



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
DHMT	district health management 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
NCD	non-communicable disease
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
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, \$29.4 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 Rwanda Biomedical Center (RBC), 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 2012, 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, FP, MCH, nutrition, gender and GBV, PBF, laboratory, community health, monitoring and evaluation (M&E) and strategic information, as well as the recently established TWG for non-communicable disease (NCD), which includes a PC sub-group. We are also members of 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. The IHDP has also absorbed the functions of the Center for Treatment and Research on AIDS, Tuberculosis and Malaria, better known as TRACPlus, into its HIV/AIDS division.

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	14	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	7	9	9	9	9
	Hospital	1	-	<i>District hospital support package only.</i>							1
	DHU	1	-	-	-	-	-	-	-	-	-
Total		50	43	39	39	40	34	42	42	44	46

PEPFAR PROGRAM AREAS

From July 1-September 30, 2012, 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 for the last quarter of the HCSP's technical implementation period.

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

The HCSP works hand in hand with sites we support. Our clinical services officers spent 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 used 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. In addition, over the last few quarters we supported relevant TWGs to develop a standardized checklist for supportive supervision countrywide, and contributed to the development of new national clinical mentorship guidelines finalized in January. Lastly, in quarter three our extended mobile district supervision scheme, discussed further in the *Sustainability* section below, became fully operational.

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.

Testing and Counseling

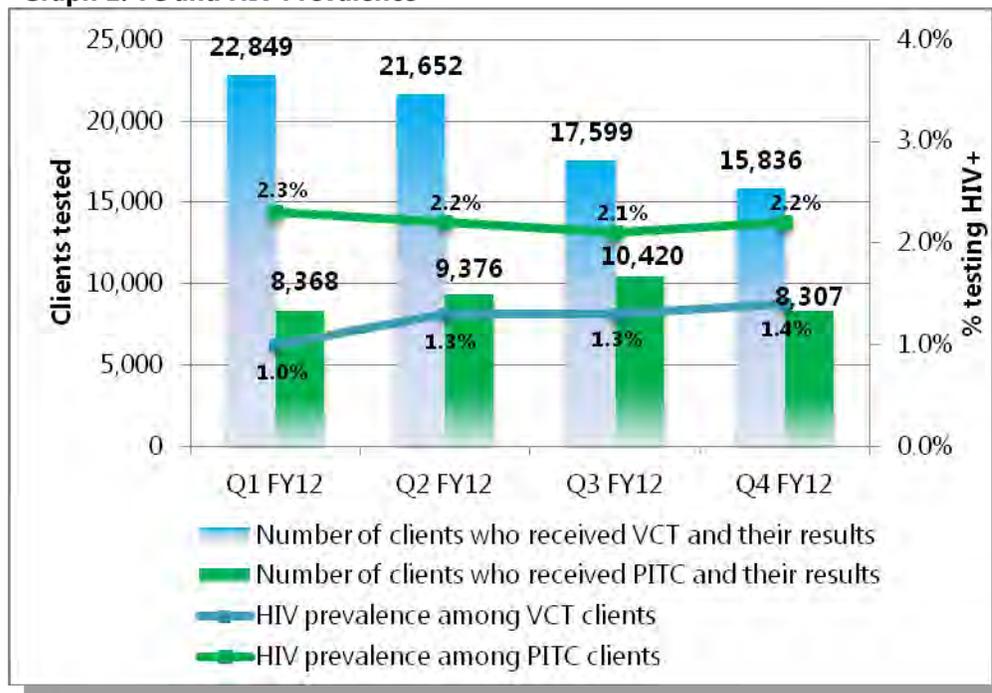
Table 2: Testing and Counseling Results

PEPFAR Indicator	Quarterly results				COP11 result	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	39	39	39	100%
Number of individuals who received TC for HIV and received their test results in a VCT setting	22,849	21,652	17,599	15,836	77,936	134,900	58%
Number of persons trained in TC	26	0	0	0	26	78	33%

TC is the entry point into care and treatment for people living with HIV (PLHIV); both voluntary TC and provider-initiated TC (PITC) are provided at all outpatient and inpatient service delivery points at all HCSP-supported facilities. Clients are given pre- and post-test counseling after which those who test HIV-positive are immediately referred and accompanied for enrolment into care and treatment services in the same facility or, at standalone PMTCT facilities where ART services are unavailable, to the nearest ART service site. Other TC services that we support include mobile and weekend TC; HIV testing integrated with TB screening, FP counseling and child immunization; 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, our supported facilities implement a family-oriented approach—using a family member such as a mother enrolled in PMTCT or ART to link with the whole family—thus enabling the testing of other family members, especially

Graph 1: TC and HIV Prevalence



children and male partners of women enrolled in PMTCT. While individuals aged 15 or older can either seek testing on their own or receive PITC, testing children under 15 requires parental consent and 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, with those testing HIV-positive linked to pediatric care and treatment.

