



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

PEPFAR Quarterly Narrative Report: Q4, FY2011

July 1 – September 30, 2011

USAID/Rwanda

Cooperative Agreement No. 696-A-00-07-00112-00

Agreement Officer's Technical Representative: Esperance Mukamana



TABLE OF CONTENTS

ACRONYMS.....	II
INTRODUCTION.....	1
PEPFAR PROGRAM AREAS	2
Testing and Counseling	3
Prevention of Mother-to-Child Transmission	5
HIV Treatment and Antiretroviral Therapy Services	8
Clinical Care	10
Palliative Care	12
Nutrition Support	14
Laboratory	16
Post-exposure Prophylaxis	18
Prevention with Positives	19
OTHER PROGRAM AREAS.....	19
FP/HIV Integration and Maternal and Child Health	19
Gender and Gender-based Violence	22
PERFORMANCE-BASED FINANCING	23
MONITORING AND EVALUATION	25
ENVIRONMENTAL MITIGATION AND MONITORING	27
OPERATIONS AND SUPPORT	27
SUSTAINABILITY	28
HIGHLIGHTED CHALLENGES.....	30
NOTABLE ACCOMPLISHMENTS	31

LIST OF TABLES AND GRAPHS

Table 1: Facilities and Services Supported by Subgrants and Fixed Obligation Grants.....	2
Table 2: Testing and Counseling Results.....	3
Table 3: PMTCT Results.....	5
Table 4: HIV Treatment Results.....	8
Table 5: Clinical Care Results	10
Table 6: Laboratory Services Results.....	16
Table 7: Post-exposure ARV Prophylaxis Results	18
Table 8: Prevention with Positives Results.....	19
Table 9: FP and MCH Results.....	19
Table 10: Gender and GBV Results.....	22
Table 11: Most Recent PBF Performance Scores, April-June 2011.....	24
Table 12: Health Centers Included in September 2011 Data Quality Audit.....	26
Graph 1: TC and HIV Prevalence.....	4
Graph 2: Male Involvement in PMTCT.....	7
Graph 3: ART Client Enrolment	9
Graph 4: Enrolment and Care at Kibagabaga Pediatric PC Center.....	13

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
COP10	2010 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
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
RRP+	Rwanda Network of PLHIV
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 (IHDP),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 July-September 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 July 1-September 30, 2011, the HCSP used funding from the President's Emergency Plan for AIDS Relief (PEPFAR) to support implementation of the 2010 Country Operational Plan (COP10) 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.

As this is the fourth quarter, we also present our final annual results. In preparation for this report we thoroughly cleaned data from throughout the year. As a result, quarterly data contributing to certain indicators in previous quarters may have changed, or may not initially appear to correspond with annual results. This is the case for training indicators in particular, where individuals may receive training more than once in a year. The sum of training data from each quarter is often higher than our annual result. While our quarterly training data represent unique individuals trained per quarter, our annual training data represent unique individuals trained over the year.

However, 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 targets may therefore appear low this year, 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 working alongside service providers and district supervisors, providing mentorship to ensure the transfer of skills and adherence to national protocols and guidelines. In year three, we developed an integrated clinical checklist to strengthen quality assurance and clinical service supervision. Tailor-made for Rwanda, the checklist is consistent with national guidelines to ensure country specificity, and covers all program areas of the HCSP. We shared the tool with the MOH in hope that it will serve as a model for enhancing existing national tools. We also supported relevant TWGs to develop a standardized checklist for supportive supervision countrywide. Throughout the quarter we contributed to the development of new TRAC Plus mentorship guidelines that will be finalized in coming months. Together with the CDC and the Elizabeth Glaser Pediatric AIDS Foundation, we reviewed draft sections related to telemedicine and private practitioners, integrating comments from TRAC Plus.

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, and we will continue to support facilities currently without multidisciplinary teams to establish them in the next year. Most recently in September, Muhondo and Kigogo health centers initiated their teams. We also worked closely this quarter with Bwisige, Ruhenda and Mulindi health centers to prepare for the launch of their own multidisciplinary teams the first week of October.

Testing and Counseling

Table 2: Testing and Counseling Results

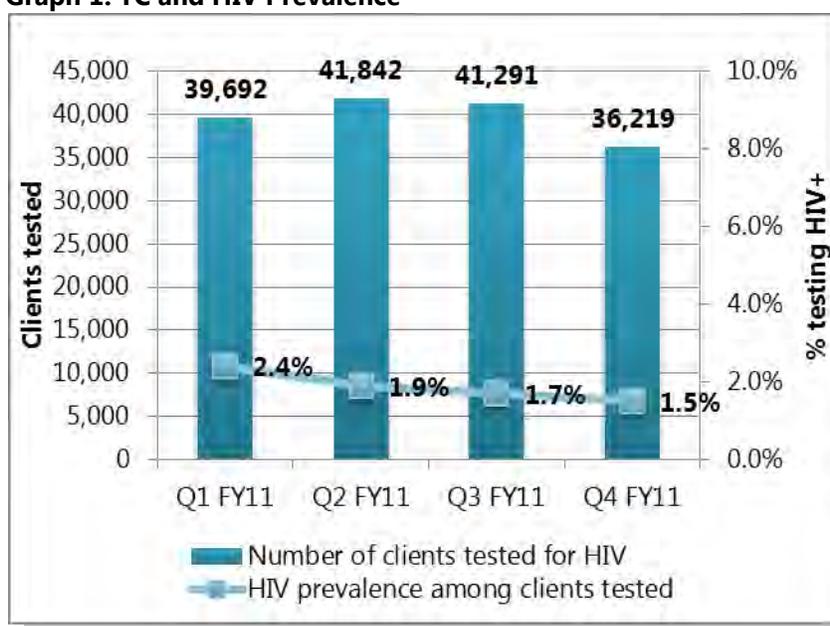
PEPFAR Indicator	Quarterly results				COP10 result	COP10 target	% of target achieved
	Oct – Dec 10	Jan – Mar 11	Apr – Jun 11	Jul – Sep 11			
Number of service outlets providing TC according to national and international standards	39	39	39	39	39	39	100%

PEPFAR Indicator	Quarterly results				COP10 result	COP10 target	% of target achieved
	Oct – Dec 10	Jan – Mar 11	Apr – Jun 11	Jul – Sep 11			
Number of individuals who received TC for HIV and received their test results (including TB)*	39,692	41,842	41,291	36,219	159,044	128,850	123%
Number of persons trained in TC	61	16	0	35	111	404	27%

* 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

Graph 1: TC and HIV Prevalence



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 **30,681** adults tested between July and September 2011, **488 (1.6%)** were found to be HIV-positive, while **38 (0.7%)** of **5,538** 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. All referrals were tracked using referral and counter-referral forms.

