatare district and hospital personnel for their dedication to providing survivors of GBV with quality care.
- **HCSP keynote and poster at national pediatric conference:** The HCSP was an active member of the steering committee that spent months organizing the Seventh Annual National Pediatric Conference on Children Infected and Affected

by HIV and AIDS, held November 9-11. We provided financial assistance to the RBC for the conference and sponsored Dr. Miriam Chipimo from the Joint United Nations Program on HIV/AIDS in South Africa as one of four international keynote speakers. The points Chipimo raised during her engaging presentation on youth-friendly services in the move toward eliminating mother-to-child transmission of HIV by 2015—and during plenary discussions throughout the conference—generated vibrant debate and directly informed final conference recommendations. In addition, we presented a poster at the conference titled *Rapid results: implementing new guidelines for promising outcomes in the prevention of mother-to-child transmission of HIV*.



Dr. Miriam Chipimo at the 7th Annual National Pediatric Conference

- **HCSP presence at conferences abroad:** A number of HCSP abstracts were presented at international conferences this quarter. One abstract titled *New beginnings: Rwanda's first pediatric palliative care center at Kibagabaga Hospital*, was presented in a poster at the International Conference of AIDS and STIs in Addis Ababa, Ethiopia, in December. The same month, at the International Conference on Family Planning in Dakar, Senegal, our FP/MCH coordinator gave an oral presentation titled, *Family planning task shifting in Rwanda: Increasing availability of services by training nurses to insert intrauterine devices*. We also used Tides Foundation funds to finance MOH FP/HIV Integration Coordinator Dr. Anicet Nzabonimpa's participation in a panel at the same conference, where he presented on the Rwandan scale-up of FP/HIV integration strategies.
- **Year five activities and budget approved by USAID:** After several discussions and revisions, this quarter USAID approved our year five program documents—including costed work plans, operations and subagreement budgets, and international travel forecast.

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