Between July and June September, **192 (1.4%)** of **14,089** adults tested for HIV in a voluntary TC setting tested HIV-positive, while **166 (2.3%)** of **7,230** adults tested in a PITC setting tested HIV-positive. Among children under 15, **28 (1.6%)** of **1,747** tested in a voluntary TC setting tested HIV-positive, while **15 (1.4%)** of **1,077** children tested through PITC tested HIV-positive. Thus, with **401 (1.6%)** HIV-positive adults and children out of **24,143** counseled and tested in voluntary TC and PITC settings, HIV prevalence within our intervention zone this quarter was approximately half the national HIV prevalence rate of 3.0%.²

Compared against our target for individuals who received TC and received their test results in a voluntary TC setting, our overall target achievement for year five is low. Two

² National Institute of Statistics of Rwanda (NISR), Rwanda Ministry of Health (MOH) and ICF International. 2011. *Rwanda Demographic and Health Survey 2010*. Calverton, Maryland, USA: NISR, MOH and ICF International.

reasons explain this result. First, our TC target setting methods changed in year five. Whereas targets for previous years considered voluntary TC, PITC and testing in TB service areas together, this year we set separate TC targets for voluntary TC, PITC, TB and other service areas. In reviewing year five performance, we now see that in setting our COP11 target for voluntary TC, we mistakenly included PITC and TB as in previous years. Second, when USAID granted the HCSP an official cost extension in quarter two, all subagreements with our supported facilities were extended from March through September with no additional funds for technical activities. As their budgets were stretched over a longer period of time, site capacity to conduct outreach campaigns, which normally increase the number of individuals tested in VCT, was limited.

Pre-nuptial 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, **642** couples received pre-nuptial TC services. Of these **1,284** individuals, **4 (0.3%)** tested HIV-positive. As well, **7 (1.1%)** couples were found to be sero-discordant and provided with additional counseling emphasizing the importance of condom use and family planning.

Prevention of Mother-to-child Transmission

Table 3: PMTCT Results

PEPFAR Indicator	Quarterly results				COP11 result	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	39	39	39	100%
Number of pregnant women with known HIV status, including women who were HIV-tested and received their results	5,969	6,403	6,047	5,626	24,045	28,028	86%
Number of HIV-positive pregnant women who received ARVs to reduce risk of mother-to-child transmission	141	171	179	128	619	751	82%
Number of infants—born to HIV-positive women—who received an HIV test within 12 months of birth	119	116	147	142	524	676	78%
Number of infants—born to HIV-positive women—who started CTX prophylaxis within two months of birth	130	125	146	135	536	676	79%

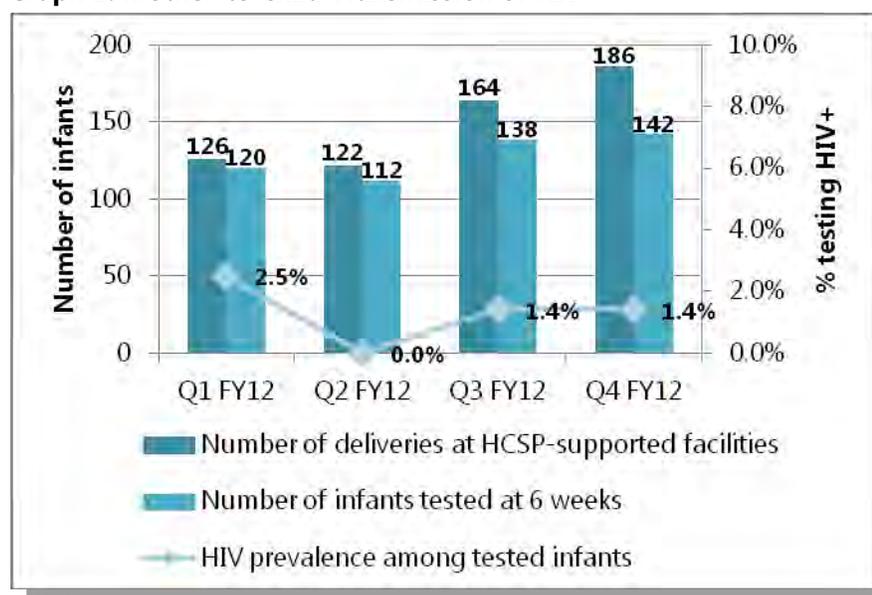
PEPFAR Indicator	Quarterly results				COP11 result	COP11 target	% of target achieved
	Oct – Dec 11	Jan – Mar 12	Apr – Jun 12	Jul – Sep 12			
Number of persons trained in PMTCT	8	0	84	103	111	78	142%

PMTCT is a major focus among 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, thus contributing to national efforts to eliminate mother-to-child transmission in Rwanda.

All PMTCT sites that we support offer the full package of PMTCT services, beginning with HIV TC for pregnant women receiving antenatal care (ANC), maternity and postnatal services. CD4 count, full blood count and other chemistry tests, with a quick turnaround of results, are done for all women who test HIV-positive. These women are then provided with antiretroviral (ARV) prophylaxis or ART, and FP services including counseling and method provision. Their infants are given ARV prophylaxis from birth through breastfeeding as well as CTX prophylaxis from six weeks, and undergo polymerase chain reaction (PCR) testing using dried blood spot (DBS) samples collected on-site and processed at the National Reference Laboratory (NRL) with results returned to the facility. The PMTCT package also includes ongoing follow-up, including nutrition support and home visits to women and their infants.