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. During this quarter, **1,070** couples received pre-nuptial TC services. Of these **2,140** individuals, **84 (3.9%)** tested HIV-positive. **Thirty (2.8%)** couples were found to be sero-discordant and provided with additional counseling emphasizing the importance of condom use and family planning.

In July, the HCSP participated in a three-day workshop organized by the Rwanda Biomedical Center (RBC) to update trainer and service provider manuals with the latest information on finger prick HIV testing, and contribute to the first draft of the national finger prick reference guide. We also collaborated with other workshop participants to develop a national finger prick testing implementation plan, and will continue next quarter to contribute to the finalization of national finger prick testing tools and training manuals.

As well, 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 testing and mobile TC services, including our annual support for national, district and facility-based World AIDS Day celebrations in December.

Prevention of Mother-to-child Transmission

Table 3: PMTCT Results

PEPFAR Indicator	Quarterly results				COP10 result	COP10 target	% of target achieved
	Oct – Dec 10	Jan – Mar 11	Apr – Jun 11	Jul – Sep 11			
Number of service outlets providing the minimum package of PMTCT services according to national and international standards	39	39	39	39	39	39	100%
Number of pregnant women with known HIV status, including women who were HIV-tested and received their results	7,168	7,790	6,634	5,978	27,570	24,037	115%
Number of HIV-positive pregnant women who received antiretroviral prophylaxis to reduce risk of mother-to-child transmission*	170	165	174	176	685	716	96%
Number of persons trained in PMTCT	467	29	0	0	435	404	108%

* Note that in preparation for this report, data from previous quarters were corrected to include pregnant women whose HIV-positive status was already known at entry.

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. With our mentorship and supportive supervision, they maintain high standards of patient care and safety. In total, we support **39** PMTCT sites. At these sites, **5,978** 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, **176 (2.9%)** were HIV-positive. They received continuous counseling on infant feeding and were encouraged to breastfeed for 18 months.

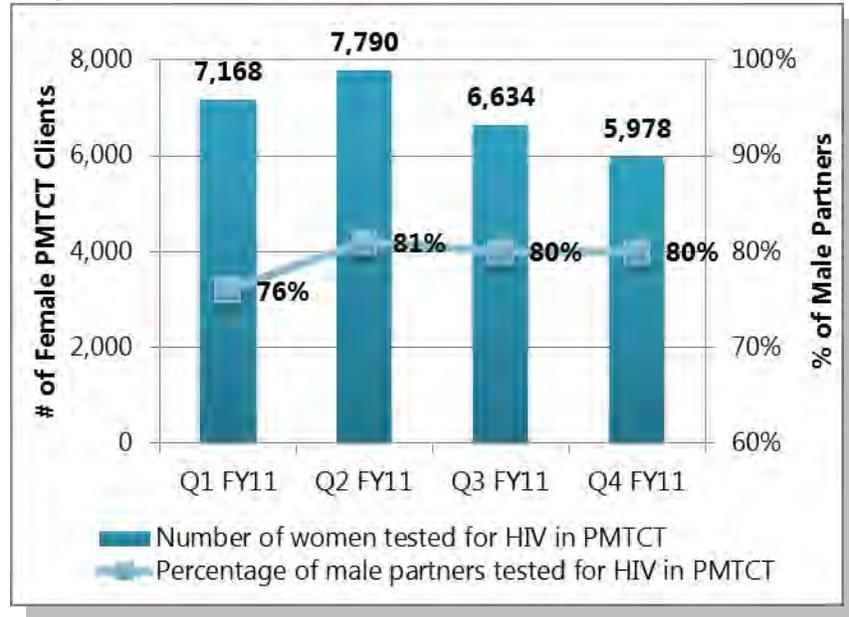
Since the advent of the new PMTCT protocol, we have supported sites to phase out azidothymidine use in favor of triple therapy prophylaxis until weaning or as lifelong treatment. This quarter, **176** HIV-positive pregnant women received triple ARV prophylaxis in a focused ANC setting. In addition to those who were tested and learned of their HIV-positive status this quarter, this figure includes 94 women with previously known HIV-positive status who may or may not have already received treatment. The 176 women also include **130** who will receive triple ART for life. No pregnant women received azidothymidine monotherapy.

This quarter, **166** HIV-positive pregnant women followed at the facilities we support delivered babies, **152 (92%)** of them at an HCSP-supported site. Furthermore, **316** HIV-positive pregnant or lactating women received food and nutritional supplementation.

The new PMTCT protocol calls for timely, effective treatment of pregnant women enrolled in PMTCT as well as their infants. To gauge success with the new PMTCT protocol at the facilities we support, this quarter we developed an additional PMTCT

mother-infant tracking system (further details are in the *Monitoring and Evaluation* section below) and analyzed data from January-June 2011. We found that of **303** HIV-positive pregnant women receiving PMTCT services at sites we support, **137 (45%)** received short-term triple ARV prophylaxis, **155 (51%)** initiated lifelong triple therapy, and **9 (3%)** received no treatment.² Treatment data for **2 (1%)** women were unavailable, and the median gestational age of ART initiation was **20** weeks. In the same period, **287** women delivered **293** infants, of whom **4** died before six weeks. Of 289 infants, **282 (98%)** received nevirapine and **275 (95%)** had

Graph 2: Male Involvement in PMTCT



undergone polymerase chain reaction (PCR) testing at six weeks by June 30. Only **2 (0.7%)** tested positive—a lower vertical transmission rate than the national average of 4.2%—and all received cotrimoxazole (CTX). We will continue to track PMTCT clients and their exposed infants in real time.

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 testing of male partners of women receiving ANC or PMTCT services. This quarter, **4,776 (80%)** male partners of women receiving PMTCT services were tested for HIV. Of these men, **70 (1.5%)** were found to be HIV-positive, referred to treatment services and advised to join PLHIV cooperatives or support groups.

Furthermore, we attended a conference hosted by the MOH in August to discuss how to strengthen male involvement in PMTCT and MCH services. In line with conference recommendations, we reaffirmed our commitment to three principal strategies to

² Five women did not seek services until the day they gave birth, and one not until she miscarried; these six women were not tested and put on treatment until after delivery. Two women denied their HIV-positive status and refused treatment, and one was lost to follow-up.

engage males in improving MCH: support for male circumcision programs at facility, district and national levels; pre-nuptial consultation services; and discordant couples counseling with testing every three months.

Next quarter, 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 MOH staff as a means of transitioning supervision and mentorship responsibilities from the HCSP to the MOH.

