



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
AZT	Azidothymidine
CDC	Centers for Disease Control and Prevention
CITC	Client Initiated Testing and Counseling
CNLS	National AIDS Control Commission
COP10	2010 Country Operational Plan
CRS	Catholic Relief Services
CTX	Cotrimoxazole
DBS	Dried Blood Spot
DHN	District Health Network
EmONC	Emergency Obstetric and Neonatal care
FOG	Fixed Obligation Grant
FP	Family Planning
GBV	Gender-based Violence
GOR	Government of Rwanda
HART	HCSP Aggregate Reporting Tool
HCSP	HIV/AIDS Clinical Services Program
HIV	Human Immunodeficiency Virus
IGA	Income-generating activity
IMNCI	Integrated Management of Neonatal and Childhood Illness
IUD	Intrauterine Device
MCH	Maternal and Child Health
MEMS	USAID Monitoring and Evaluation Management Services
MIGEPROF	Ministry of Gender and Family Promotion
MOH	Ministry of Health
M&E	Monitoring and Evaluation
NRL	National Reference Laboratory
OSSTL	Operations and Support Senior Team Leader
PAQ	<i>Partenariat pour l'Amélioration de la Qualité</i>
PBF	Performance-based Financing
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
PwP	Prevention with Positives
RH	Reproductive Health
RRP+	Rwanda Network of People Living with HIV/AIDS
SGBV	Sexual and Gender-based Violence
STA	Senior Technical Advisor
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 National AIDS Control Commission (CNLS), district health units, 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 January-March 2011, we supported **93** subgrants:

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

Table 1 below depicts how our support is provided across different sites and services in the districts of Gasabo, Gicumbi, Nyagatare and Rulindo.

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

		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	-	-	-	-	-	-	-	-	-

		Number of subgrants	PBF	Number of sites by service supported							
				TC	PMTCT	DBS	ART	PC	TB/HIV	FP/HIV	GBV
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

These grants are designed to support health centers, hospitals and district health units in achieving district and national objectives. An HIV and AIDS clinical services project by name, our work is strengthened by our commitment to palliative care and service integration, as well as the cross-cutting fields of 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. Twice every fiscal year,¹ we organize with each DHU a two- or three-day meeting that brings together all the sites we support to evaluate performance and target achievement, find solutions to obstacles impeding the implementation of activities, and revise work plans and budgets. The most recent meetings were held over three weeks in January and February. Participants, including representatives of USAID and all the health facilities we support, identified a number of areas that would benefit from increased support from the HCSP. Among them were joint review and planning; subgrantee reporting and payment procedures; new and refresher training in accounting and data management for health facility staff; and routine feedback between the HCSP and sites, especially on financial reporting.



In January, the HCSP organized with each DHU two- or three-day meetings to evaluate performance and revise work plans and budgets.

Also this quarter, from March 28-30, three HCSP team leaders completed a three-day training session on USAID/CDC administrative compliance requirements organized in

¹ The subgrants we have with our partners are aligned with the fiscal year of both the Government of Rwanda and IntraHealth: July 1 to June 30.

Kigali by the Center for Development Excellence. They are already applying their knowledge to their daily work.

Our technical and management staff participate in several technical working groups (TWGs) of the Rwandan Ministry of Health (MOH), including the TWGs for HIV prevention, HIV care and treatment, tuberculosis (TB)/HIV integration, palliative care, 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 Pediatric HIV/AIDS Steering Committee, the PBF Extended Team, the Quantification Committee and the Joint Action District Forum. We have also been active in the CNLS-led steering committee for the 6th International Conference for Exchange and Research on HIV/AIDS (to be held in Kigali in June 2011) since this group's first meeting in February. Such participation provides a forum for the HCSP to share lessons we have learned as well as learn from the lessons of others. It also enhances our partnership with the MOH and aligns our work to Rwandan priorities. For example, next quarter we will begin to explore how the HCSP may support finger prick HIV testing and male circumcision activities.