When the new national PMTCT protocol took effect in November 2010, mono and dual ARV prophylaxis for eligible HIV-positive pregnant women were replaced with more effective triple ARV prophylaxis provided through breastfeeding (up to 18 months) at ART and standalone PMTCT facilities. There was no change in lifelong ART for eligible women. In quarter two the MOH released new national HIV treatment guidelines that require

Graph 2: Mother-to-child Transmission of HIV



lifelong ART for all HIV-positive pregnant women, irrespective of CD4 count or clinical staging. In light of these changes, the MOH is in the process of accrediting standalone PMTCT sites as ART sites throughout the country. While this represents a significant improvement in the quality and accessibility of care provided to mothers and infants in PMTCT, it also places a new burden on providers at newly accredited sites. In an effort to ease this burden, the HCSP increased supportive supervision and mentorship to the PMTCT facilities we support and, in collaboration with DHUs and district hospitals, extended our mobile district physician scheme to stand-alone PMTCT facilities. The scheme, whereby district hospital physicians and district supervisors for M&E and laboratory services travel weekly to health centers to provide integrated technical oversight, was previously implemented in ART sites only (see the *Sustainability* section for further details). As a result, PMTCT and ART facilities alike greatly benefit from their district physicians' oversight and mentorship.

In total, we support PMTCT services at **39** facilities. At these sites, **5,626** pregnant women knew their HIV status this quarter, including women who were tested and received their results in a focused ANC or maternity setting, which includes PMTCT. In total, **148 (2.6%)** pregnant women were HIV-positive—counting 79 with previously known HIV-positive status—lower than recent estimates of national HIV prevalence among pregnant women in Rwanda.³ All received continuous counseling on infant feeding and were encouraged to breastfeed for 18 months. With regard to treatment, **128 (86%)** received triple ART for life. As per national HIV guidelines, all HIV-positive pregnant women should receive lifelong ART. At the end of the quarter, **4 (3%)** of the other HIV-positive pregnant women were ineligible; **1 (<1%)** were awaiting confirmation of their eligibility; **1 (<1%)** was in denial about her positive status and refusing treatment; **4 (3%)** had been referred elsewhere; and **10 (7%)** were lost to follow-up.

The facilities we support conduct early infant diagnosis in line with the national program which requires infant testing from six weeks to 18 months. This quarter, **186** HIV-positive pregnant women delivered babies at HCSP-supported sites. In total, **142 (76%)** HIV-exposed infants underwent HIV testing within one year of birth at HCSP-supported facilities, and **135 (73%)** were started on CTX prophylaxis at six weeks. Of those who received their results by the end of the quarter, **2 (1.4%)** tested HIV-positive. Through our quality assurance and supportive supervision activities, we intend to reinforce the application of national protocols to ensure that all HIV-exposed infants are tested and given ARV and CTX prophylaxes.

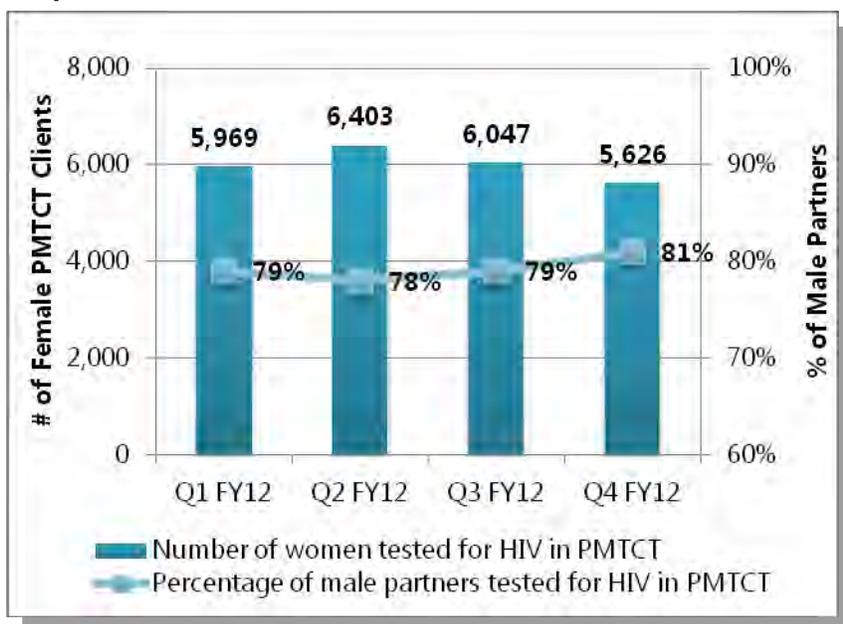
³ The World Health Organization's *Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access, Progress Report 2011* estimates HIV prevalence as 4% among pregnant women in Rwanda.

Furthermore, **521** HIV-positive pregnant or breastfeeding women received food and nutritional supplementation.

In collaboration with local authorities, PLHIV community volunteers, HCSP-supported health facilities and their mother support groups, we organized sensitization and education sessions for families of HIV-

positive women enrolled in PMTCT services. The health facilities we support also conducted routine testing of male partners of women receiving ANC or PMTCT services.

Graph 3: Male Involvement in PMTCT



The health facilities we support also conducted routine testing of male partners of women receiving ANC or PMTCT services. This quarter, **4,565 (81%)** male partners of women receiving PMTCT services were tested for HIV. Of these men, **72 (1.6%)** were found to be HIV-positive, referred for enrolment into HIV care and treatment services, and advised to join PLHIV cooperatives or support groups.