HIV Treatment and Antiretroviral Therapy Services

Table 4: HIV Treatment Results

PEPFAR Indicator	Quarterly results				COP10 result	COP10 target	% of target achieved
	Oct – Dec 10	Jan – Mar 11	Apr – Jun 11	Jul – Sep 11			
Number of service outlets providing ART	25	25	25	25	25	25	100%
Adults and children with advanced HIV infection newly initiating ART	316	261	275	226	1,078	2,130	51%
Adults	287	243	249	202	981	1,810	54%
Children	29	18	26	24	97	320	30%
Adults and children with advanced HIV infection receiving ART therapy	6,038	6,083	6,302	6,485	6,485	7,569	86%
Adults	5,503	5,571	5,781	5,965	5,965	6,434	93%
Children	535	512	521	520	520	1,135	46%
Adults and children with advanced HIV infection who ever started on ART	9,185	9,446	9,721	9,947	9,947	10,626	94%
Adults	8,318	8,561	8,810	9,012	9,012	9,032	99.7%
Children	867	885	911	935	935	1,594	59%
Adults and children known to be alive on ART 12 months after initiation of ART	247	452	318	261	1,278	1,426	90%
Adults	211	422	286	238	1,157	1,212	96%
Children	36	30	32	23	121	214	57%
Number of persons trained in ART	12	0	34	30	76	404	19%

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, and viral load tests at one year, while integrating TB, nutrition, PC, GBV, nutrition and FP services. In September, **30** service providers from Gasabo and Gicumbi districts were trained at Kibagabaga Hospital in comprehensive care and treatment for PLHIV. We also trained **56** community volunteers

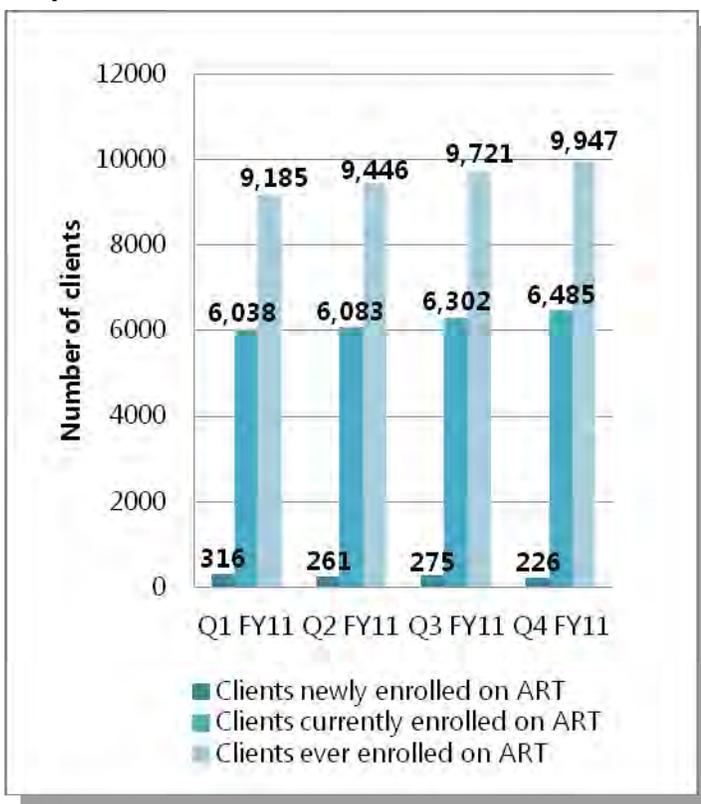
this quarter to facilitate referrals and linkages between the facility and community, and provide home-based care of PLHIV.

During this quarter, **202** adults and **24** children with advanced HIV infection newly initiated ART, bringing the HCSP to 54% and 30% of our COP10 targets for adults and children, respectively. As HCSP-supported sites increase their efforts to identify new sero-positive clients and put them on treatment, we continue to monitor this indicator to determine whether it is in fact reflective of a decreasing trend regarding infection. Timely HIV testing and early initiation of Bactrim have markedly improved the health outcomes of HIV-positive clients, delaying the start of ART—a possible reason for low target achievement thus far on this indicator. Screened HIV-positive clients who were not yet eligible for ART were regularly followed up and evaluated.

At the end of this quarter, **5,965** adults and **520** children with advanced HIV infections were receiving ART. In total, **9,947** individuals have ever received ART at HCSP-supported sites, including **9,012 (91%)** adults and **935 (9%)** children under 15. Moreover, of the 282 clients who newly initiated ART from July-September 2010, **261** 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 four in year three had since transferred to sites outside of our intervention zone.

The HCSP recognizes pediatric ARV treatment as a program priority. Currently, children constitute 9% 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

Graph 3: ART Client Enrolment



with PLHIV cooperatives to sensitize communities on the services available to them. This quarter, our staff participated in numerous pediatric TWG meetings to update the pediatric HIV curriculum for service providers, as well as meetings of the 7th National Pediatric Conference steering committee.

We also mentored three ART nurses at Nyagatare Hospital in care and treatment for adolescents living with HIV. Physicians at Nyagatare Hospital will receive the same mentorship next quarter, as will ART service providers at the other three hospitals we support. 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. 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.

Clinical Care

Table 5: Clinical Care Results

PEPFAR Indicator	Quarterly results				COP10 result	COP10 target	% of target achieved
	Oct – Dec 10	Jan – Mar 11	Apr – Jun 11	Jul – Sep 11			
Number of HIV-positive adults and children receiving a minimum of one clinical service	12,145	10,731	10,758	10,362	12,754	15,518	73%
Adults	10,847	9,773	9,581	9,398	1,1090	13,190	84%
Children	1,298	958	1,177	964	1,664	2,328	72%
Number of HIV-positive persons receiving Cotrimoxazole (CTX) prophylaxis	10,738	10,632	9,972	10,317	10,317	15,518	67%
Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	771	833	768	944	1,148	1,030	112%
Number of HIV-positive patients who were screened for TB in HIV care or treatment settings	12,145	10,731	10,238	10,027	10,317	15,518	67%
Number of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	53	56	43	56	208	155	134%
Number of infants—born to HIV-positive women—who received an HIV test within 12 months of birth	108	116	134	140	498	680	73%

PEPFAR Indicator	Quarterly results				COP10 result	COP10 target	% of target achieved
	Oct – Dec 10	Jan – Mar 11	Apr – Jun 11	Jul – Sep 11			
Number of infants—born to HIV-positive women—who started CTX prophylaxis within two months of birth	143	108	134	148	533	680	78%
Number of persons trained in any HIV service	549	113	40	30	650	404	161%
Umbrella Care Indicators							
Eligible adults and children provided with a minimum of one care service	10,704	10,902	11,555	12,132	15,817	15,518	102%
Adults	9,816	9,848	10,411	11,138	14,016	13,190	106%
Children	888	1,054	1,144	994	1,801	2,328	77%

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, **30** providers were trained in HIV-related clinical services.