PEPFAR PROGRAM AREAS

From January 1 – March 31, 2011, the HCSP used President's Emergency Plan for AIDS Relief (PEPFAR) funding to support implementation of the 2010 Country Operational Plan (COP10) and help the MOH expand HIV and AIDS clinical service activities and capacity in testing and counseling (TC), prevention of mother-to-child transmission (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. In preparation for our year four semi-annual reporting, we took the opportunity to thoroughly clean our data; we crosschecked results with data sources, eliminated double counting, and consulted with the USAID Monitoring and Evaluation Management Service (MEMS) to ensure accurate calculations. As a result, some of our quarter one data have changed. The figures presented in this report are considered final.

The HCSP works hand in hand with the sites we support. Our clinical services officers spend approximately 80% of their time working alongside health service providers, ensuring adherence to national norms and guidelines. In year three, we developed and field tested a clinical checklist to strengthen quality assurance and clinical service supervision. The checklist was tailor-made for Rwanda, consistent with national guidelines to ensure country specificity, and covers all program areas of the HCSP. The component on GBV, the final program area to be added, was field tested in October and

will be revised as needed by the GBV TWG in its next meeting. Even though the GBV TWG could not meet this quarter, our technical staff already use the checklist in their supportive supervision and find it to be effective. We have shared the tool with the MOH in the hope that it will serve as a model for enhancing existing national tools.

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	100%
Number of individuals who received TC for HIV and received their test results (including TB)	39,692	41,842*			81,534	128,850	63%
Number of persons trained in TC	72	29			101	404	25%

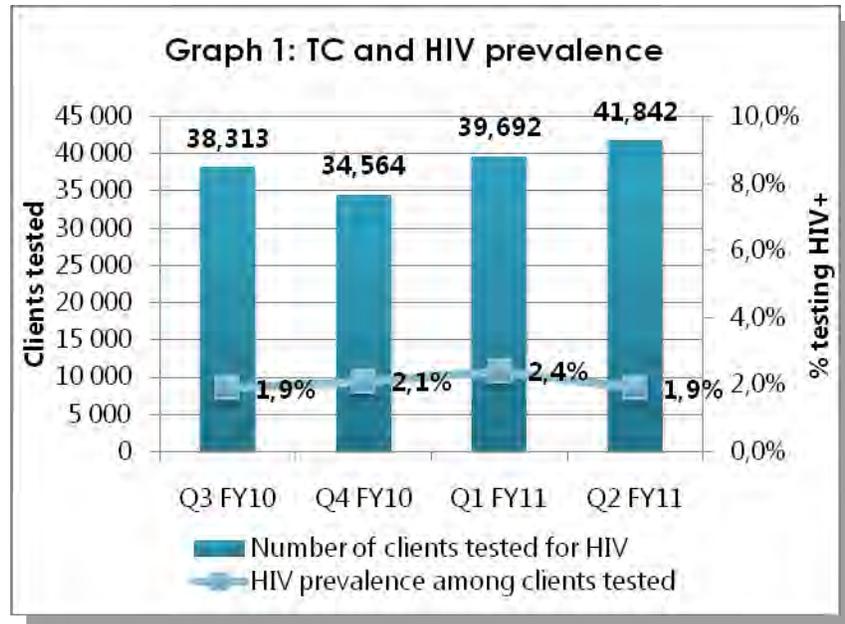
* Note that this figure does not include pregnant women tested in PMTCT.

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 people living with HIV (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 for testing children. While individuals aged 15 or older can either seek testing on their own or receive provider-initiated testing and counseling (PITC), testing children under 15 requires parental involvement. A family approach in all HCSP-supported sites ensures that parents who bring their children for vaccinations or any other service are also 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.

The national campaign against HIV and AIDS, launched on World AIDS Day on December 1, came to an end this quarter. Throughout the campaign the sites we support extended their TC services so that clients could be tested Monday through Friday and on many weekends. We also supported mobile TC services and distributed **28,800** condoms throughout the districts we support. Our staff participated in campaign closing ceremonies in Gasabo and Nyagatare Districts.

As of the end of this quarter, we reached only 25% of our COP10 TC training target. Because we train service providers according to need, it is likely that we overestimated

this target. Thanks to effective training coverage in previous years, our capacity building efforts now concentrate on refresher training, post-training follow-up and mentorship. Only when new service providers join the health facilities we support, or when we initiate support for new sites, do we conduct full training. During this



quarter, **29** new service providers from the sites we support in Gicumbi and Rulindo received initial training in TC services.