HIV Treatment and Antiretroviral Therapy Services

Table 4: HIV Treatment Results

PEPFAR Indicator	Quarterly results				COP11 result	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	34	34	25	136%
Adults and children with advanced HIV infection newly initiating ART	192	300	361	208	1,061	1,460	73%
Adults	173	265	344	196	978	1,241	79%
Children	19	35	17	12	83	219	38%
Adults and children with advanced HIV infection receiving ART	6,739	6,759	6,999	7,206	7,206	7,984	90%
Adults	5,988	6,237	6,469	6,731	6,731	6,786	99%
Children	545	522	530	475	475	1,198	40%
Adults and children with advanced HIV infection ever started on ART	10,243	10,401	10,644	11,051	11,051	11,057	99.9%

PEPFAR Indicator	Quarterly results				COP11 result	COP11 target	% of target achieved
	Oct – Dec 11	Jan – Mar 12	Apr – Jun 12	Jul – Sep 12			
Adults	9,013	9,457	9,687	10,374	10,374	9,399	110%
Children	1,230	944	957	677	677	1,658	41%
Number of persons trained in ART*	3	0	84	103	111	50	22%

* Note that this figure excludes individuals from facilities outside the IntraHealth HCSP intervention zone.

The HCSP supports a total of **40** accredited ART sites, **34** of which are fully operational and contributed data for this report. As of September 30, the 6 remaining sites—Rwahi, Nyagatare, Cyondo, Muhambo, Bugaragara and Mimuri health centers—had not yet completed training and equipment procurement following their new accreditation, but will be operational soon. Each ART site we support offers a comprehensive pediatric and adult ART package that includes CD4 counts, clinical chemistry and hematology tests, clinical clearance testing and monitoring, and viral load tests once a year, while integrating TB, nutrition, PC, GBV, and FP services. The HCSP continued to closely collaborate with the RBC to train and mentor service providers in the new national HIV care and treatment guidelines this quarter, following the RBC guide for clinical mentoring.

The HCSP technically and financially supported task shifting training efforts led by the RBC in our supported districts. Last quarter, two HCSP staff were certified as national task shifting trainers during a training of trainers session held in Musanze. Throughout this quarter, they organized with RBC district-wide task shifting training sessions for providers in our supported districts. Such trainings will increase the number of service providers trained to deliver quality ART services to HIV-positive clients according to national guidelines and protocols—eventually, to at least two nurses per health facility. Across our supported districts, **26** nurses were trained in Gasabo, **25** were trained in Gicumbi, **26** in Nyagatare, and **25** in Rulindo. Among them, only one provider in Gasabo failed the post-training test, requiring her to retake the training in a later session.

During this quarter, **196** adults and **12** children with advanced HIV infection initiated ART. We reached only 73% of our target to start new clients on ART for year five. Despite efforts to identify new positive clients and recover clients lost to follow-up—and put them on treatment—this indicator seems to be following a decreasing trend. Timely HIV testing and early initiation of prophylaxis have markedly improved the health of HIV-positive clients, delaying the start of ART—a possible reason for low target achievement of this indicator.

At the end of this quarter, **6,731** adults and **475** children with advanced HIV infections were receiving ART. In total, **11,051** individuals have ever received ART at HCSP-supported sites, including **10,374 (94%)** adults and **677 (6%)** children under 15.

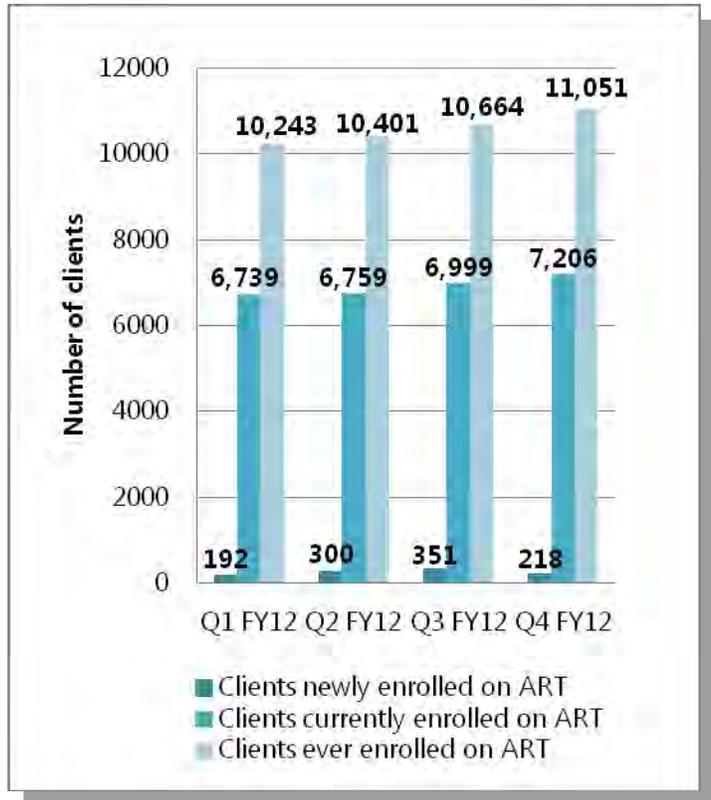
Last quarter, ART service personnel at Nyagatare Hospital expressed their need for greater capacity in pediatric HIV and AIDS clinical service provision. In collaboration with them and other hospital staff, we realigned their subgrant budget to accommodate a study visit to Kibagabaga Hospital’s pediatric palliative care center for the physician in charge of ARV services at Nyagatare Hospital. This week long visit took place in September.