Between July 1 and September 30, **9,398** HIV-positive adults (**36%** males and **64%** females) and **964** HIV-positive children (**49%** males and **51%** females) received a minimum of one clinical service at an HCSP-supported site. Of these adults and children, **10,317 (99.6%)** 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, **10,027** HIV-positive patients were screened for TB in HIV care and treatment settings, and **56** initiated TB treatment. As well, **679** registered TB patients received HIV TC and results. While on a supportive supervision visit at Nyagatare Hospital last quarter, one of our field team leaders recognized a need for training in fine needle aspiration biopsy, a simpler, quicker alternative to open biopsy for the diagnosis of TB. In July, he mentored two physicians at Nyagatare Hospital in this practice. We have planned the same activity, combined with mentorship in adolescent HIV care and support, for next quarter in the other three hospitals we support.

The HCSP does not collect data on the number of live births each quarter. Even so, as mentioned above, we know that **166** HIV-positive pregnant women followed at the sites we support also delivered at these sites. In total, **140** infants underwent dried blood spot (DBS) PCR testing between four and eight weeks of age. Of those who received their results by the end of the quarter, **5 (3.6%)** tested HIV-positive and were referred

for treatment and continuous follow-up. This quarter, **148** infants were started on CTX prophylaxis within two months of birth.

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. Training for these mother counselors continued this quarter. 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.

The HCSP paid community health insurance (*mutuelles*) for **3,155** indigent PLHIV and their families this quarter.

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.

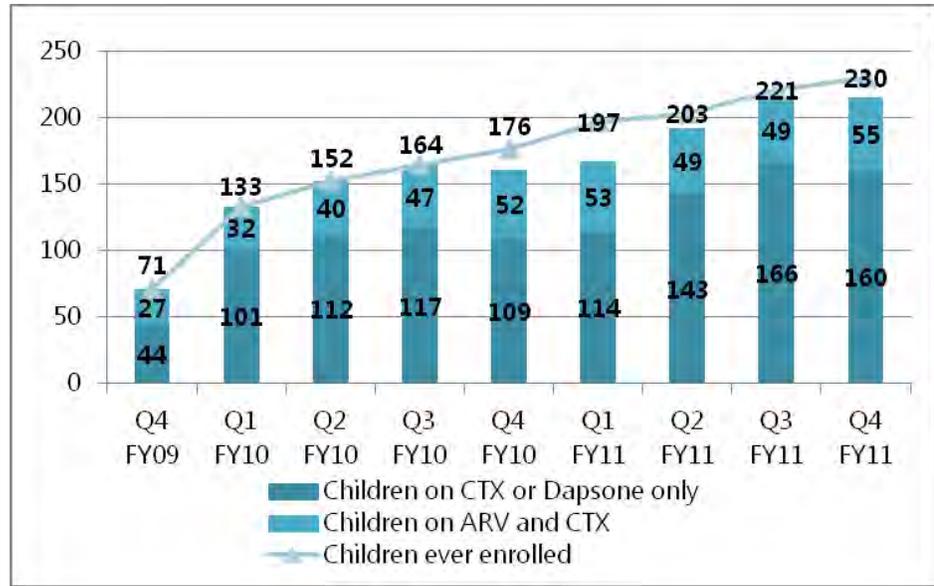
With our partner Mildmay International, the HCSP ensured the provision of PC services to **12,132** PLHIV (**92%** adults and **8%** children) this quarter. As well, **56** community volunteers were trained in PC.

Our national-level PC activities advanced significantly this quarter. We ensured that all district hospitals in the country received at least soft copies of the national policy documents, and we nearly finished distributing hard copies to the sites we support. We assisted the MOH to develop a job description for the national PC coordinator, and expect recruitment to be completed early next quarter. We also hosted numerous meetings of the PC TWG and its specialized core group whose work this quarter concentrated on drafting the national in-service training curriculum and training manual. We anticipate that the training curriculum, training manual and two-year implementation plan will be validated by the MOH early next quarter. Once they are, we will provide funding and technical support to organize a training session for national PC trainers, and implement the plan.

Additionally next quarter, we will organize a study tour for one MOH pharmacist and one RBC pharmacist at Hospice Africa and the pharmacy at Mulago Hospital in Uganda to learn best practices in oral morphine distribution and management. We will also collaborate with the PC TWG, CAMERWA and the MOH to rapidly assess and quantify opioid needs in Rwanda. The assessment will determine the appropriate quantity of morphine to order from the International Narcotics Board. We hope to begin the assessment next quarter.

The Pediatric Palliative Care Center at Kibagabaga Hospital continued to progress this quarter. As of September 30, **230** children under 18 were ever enrolled, **160** on CTX or Dapsone only, and **55** on both ARV and CTX. None were malnourished

Graph 4: Enrolment and Care at Kibagabaga Pediatric PC Center



and average adherence was estimated at 99%. While **1** child was transferred to another facility and none died, **14** HIV-exposed children under 18 months were discharged as a result of their confirmed negative status. These 15 children explain the gap in Graph 4 between children ever enrolled and children on treatment.

Psychosocial support comprises an important aspect of the comprehensive care provided at the center. This quarter, **92** children and **92** parents and guardians participated in support groups. With our support, Kibagabaga Hospital also established a new cooperative for parents and guardians of enrolled HIV-positive children. Members meet regularly to learn from each other how to support the development of the children under their care, from assuring adequate nutrition to implementing income generation activities (IGA) to pay for school fees.

In light of its achievements, Kibagabaga Hospital mentors neighboring health centers in Gasabo, sharing its best practices, to enable them to initiate and manage their own PC units. Last quarter, we stepped up our efforts to extend Kibagabaga’s multidisciplinary, family-centered approach to all the ART service sites we support. In June, we began

facilitating 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. She will complete her mentorship visits to all ART sites next quarter.

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. Much of July was devoted to post-training follow-up in Gasabo, mentoring service providers and PLHIV cooperative members in nutritional management and IGA management.

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 began a special nutrition education program this quarter that targets mothers enrolled in PMTCT services. The program was launched in August with a televised nutrition education session for mothers, and continues with additional sessions for community health workers, PLHIV cooperative members and health center personnel in charge of nutrition throughout Gasabo District, better preparing them to support mother participants to apply what they learned. Monthly education sessions for mothers will resume in January. The hospital also began to mentor health centers in establishing their own nutrition programs, organizing, for example, a nutrition education session at Rubungo Health Center at the end of September. In the long-term, hospital staff aim to extend the program to schools and other public institutions.