Indeed, the HCSP recognizes pediatric ARV treatment as a program priority. Currently, children constitute 7% of all clients on ARV at the facilities we support, a proportion in line with national

figures and the experiences of other partners in Rwanda. Even so, we recognize that compared with our target, few HIV-positive children initiated ART during year five. Our target achievement of this indicator has been low throughout the project, despite our training and supportive supervision in pediatric care, and implementation of many strategies to increase the enrolment of HIV-positive children into care and treatment. These strategies include using effective tracking systems to encourage the return to care of more children lost to follow-up, integrating PITC into pediatric and outpatient wards and voluntary TC with parental consent at all other service delivery 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 recent quarters we conducted a series of mentorship visits to physicians and ART nurses at each of the four district hospitals we support, focused on 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. Therefore, in

Graph 4: ART Client Enrolment



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				COP11 result	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	10,458	10,901	10,536	11,625	11,625	11,527	101%
Adults	9,552	9,907	9,716	10,576	10,576	9,698	109%
Children	906	994	820	1,049	1,049	1,829	57%
Number of HIV-positive persons receiving cotrimoxazole (CTX) prophylaxis	10,337	10,779	10,536	11,486	11,486	11,527	99.6%
Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	858	539	326	95	921	1,058	81%
Number of HIV-positive patients who were screened for TB in HIV care or treatment settings	10,337	10,779	10,536	11,486	11,486	11,527	99.6%
Number of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	36	42	29	17	124	185	67%
Number of persons trained in any HIV service	33	17	84	137	228	90	182%

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; nutritional support and infant weaning; and care delivered by community volunteers to clients in their homes. During this quarter, **137** providers were trained in HIV-related clinical services.

Between July 1 and September 30, **10,576** HIV-positive adults (**36%** males and **64%** females) and **1,049** HIV-positive children (**49%** males and **51%** 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. In HIV care and treatment settings, patients are routinely screened for TB and those with TB are referred to the facility's TB service area. Although our target achievement for the number of HIV-positive clients who started TB treatment may be low, we do not believe this reflects any weakness in the actual care provided at our supported sites. This quarter, **11,486** PLHIV were screened for TB and **17** tested positive for TB and initiated treatment. Similarly, TB patients are routinely screened for HIV. As well, **106** registered TB patients received HIV TC and results.

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- and facility-based mother support group 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 peer counselors for other women, particularly new mothers receiving PMTCT services. In previous quarters, we trained 39 mother counselors. They coordinate and manage peer support groups, adherence counseling, home visits, and the tracking of mother-infant pairs 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. From the time of diagnosis until end of life, 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 at all supported facilities to **11,625** PLHIV (**93%** adults and **7%** children) this quarter.

In June, the MOH senior management team approved a number of new PC tools, including patient files, home-based care records, referral forms, and reporting templates. This quarter, we liaised with local printers to produce these materials. The RBC will be responsible for disseminating the materials, and orienting providers on their use, at hospitals whose staff are trained to provide PC services.

We also anticipate that the NCD TWG will host a workshop at the end of 2012 to mobilize resources for NCD interventions; PC will feature prominently in this discussion

which should ensure the inclusion of PC in the NCD strategic plan, currently in draft form.

Trainers from the five provincial hospitals trained in quarter two will lead subsequent training at the district, health center, and community levels, and oversee the first phase of PC integration into core health services countrywide. Thus far, multidisciplinary PC teams at the trained hospitals are established and functioning. For example, the PC team at the University Teaching Hospital of Kigali meets every Thursday to discuss complicated cases and coordinate care, and this quarter Kanombe Military Hospital's team was established and quickly got involved in setting up a new pain management unit at their hospital.

In August, we conducted PC training sessions for a multidisciplinary group of providers—physicians, nurses, social workers, nutritionists, pharmacists, and mental health counselors—at the four district hospitals we support. In total, **34** providers were trained. National trainers from the MOH led these sessions together with the HCSP, and will facilitate post-training follow-up and mentorship after the close of HCSP technical activities.

Also this quarter, we oversaw minor renovations and procurement of items such as tables, chairs, and toys to set up child-friendly pediatric PC spaces at Byumba and Nyagatare hospitals. The new spaces are modeled after the Kibagabaga Hospital pediatric PC center, and will serve as attractive waiting and play areas for children receiving ART services.

Also, in recognition of the importance of facility-community linkages along the continuum of care, we procured home-based care kits for community volunteers associated with the ART facilities we support to facilitate their home visits to PLHIV. The kits contain necessities such as thermometers, gloves, condoms, oral rehydration salts, soap, raincoats, umbrellas, rubber boots and other essential items.

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. This quarter, we collaborated with the hospital to stage nutritious cooking demonstrations and distribute 50 goats among impoverished families in Ndera Sector, the Rubungo Health Center catchment area. The other three districts we support are also replicating this nutrition program. In Gicumbi this quarter, we collaborated with Byumba Hospital to hold a similar cooking demonstration and distribute 80 goats among impoverished families at Rushaki Health Center. We expect the impact of these activities to be twofold: participants will adopt more nutritious cooking techniques, improving their nutritional status; and the small livestock will become a source of income.

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, Ibyiringiro activities reached **524** HIV-exposed infants aged 6 to 18 months, as well as **124** pregnant and lactating women.

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.

As of the end of this quarter, **8,679** PLHIV had kitchen gardens. The gardens grow vegetables, 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 July and August, the HCSP nutrition officer, a national-level master trainer in the maternal, infant and young child nutrition counseling package, collaborated with Kibagabaga, Byumba, and Rutongo hospitals and district and site-level trainers to train **903** community health workers in Gasabo, **1,261** in Gicumbi, and **730** in Rulindo. Training participants included community health workers from outside our intervention zone.

Laboratory

Table 6: Laboratory Services Results

PEPFAR Indicator	Quarterly results				COP11 result	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	45	45	45	100%
Number of lab personnel at HCSP-supported sites trained	0	29	0	51	74	45	164%

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 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 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.⁴

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. Since then, we have been working with SCMS to facilitate procurement and install equipment on site as it becomes available. We distributed all remaining laboratory equipment during August and September.

⁴ Miyove Prison does not offer PMTCT services.

Together with MOH trainers, our laboratory support officer trained **17** laboratory technicians and **16** nurses from Gasabo in post-vasectomy semen analysis and counseling this quarter, including 9 laboratory technicians and 9 nurses from outside our intervention zone. Thus, where vasectomy services are provided at facilities we support, at minimum one laboratory technician and one nurse are trained per site.

In August, **45** laboratory technicians from our supported facilities and **1** from a non-HCSP-supported site were trained in waste management and laboratory safety precautions including proper identification, storage, and disposal of expired or damaged chemical and hazardous products.

Post-exposure Prophylaxis

Table 7: Post-exposure ARV Prophylaxis Results

PEPFAR Indicator	Quarterly results				COP11 result	COP11 target	% of target achieved
	Oct – Dec 11	Jan – Mar 12	Apr – Jun 12	Jul – Sep 12			
Number of persons provided with PEP	79	106	86	62	333	350	95%
Number of providers at HCSP-supported sites trained in PEP provision	7	0	84	103	131	90	146%

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.

Between July and September 2012, **72** individuals were provided with PEP: **11** individuals were provided with PEP for occupational reasons and **61** for non-occupational reasons, including **37** survivors of sexual violence. 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, we are told by health centers, communities have also become more conscious of the need to seek PEP as soon as possible after exposure. As a result of 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	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	10,901	10,536	10,901	10,901	11,527	95%
Number of service providers trained in PwP at HCSP-supported facilities	41	9	84	137	137	90	152%

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 TC 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, **137** service providers from HCSP-supported facilities were trained to provide PwP services and **10,901** 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	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	45	45	45	100%
Number of women who attended the first ANC visit of their pregnancy	5,754	6,457	6,078	5,592	23,881	28,028	85%
Number of deliveries attended by a skilled birth attendant	6,172	5,114	6,100	6,394	23,780	17,097	139%

HCSP Key Indicator	Quarterly results				COP11 result	COP11 target	% of target achieved
	Oct – Dec 11	Jan – Mar 12	Apr – Jun 12	Jul – Sep 12			
Infants under 12 months who received DPT3 (Diphtheria, Pertussis, Tetanus) vaccinations	6,670	6,315	5,661	6,321	24,967	28,028	89%
Children under five who received Vitamin A	67,942	14,335	7,599	2,674	92,550	121,040	76%

In follow-up to a community education campaign on tubal ligation in Nyagatare and Rulindo districts last quarter, in July the HCSP facilitated training sessions on tubal ligation for **20** providers: five from each of the districts we support. The training focused on performing mini laparotomy which, under local anesthesia, reduces post-operation complications. The training participants will be certified by MOH trainers following a period of practice and mentorship.

Across each of the districts we support, **83,706** 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 in quarter four of last year. 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.

This quarter, we launched CBP training in Gasabo and Nyagatare districts. First, **17** facility personnel in charge of community health were trained in FP, and **23** facility-level FP trainers were oriented on CBP tools. Thereafter, the facility FP trainers led **478** community health workers in Gasabo and **630** in Nyagatare through two weeks of theoretical and practical CBP training. We also purchased registers, forms for referrals and reporting, and other tools so that community health workers in these two districts can begin implementing CBP activities. Post-training mentorship and certification will be overseen by the MOH and district- and facility-level trainers.

Last quarter we finished refurbishing and partitioning Ndera Health Post in Gasabo District so that FP services, including gynecological exams and IUD insertion, could be provided in a private space. This quarter we procured important equipment such as a gynecology lamp and table, an IUD kit, and Jadelle removal kit, enabling the health post to provide FP services to the great number of HIV-positive clients at nearby Rubungo Health center, a faith-based facility that does not offer FP services.

In the interest of sustainability, we created a pool of trainers in emergency obstetric and neonatal care (EmONC) in each district we support. Each district selected its trainers in quarter two, who then underwent 10 days of training to become trainers in March. In total, 16 district trainers, 4 from each district, were trained. Throughout this quarter, all 16 trainers across the four hospitals received post-training follow-up and mentorship from the HCSP and MOH. Each has identified EmONC needs in their respective districts and mentors the health centers under his or her supervision. As well, each of the 16 was certified during quarter four sessions to train an additional **24** providers from Gasabo, **24** from Gicumbi, **24** from Nyagatare, and **22** from Rulindo in EmONC. The MOH will support the costs of all subsequent post-training follow-up activities.