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 (Rurenge and Matimba health centers) where PMTCT services are supported by the Global Fund. During this quarter, activities reached **523** HIV-exposed infants aged 6 to 18 months, as well as **31** pregnant and lactating women. In September, as part of Ibyiringiro activities, the HCSP nutrition officer trained **39** service providers on nutrition

management as per the new PMTCT protocol. She also participated in all steering committee meetings, notably those to plan for the Food by Prescription program, which will provide malnourished ART clients with supplementary food and nutrition counseling.

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. Fish farming at Kayanga Health Center and hen raising at Gikomero Health Center have enjoyed particular success. The presidents of both centers' cooperatives told us that it is thanks to HCSP training that they were able to design and eventually fund their projects.



IGA for PLHIV (from top left, clockwise): hens and the garden at Gikomero Health Center, pigs at Rukomo Health Center and fish farming at Kayanga Health Center

As of the end of this quarter, **8,648** 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 work with the World Food Program (WFP) on the Food for ART program, which provides support to adult and child ART patients who are malnourished. During this quarter, **836** ART patients were supported by Food for ART. In August, Nyagatare Hospital and Rushaki, Rukozo and Kigogo health centers experienced stock outs in corn

soy blend packets and oil due to delayed deliveries from WFP. The problem was resolved in September.

We also provided management and monitoring support to the **17** additional PLHIV cooperatives with whom we signed subagreements last quarter to implement nutrition-related IGA with funding from WFP. Twelve cooperatives completed their projects by the end of September. Munyinya and Rutare health centers reported that their new hens were already laying eggs, while Rukomo Health Center celebrated the birth of seven piglets. The remaining five IGA will end in early October.

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 validate the national maternal, infant and young child nutrition counseling package this quarter, and committed to training service providers in Gasabo, Gicumbi and Rulindo next quarter.³

Laboratory

Table 6: Laboratory Services Results

PEPFAR Indicator	Quarterly results				COP10 result	COP10 target	% of target achieved
	Oct – Dec 10	Jan – Mar 11	Apr – Jun 11	Jul – Sep 11			
Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	45	45	45	45	45	45	100%
Number of lab personnel trained	0	28	63	0	84	45	187%

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.

In July, we installed hematology and biochemistry equipment at Cyabayaga Health Center and provided special mentorship to their laboratory technicians in its use. We

³ Nyagatare service providers will be trained by PSI.

had also planned to coordinate training sessions this quarter for new laboratory technicians on hematology and biochemistry. Unfortunately, they could not be arranged due to the unavailability of trainers.

Last quarter, to accelerate the procurement of essential laboratory equipment not yet in place at certain facilities we support, we submitted to Supply Chain Management Systems (SCMS) a detailed list of all needed equipment, much of which had been requested in previous years. We have since been working with SCMS to facilitate the procurement and install all equipment on site as it becomes available. Biochemistry and hematology analyzers were received this quarter and installed at Bushara, Gihogwe, Kiyanza, Kabuga and Rukomo health centers. All ART sites that we support now have these machines.

We also received five 30 kva generators from Management Sciences for Health in July. Next quarter we will work with the supplier, AZ Impex, to arrange for delivery and installation at Gisiza, Kigogo, Gikomero, Kabuga and Kiyanza health centers.

We support **45** laboratories with the capacity to perform clinical laboratory tests, including all tests necessary for HIV and AIDS clinical services. In August, we coordinated a training session on DBS/PCR and rapid HIV tests for **13** laboratory technicians and **13** nurses who came from either new TC/PMTCT sites (Ruhenda, Mulindi, Muhondo, Gihogwe and Mimuri health centers) or were newly recruited personnel in need of training (from Bwisige, Kayanga, Nyagatare, Cyondo, Bugaragara, Karangazi, Rurenge and Matimba health centers). The session was financed by the NRL. All facilities we support are now trained to use the new HIV rapid testing algorithm, and all but one are trained in DBS collection for PCR.⁴

Our laboratory support officer trained **33** laboratory technicians and **29** nurses from Musanze and Gakenke districts in post-vasectomy semen analysis at a three-week MOH-led session in Musanze this quarter. Where vasectomy services are provided at facilities we support, service providers are already trained in semen analysis.

Also this quarter, we collaborated with the director of Nyagatare Hospital to provide supportive supervision and mentorship to **15** health center laboratory technicians in Nyagatare who were trained in logistics and commodity management last quarter. Matimba and Ntoma health centers in particular had experienced problems with stock-outs of laboratory reagents and consumables, but with mentorship these problems were

⁴ Miyove Prison has not launched PMTCT services.

resolved. Next quarter, we will also train health facility pharmacy managers in Gicumbi and Nyagatare.

Also next quarter, we will coordinate the training of one laboratory technician per facility we support on biosafety and laboratory waste management, as well as sample transportation.

Post-exposure Prophylaxis

Table 7: Post-exposure ARV Prophylaxis Results

PEPFAR Indicator	Quarterly results				COP10 result	COP10 target	% of target achieved
	Oct – Dec 10	Jan – Mar 11	Apr – Jun 11	Jul – Sep 11			
Number of persons provided with PEP	53	56	57	84	250	82	305%
Number of providers at HCSP-supported sites trained in PEP provision	274	85	16	52	427	404	106%

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, **52** providers from HCSP-supported facilities were trained to provide PEP.

Between July and September 2011, **30** individuals were provided with PEP. Throughout the year, **32** individuals were provided with PEP for occupational reasons and **218** for non-occupational reasons, including **163** survivors of sexual violence. This brings us well above the COP10 target for PEP service provision. Whereas the norm used 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				COP10 result	COP10 target	% of target achieved
	Oct – Dec 10	Jan – Mar 11	Apr – Jun 11	Jul – Sep 11			
Number of PLHIV reached with a minimum package of PwP interventions	10,402	9,626	10,758	10,362	13,015	12,415	105%
Number of service providers trained in PwP	208	277	16	30	650	404	161%

The HCSP undertook several PwP activities this quarter. These included mentorship of PLHIV cooperatives and their members; financing, monitoring and technical support of IGA; strengthening of peer support groups; sensitization regarding FP and dual protection from HIV and undesired pregnancies; partner testing; condom distribution; and TB and STI screening. The number of service providers trained in PwP includes unique individuals trained in TC, PMTCT, ART and FP. This quarter, **30** service providers were trained to provide PwP services and **10,362** 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				COP10 result	COP10 target	% of target achieved
	Oct – Dec 10	Jan – Mar 11	Apr – Jun 11	Jul – Sep 11			
HCSP-supported sites providing FP counseling and other services	44	46	46	46	46	45	102%
Number of women who attended their first ANC visit	7,106	7,627	6,718	5,975	27,426	22,000	125%
Number of deliveries attended by a skilled birth attendant	3,318	4,778	6,030	5,610	19,736	24,037	82%
Infants under 12 months who received DPT3 (Diphtheria, Pertussis, Tetanus) vaccinations	4,873	4,360	5,492	10,560	25,285	22,000	115%
Children under five who received Vitamin A	60,123	2,466	2,814	32,735	98,138	122,000	80%

In quarter four, we continued to provide technical, financial and logistical assistance to site-level FP trainers from Gasabo, Gicumbi, Nyagatare and Rulindo—including facilities

that do not receive our formal support—while they transferred FP skills to their colleagues through on-the-job training. Trainees are now also able to complete the practical component of their training in intrauterine device (IUD) insertion; we procured 74 uterometers to complete the IUD kits that arrived from Europe last quarter, now in use at all facilities in the four districts.

Between June and September, **132** service providers in Gicumbi were trained by site-level FP trainers and mentored with assistance from the HCSP FP/MCH coordinator and national trainers. In addition, all **75** service providers trained on the job last quarter in Rulindo passed their final evaluations in August. All of these providers can offer short-term FP methods and insert Jadelle implants. However, not all are certified in IUD insertion, as national protocol requires that a service provider successfully insert at least three IUDs under the supervision of a trainer before full certification can be granted. This can take time because the opportunity to insert an IUD depends entirely on the personal choices of clients. A final post-training evaluation of the providers' skills and knowledge will take place next quarter.

In July, we coordinated travel from Nyagatare District by **4** site-level FP trainers from Bugaragara, Rurenge, Tabagwe and Cyondo health centers to be certified in IUD insertion in Gicumbi, where there is relatively greater IUD uptake among health center clients. Immediately following their certification, on-the-job training began in Nyagatare District. The training was launched with an orientation workshop on August 25 for **45** participants including health center directors, district trainers and site-level trainers. Three weeks later, the same workshop was held in Gasabo to launch their round of training, slightly delayed due to scheduling conflicts at Kibagabaga Hospital. On-the-job training in FP will finish next quarter in all districts.

In total, **89,117** clients—including men having undergone vasectomy—used a modern FP method this quarter. As well, the 10 vasectomy mannequins that we ordered last quarter arrived in September and are now used in MOH-led vasectomy trainings.

From July 19 to 22, the HCSP supported special outreach activities as part of the nationwide biannual MCH campaign. The services on offer included FP counseling and method provision, vaccination, and community sensitization on malaria and insecticide-treated bed nets. Our support included making five rental vehicles available to the MOH for dispatch throughout the districts we support, both the week before and during the campaign. Also, under the direct supervision of district hospital directors, one of our field team leaders provided technical assistance and supervised campaign activities at Ntoma, Rurenge, Rukomo, Karangazi and Muhambo health centers.

This quarter, through our participation in the MCH TWG, we helped finalize data collection and supervision tools for the community-based provision (CBP) of FP. CBP is a key strategy to improve client access to FP counseling and methods, an important objective of the HCSP. Training in CBP began this 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 Rulindo this quarter, we coordinated FP training for **16** facility personnel in charge of community health. We also oriented **15** site-level FP trainers in Rulindo on training manuals, supervision tools and data collection tools for CBP, themes on which they will in turn train community health workers next quarter. An orientation meeting was also held in September and attended by **59** local authorities, including the MOH community health supervisor, the director of Rutongo Hospital, district personnel in charge of community health and many other representatives from the sector and facility levels. We began the same sequence in Gicumbi this quarter, training **24** facility personnel in charge of community health in FP.

By the end of quarter three, 183 providers throughout the districts we support were trained in emergency obstetric and neonatal care (EmONC) and maternal death audit. As with all other trainings, post-training follow-up and supervision, as well as on-the-job skills transfer to other colleagues at the health center, followed. This quarter **22** providers in Rulindo and **25** in Gicumbi received such follow-up and supervision.



An infant sleeps during EmONC post-training follow-up at Giti Health Center

After three months, they will be evaluated and certified. Post-training follow-up will take place in Gasabo and Nyagatare next quarter. And in the interest of sustainability, we are planning a 17-day training session for district-level trainers in comprehensive EmONC for either quarter one or two of year five, leaving 4 EmONC trainers in place in each district we support before the end of the project.

In September, in collaboration with the MOH and national trainers, we coordinated and financed training sessions for service providers at the sites we support in essential newborn care: **23** were trained in Gasabo, **24** in Gicumbi, and **24** in Rulindo. Nyagatare trainings will take place once on-the-job FP training is complete at all facilities. As well, thanks to integrated programming with an IntraHealth FP and MCH project funded by the Hewlett Foundation, all the sites we support received post-abortion care kits and were trained in their use this quarter.

Also of note this quarter, we participated in several MCH TWG meetings to produce a draft behavior change communication strategy.

Gender and Gender-based Violence

Table 10: Gender and GBV Results

HCSP Key Indicator	Quarterly results				COP10 result	COP10 target	% of target achieved
	Oct – Dec 10	Jan – Mar 11	Apr – Jun 11	Jul – Sep 11			
HCSP-supported sites providing GBV services	46	46	46	46	46	45	102%
GBV survivors who received care and support	174	255	230	248	907	324	280%
Health facility personnel trained in care and treatment of GBV survivors*	438	164	42	18	662	552	120%

* 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. At minimum, 3 providers at each health center and 15 providers at hospitals are trained to provide care to GBV survivors. In Gicumbi and Nyagatare, all personnel at HCSP-supported sites are trained. Further training will be held across all four districts next quarter for health center personnel in charge of community health workers, the community health workers themselves, site-level data managers and GBV focal points.

Throughout quarter four, **248** GBV survivors received adequate care and support. Documentation of this care and support was facilitated by the introduction of new client registers with integrated GBV components at the sites we support. We have proposed the new register to the MOH for national adoption. We also contributed technical and financial assistance to the MOH this quarter for a two-day national workshop to

harmonize national GBV indicators and tools, including client registers. A draft set of indicators is currently under review by the GBV TWG.

In response to a recent rotation within the Rwandan National Police that transferred all police trained last year in GBV from the districts we support elsewhere, another round of GBV service training for police benefitted 58 police officers last quarter. Post-training follow-up and mentorship took place this quarter and will continue into the next.