In July and August, we supported training for **34** providers in Gicumbi, **32** in Nyagatare, and **25** in Rulindo on the integrated management of neonatal and childhood illness (IMNCI). Gasabo District providers were previously trained by another partner. As a result of these trainings, the facilities we support fulfill the MOH requirement of at least four providers per facility trained in IMNCI.

Gender and Gender-based Violence

Table 10: Gender and GBV Results

HCSP Key Indicator	Quarterly results				COP11 result	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	45	45	45	100%
GBV survivors who received care and support	287	273	307	227	1,094	450	243%
Individuals trained in care and treatment of GBV survivors*	251	1,563	291	391	2,496	3,669	68%

* Note that results include both service providers and community health workers from facilities we 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 provide a district support package only, and Miyove Prison. All personnel at HCSP-supported facilities are trained to provide care to GBV survivors. This quarter, we organized training for **391** community health workers in Rulindo. We also launched a mobile supervision scheme for GBV this quarter whereby district GBV focal points and trainers visited the health centers and community health workers under their supervision to provide post-training mentorship, and ultimately reinforce facility-community linkages for sustained follow-up and monitoring of GBV survivors.

While setting targets for year five, we were still awaiting MOH guidance regarding the kind of community health workers to train in GBV services. During the course of the year, the MOH instructed that only binome community health workers should be trained in GBV. With our Rulindo training session this quarter, we fulfilled this requirement. However, because we had initially planned to train other types of community health workers as well, our target achievement is low on this indicator.

Throughout quarter four, **227** GBV survivors received appropriate care and support. Documentation of this care and support was facilitated by client registers with integrated GBV components at the sites we support. Unfortunately, due to delays in procurement by the MOH of the newly approved national registers, we were unable to distribute these important tools to our supported sites.

The one-stop GBV service center at Nyagatare District Hospital was operational throughout this quarter, with a full-time police officer on site. Apart from providing continued care to survivors of violence, a major component of the center's work is to promote the services on offer. The hospital uses radio spots to educate people about the importance of seeking health services after violence. Health center personnel also sensitize their clients about GBV services during all consultations. Also this quarter we supported the hospital in a specialized campaign to eliminate GBV at the family level. During the campaign, more than 600 families experiencing conflict were identified, and support groups and community monitoring systems were established in attempt to resolve the conflicts. District authorities are also exploring ways to mobilize funds for IGA to be managed by the new support groups.

We have also taken first steps toward launching a one-stop GBV service center at Byumba Hospital in Gicumbi District. Last quarter we accompanied the MOH and Rwanda National Police during a needs assessment to determine the immediate feasibility of establishing a one-stop center at the hospital. Major needs identified include minor renovations, material procurement, and staff training. In light of the limited time left before close of the HCSP, and in consultation with USAID and

IntraHealth headquarters, we committed to supporting renovations and procurement, both of which were completed this quarter.

After a protracted process, the MOH approved the contents of the national GBV kits in May 2011. Even so, they are still unavailable at CAMERWA. For this reason we chose to procure the materials on our own from local pharmacies, and distributed them among our supported sites this quarter. At the same time, we disseminated information, education and communication materials developed as part of the PEPFAR Special Initiative on Sexual and Gender-based Violence, and revised by the GBV TWG.

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. 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 October, 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 2012

District	Lowest Quality Score (%)	Highest Quality Score (%)
Gasabo	82.6	98.8
Gicumbi	17.7	99.8
Rulindo	89.7	86.3
Nyagatare	64.1	94.8

Miyove Prison again received the lowest quality score in Gicumbi (17.7%) last quarter, and receives intensive support for its dispensary services. Nyagatare Health Center has made a conscientious effort to raise its quality scores in recent quarters, but remains with the second lowest score in the district (64.1%). 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 (82.6%) last quarter. In Rulindo, Remera-Mbogo Health Center achieved the lowest score (89.7%).

The highest scores last quarter were achieved by Jali Health Center in Gasabo (98.8%), Mukono Health Center in Gicumbi (99.8%), Murambi Health Center in Rulindo (96.3%) and Mimuli Health Center in Nyagatare (93.2%).

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.

MONITORING AND EVALUATION

When in August 2010 the MOH put in place new data collection tools and an upgraded TRACNet reporting system that incorporates TC/PMTCT data with ART data, we intensified our training and support to data managers to ensure correct collection, management and reporting of service data. Again in quarter two, the MOH introduced new registers and tools for ANC, maternity, FP, and mother-infant pair follow-up. The M&E team immediately oriented HCSP clinical services officers who, together with district-level M&E officers and their respective district mobile supervision teams, continue to mentor health facilities to ensure high quality data. Rulindo was the last of our supported districts to receive formal introduction to the tools. With the MOH and Rutongo Hospital, we organized an orientation session from July 31-August 1 for **12** nurses from Rulindo health facilities—including some from outside the HCSP intervention zone—to ensure the correct and complete use of the new tools.

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. We closely monitor facility-level clinical service data, ensuring their reliability and validity, and participate in supportive supervision visits with other HCSP technical staff, and hospital and district supervisors.

Responsibility shared among all stakeholders improves the sustainability of best practices in data generation and management.

Our M&E team will be of vital importance during the administrative close-out of the HCSP, and special attention was awarded this quarter to ensure that all data management systems are completely filled with accurate data and generally running smoothly, both centrally in the IntraHealth Kigali office as well as in our supported districts and facilities.

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 year, 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.