In partnership with Nyagatare District, the HCSP led the process of establishing a one-stop GBV service center at Nyagatare District Hospital. All staff are now in place: one A0 psychologist, one A2 nurse and one A2 social worker were recruited in August. They received training in care and support for GBV survivors along with **15** other hospital staff, **3** police officers and **1** lawyer from the district high court. Equipment procurement and renovations costing Rwf 9.8 million will conclude in October. Shortly afterwards, the center will become operational. Its inauguration will coincide with extensive community sensitization throughout the district, combining radio messages with sessions to orient anti-GBV committee members on their role in helping GBV survivors access one-stop-center services. To date, only two other such centers exist in Rwanda: the Isange One-Stop Center at Kacyiru Police Hospital and the one-stop center at Gihundwe Hospital in Rusizi District. We also lent our expertise this quarter to discussions within the GBV TWG about scaling up the one-stop GBV center strategy throughout the country.

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, next quarter we will provide 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.

PERFORMANCE-BASED FINANCING

As of September 30, **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. 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 Nemba, Ruli, Muhima and Nyamata. 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 November, 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, April-June 2011

District	Lowest Quality Score (%)	Highest Quality Score (%)
Gasabo	71	96
Gicumbi	24*	98
Rulindo	91	99
Nyagatare	75	92

* Note that this score was achieved by Miyove Prison in its first ever PBF evaluation.

Having never before been evaluated for PBF, Miyove Prison received the lowest quality score in Gicumbi (24%) last quarter. This may be partially explained by the fact that the prison does not offer all health services as would a health center, nor was its structure originally designed to do so. Even so, the HCSP and district supervisors will use the PBF-generated data to prioritize the prison's supportive supervision and technical assistance needs.

Rutare Health Center achieved the second-lowest quality score in Gicumbi (67%), continuing its trend of the past several quarters. Together with Byumba Hospital and sector representatives, we continue to work closely with health center leadership and providers to address problems on-site, such as frequent staff turnover and a poor burn rate. Given the center's slow improvement, in August we made a written request to the district mayor for his direct intervention and also instituted biweekly follow-up visits by one of our field team leaders. A new director will join the health center in October, and we will provide continuous, focused support to him.

Nyagatare Health Center has also made a conscientious effort to raise its quality scores this year, but, along with Nyagatare Hospital, achieved the lowest score in the district (75%) last quarter. In past quarters, we 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 (71%) last quarter.

The highest scores last quarter were achieved by Jali Health Center in Gasabo (96%), Munyinya Health Center in Gicumbi (98%), Rukozo Health Center in Rulindo (99%) and Cyondo Health Center in Nyagatare (92%).

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 year five 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. Starting last quarter, data managers at the district hospitals we support assume primary responsibility for technical assistance at the health center level. This approach has worked well thus far. 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, as of this quarter, our training database, containing data from October 2010, 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 undertook a number of different exercises this quarter to closely monitor facility-level clinical service data, ensuring their reliability and validity. In July, the HCSP senior technical advisor, with relevant HCSP team leaders and clinical services officers, visited

Kibagabaga Hospital and Rwesero Health Center to rapidly assess the flow, collection, verification, and reporting of service data at facility-level. They 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 also since instituted monthly quality assurance and improvement visits to the facilities we support, with increased collaboration between M&E and clinical staff. Moreover, this quarter the HCSP M&E team initiated weekly presentations to other HCSP staff on program results against targets.

In September, we conducted a data quality audit at 41 of our supported sites. We confirmed a number of strengths among the sites, including the consistent filing of copies of their submitted reports, well-organized ART patient files and ANC registers, and complete electronic patient records at ART sites.

Table 12: Health Centers Included in September 2011 Data Quality Audit

District	Health Centers
Gasabo	Gihogwe, Gikomero, Jali, Kayanga, Kibagabaga Hospital, Rubungo
Gicumbi	Byumba, Byumba Hospital, Bushara, Gisiza, Giti, Kigogo, Miyove Prison, Mukono, Muhondo, Ruhenda, Rushaki, Rwesero, Tanda
Nyagatare	Bugaragara, Cyabayaga, Cyondo, Kabuga, Karangazi, Matimba, Mimuri, Muhambo, Ntoma, Nyagatare, Nyagatare Hospital, Rukomo, Rurenge
Rulindo	Kajevuba, Kinihira, Kiyanza, Murambi, Muzanza, Remera-Mbogo, Rukozo, Rwahi, Tumba

We also uncovered a number of challenges that we have begun to address. Chief among them were data compilation inaccuracies due to failure to crosscheck different data sources, namely client registers, patient files and IQChart; discrepancies between data sources, reports submitted to IntraHealth and reports submitted via TRACNet; incomplete patient files, including missing expected delivery dates on ANC cards; irregular data entry into IQChart; and lack of PMTCT registers in line with the new protocol. Immediately after the DQA session at each health facility, our staff met the facility director and other personnel to brief them on preliminary results and strategies for improvement.

Training on the latest version of IQChart, rescheduled by Futures Group for this quarter, was unfortunately once again postponed until further notice due to the unavailability of their trainers. Until this training takes place, we are unable to use IQChart to manage patient-level data in TC and PMTCT. However, in August, we developed a simple system in Microsoft Excel 2007 to track patient-level PMTCT data. The system captures district/facility data on mother HIV serostatus, CD4 count, treatment and gestational

age; and infant prophylaxis and testing. The exercise identified an additional 122 pregnant women and 43 exposed infants that had not previously appeared in facility reports from January-June 2011, and allows for analysis of linked mother-infant services or outcomes. In the absence of the latest version of IQChart, our next step will be to create a PMTCT tracking database for real-time monitoring of PMTCT interventions and outcomes.

Our M&E team participated in a number of external meetings, including those of the M&E TWG and the TRACNet technical support unit. We also fulfilled a joint request from the MOH and USAID to assist in a national assessment of the management of MCH indicators. Two facilities supported by the HCSP, Karangazi and Rukomo health centers, were included in this assessment.

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. This 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.

In addition, this quarter we hosted a meeting with an external USAID environmental consultant to discuss our implementation of the activities in the plan.

OPERATIONS AND SUPPORT

Site renovations at one of our newest TC/PMTCT sites, Muhondo Health Center, were completed this quarter. In collaboration with Gasabo District, we also continued to oversee renovations at Gikomero Health Center, which was partially destroyed last year during an accidental fire. After discovering in quarter three that the damage was more extensive than first thought, the district developed a new scope of work with a total budget of Rwf 16,927,160 that we, in consultation with our headquarters, approved. As of the end of this quarter, we were still accepting bids on the new contract.

In May, 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 Rwf

13,430,000 for the procurement of needed equipment and materials at the health posts. The procurement process began this quarter. Needed furniture was delivered in September, and medical equipment should be delivered early next quarter.

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. This quarter, we oriented accountants and health facility directors at Matimba, Karangazi, Ntoma, Mimuri and Cyabayaga health centers in the tender process.

Also this quarter the HCSP successfully entered our year four expenditures and year five budget allocations into the MOH health resource tracker, submitting the information well within the deadline. Financial data were categorized according to HCSP objectives, supported sites, activities and inputs, providing a clear picture of our specific contribution towards helping the Government of Rwanda (GOR) achieve its goals and objectives.

Besides subgrant monitoring and financial management, HCSP operations and support services coordinated the renewal of IntraHealth's status as a nongovernmental organization in Rwanda. In preparing our application, we held many meetings over several weeks with our district partners to review our previous reports and year five work plan. The districts approved and endorsed our application, and our status was renewed for another year.

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 enter 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 rate and 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.

Until a harmonized approach is found, we are using a set of graduation criteria that allows us to classify our supported sites and tailor our support to them according to their readiness for transfer. The criteria measure site performance and capacity against clinical indicators in TC, PMTCT, ARV and PC, as well as against operational indicators related to financial and administrative management, and M&E.

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 transition team met with the directors and supervisors at Byumba and Rutongo hospitals to develop plans for the integrated supportive supervision of health centers. District supervisors will lead the implementation of these plans with technical and financial support from the HCSP. Byumba Hospital developed a plan for October, the success of which will be evaluated in a meeting with the HCSP on October 31. Similarly, Rutongo Hospital developed a quarterly plan ending in December. Kibagabaga and Nyagatare hospitals will develop their first plans next quarter. During this exercise, we will also identify district supervisors' areas for improvement, and build capacity as required.

The HCSP is equally involved in planning and supporting activities with district-level institutions. For example, in July, we presented and discussed our year five activities during a meeting of key district stakeholders in Gasabo, among them health facility directors, sector authorities and the DHU director. We also participated in Joint Action Development Forum initiatives, including a workshop in Rulindo organized by the National Decentralization Implementation Secretariat and the Netherlands Development Organization to learn about programming methods and tools, and the Nyagatare general assembly meeting in September that began preparations for an open day event next quarter. Moreover, our field and transition team leader serves as chairman of the Rulindo forum.

Indeed, the role of the district will be central to a successful transition. This 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 district health system strengthening teams (DHSST). Responsible for overall coordination of the district health system, each



Members of the Gicumbi DHSST core team

DHSST is composed of a core 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. In September, the core team in each district we support elected presidents, vice-presidents and secretaries. The Nyagatare core team also elected the HCSP Nyagatare field manager to coordinate invitations to upcoming meetings. 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.

- **Inconsistencies between national registers and PMTCT protocol:** While updated registers in line with the new PMTCT protocol are being piloted in Gasabo District, the other districts we support must continue to find creative ways to sufficiently document and report on the services they provide to ANC and postnatal clients. This quarter, in order to better monitor the quality of care and client health outcomes, the HCSP developed a tracking system in Microsoft Excel 2007 that relies on many different data sources. In relevant TWGs and other meetings, we will continue to advocate for the rapid finalization of new registers.
- **Implementation of the national PC program:** Although our national-level PC activities advanced significantly this quarter, the lack of a national PC coordinator still represents a major obstacle to supporting the MOH in operationalizing the national PC policy. Despite funding and strong political will, overstretched human resources have meant that the national implementation plan is yet to be finalized. However, recruitment for the national coordinator began this quarter, and we hope the coordinator will be in place very early in year five.
- **Delayed start of WFP-financed IGA at certain sites:** In quarter three, we signed subagreements with 17 PLHIV cooperatives to implement nutrition-related IGA with funding from WFP. Rurenge and Muyanza health centers initially experienced setbacks related to miscommunication within the cooperatives, but with assistance from the HCSP nutrition officer all issues were resolved and a plan was made to spend and document their funding without further delay. Kinihira

Health Center activities were also held up by a delayed bank transfer; the funds were delivered after the nutrition officer accompanied the cooperative president and the health center director to the bank to discuss the issue. Twelve cooperatives completed their projects by the end of the quarter.

NOTABLE ACCOMPLISHMENTS

We achieved some significant accomplishments this quarter that merit special mention. This section summarizes those not previously discussed.

- **Kibagabaga Hospital and Mukono Health Center recognized by external visitors:** In July, Kibagabaga Hospital was selected for a visit by C. Patricia Alsup, the incoming director of the Office of Central African Affairs in the United States Department of State's Bureau of African Affairs. The hospital director and other staff were gracious hosts and gave an engaging presentation on the facility's activities and achievements. In August, a journalist from the GlobalPost visited Mukono Health Center to learn more about health service integration and vasectomy services. He reported he was pleased with the visit, and published an article on the GlobalPost website days later.



Ms. Alsup (second from left) at Kibagabaga Hospital

GlobalPost article: <http://www.globalpost.com/dispatches/globalpost-blogs/global-pulse/integrated-health-care>

- **Upcoming HCSP participation in international conferences:** A number of HCSP abstracts were accepted to international conferences taking place next quarter. One abstract titled "Capacity Building to Increase Sustainable Delivery of HIV Services: A Case Study of Byumba District Hospital, Rwanda" was ranked among the top 20 submitted and accepted for discussion during the USAID Office of HIV/AIDS partner meeting in October. Another abstract, "New beginnings: Rwanda's first pediatric palliative care center at Kibagabaga Hospital," was also accepted as a poster at the International Conference of AIDS and STIs in Addis Ababa, Ethiopia, in December. We also supported MOH FP/HIV Integration Coordinator Dr. Anicet Nzabonimpa to prepare an abstract on the Rwandan scale-up of FP/HIV integration strategies, which will be presented as part of a panel at the International Conference on Family Planning at Dakar,

Senegal, in December. At the same conference, our FP/MCH coordinator will deliver an oral presentation titled, "Family planning task shifting in Rwanda: Increasing availability of services by training nurses to insert intrauterine devices."

- **Transition towards a country program model:** Consistent with IntraHealth plans and priorities globally, the IntraHealth/Rwanda office made further progress during the quarter towards operationalizing a country program model. Rather than managing projects vertically (i.e., in isolation from others), we are increasingly moving towards an integrated, horizontal management approach where activities funded by different donors are managed holistically as part of a single program. This is particularly evident in our FP/MCH work. This quarter, we began joint planning, implementation, and supervision of FP/MCH activities funded by the HCSP, the Hewlett Foundation, and the Tides for Africa Foundation. We even reorganized office seating arrangements to have all FP/MCH staff, regardless of donor, sit and work together in the same office space. This integrated management approach has created synergies between activities and helped us avoid duplication. We believe it allows us to maximize the financial support of each individual donor.

For more information, please contact:

Christian Stengel, Chief of Party

IntraHealth International HIV/AIDS Clinical Services Program

Office: +250.252.503.567/9

Mobile: +250.78.840.3154

Email: cstengel@intrahealth.org