As above, in August, **46** laboratory technicians were trained in waste management and laboratory safety precautions including proper identification, storage, and disposal of expired or damaged chemical and hazardous products.

OPERATIONS AND SUPPORT

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—a reflection of in-depth understanding of USAID rules and regulations. Our efforts to strengthen facilities and districts' management skills have paid off: we are confident in their ability to manage other donor funds in the absence of our support.

Facility renovation work concluded this quarter. At Byumba and Nyagatare hospitals, we supported renovations to create child-friendly pediatric PC spaces. We also completed renovations and procurement for Byumba Hospital's one-stop GBV service center. The official handover by the contractor will occur in October.

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 drew nearer to the end of the project, our capacity building efforts favored 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, was tasked with ensuring the HCSP's smooth exit from the sites we support. The GOR, USAID, IntraHealth and other USAID-funded clinical partners continued to move forward this quarter in our harmonized approach to transition. A thorough evaluation identified Gicumbi as the strongest of our supported districts and the first to eventually be transferred to the MOH under the USAID Family Health Project led by Chemonics. Health personnel salaries and PBF will be managed by the MOH with the start of October.

In this last quarter of technical implementation, 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. The HCSP technical team worked directly with district hospital supervisors to streamline planning and ensure joint supervision visits based on real needs as well as program priorities. We continued to support our extended mobile district supervision scheme. In collaboration with district authorities and hospital personnel, we integrated data managers and laboratory technicians into each district's mobile supervision plan. Expanding upon our mobile approach not only reinforces the sustainability of district supervision, it ensures structures and personnel are in place to provide technical mentorship, even after the HCSP's close.

We are certainly deeply involved in planning and supporting activities with district-level institutions. For example, throughout the quarter we participated in Joint Action Development Forum initiatives in each of the districts we support. The role of the district will be central to a successful transition. In the last quarter of year four, 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 management teams (DHMT). Responsible for overall coordination of the district health system, each DHMT 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. DHMT meetings were held quarterly, and the districts were responsible for covering all costs. HCSP staff participated in each district's DHMT meeting this quarter. Going forward, the HCSP will work closely with each DHMT to strengthen district capacity in health system management.

Mindful that health workers constitute the crux of the Rwandan health system, from September 3-4 we facilitated a workshop to prevent health worker burnout, attended by **20** Gasabo and Gicumbi HIV and AIDS service providers. Together with an external consultant, HCSP staff covered important themes such as indirect trauma, seeking counseling, and relaxation techniques, to teach providers how to take care of themselves and prevent burnout.

HIGHLIGHTED CHALLENGES

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

- **Year five work plan implementation and monitoring:** In the final quarter of normal program activities, it was more important than ever that we closely monitor activity implementation to ensure that all activities were successfully completed and all funds spent according to our work plan and budgets. In the context of limited time and ad hoc requests from our partners, following our work plan as precisely as possible—and feasible—was a noteworthy challenge. We collaborated not only with our subgrantees but also our headquarters office and USAID to maximize our impact and ensure full spending, tracking activity progress and expenditures daily.
- **High turnover of HCSP staff at project close:** As the closing date of the HCSP draws nearer, HCSP staff are understandably securing new positions with other projects, particularly the Chemonics-led Family Health Project. This quarter, a number of staff members left the HCSP in pursuit of other endeavors. We have instituted succession plans and hired temporary staff as necessary to ensure that the HCSP remains fully operational.

NOTABLE ACCOMPLISHMENTS

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

- **Three posters presented at the 19th International AIDS Conference in Washington, DC:** In July, three HCSP posters were showcased in Washington, DC at the 19th International AIDS Conference: *Pediatric HIV-free survival at 18 months in IntraHealth-supported prevention of mother-to-child transmission programs in Rwanda*; *Rapid results, promising outcomes: PMTCT results over two years in Rwanda*; and *Retrospective tracking for prospective monitoring: following HIV-positive mothers and their infants in Rwanda*. Each of the posters presented data managed in our PMTCT mother-infant tracking database.
- **ART accreditation for 15 new facilities:** In light of new national HIV treatment guidelines, the MOH is in the process of accrediting standalone PMTCT site throughout the country as ART sites. To date, **15** of our supported PMTCT standalone sites are newly accredited. With HCSP training and mentorship, ART services are already operational at **9** facilities: Tanda, Giti, Gisiza, Muhondo, Ruhenda, Murambi, Bwisige, Mulindi, and Remera-Mbogo health centers.
- **Important renovations for specialized services at district hospitals:** Essential infrastructure and equipment were put in place this quarter for child-friendly pediatric PC spaces at Byumba and Nyagatare hospitals, modeled after Kibagabaga Hospital's successful pediatric PC center. The new spaces will allow for improved pediatric care at both hospitals. Also this quarter, we completed renovations and procurement for Byumba Hospital's new one-stop GBV service center, a welcome addition to the hospital that will ensure integrated, high quality care for survivors of violence.
- **Significant cost share achievements:** Cost share refers to contributions, whether financial or in kind, by other partners to a project. High achievements in cost share reflect strong relationships between the lead implementer and its partner associations, and efficiency in leveraging resources. The HCSP's cost share requirement is 10% of our total budget which, after the cost extension granted by USAID in May, equals \$2,935,713. Thanks to successful collaboration with our local partners, our cost share to date is \$2,994,455, with another \$87,796 in process.

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