Of **37,597** adults tested between January and March 2011, **744 (2.0%)** were found HIV-positive, while **32 (0.8%)** of **4,245** children tested were HIV-positive. All who tested positive were immediately referred 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 HCSP-supported sites, 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, **1,038** couples received pre-nuptial TC services. Of these **2,076** individuals, **44 (2.1%)** tested HIV-positive. **Twenty-seven (2.6%)** couples were sero-discordant. For sero-discordant couples, on-site HIV counselors provided additional counseling with emphasis on the importance of condom use and family planning.

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

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	100%
Number of pregnant women with known HIV status, including women who were HIV-tested and received their results	7,168	7,790			14,958	24,037	62%
Number of HIV-positive pregnant women who received antiretroviral prophylaxis to reduce risk of mother-to-child transmission	107	98			205	716	29%
Number of persons trained in PMTCT	467	29			496	404	123%

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. We continue to participate actively in the PMTCT subcommittee of the Prevention TWG, particularly in the review and revision of protocols, and their implementation at site level.

All HCSP-supported PMTCT sites offer the full package of PMTCT services that consists of HIV testing and counseling; antenatal care (ANC); maternity services; provision of 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.

The HCSP supports **39** PMTCT sites. At these sites, **7,790** pregnant women knew their HIV status, including women who were tested and received their results in a focused ANC setting, which includes PMTCT. Of these women, **196 (2.5%)** were HIV-positive. They received continuous counseling on infant feeding and were encouraged to exclusively breastfeed for the first 18 months.

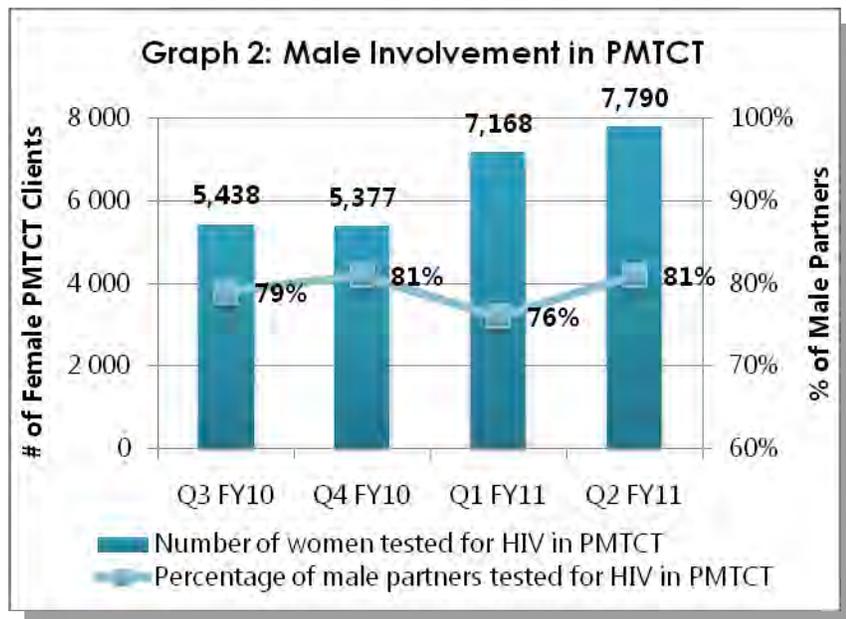
This quarter, **98** pregnant women received ARV prophylaxis in a focused ANC setting. In addition to women who were tested and learned of their HIV-positive status this quarter, they included 85 women with previously known HIV-positive status who may or may not have already received treatment. Since the new PMTCT protocol took effect in

November, we have been supporting sites to phase out azidothymidine (AZT) use in favor of triple therapy. While **2** pregnant woman received azidothymidine monotherapy this quarter, triple therapy was provided to the other women, **29** of whom will receive it for life.

Also, **140** HIV-positive pregnant women followed at HCSP-supported health service sites delivered babies this quarter, and **136 (97%)** of them delivered at an HCSP-supported site. Furthermore, **327** HIV-positive pregnant or lactating women received food and nutritional supplementation.

In collaboration with local authorities, PLHIV community volunteers and the health facilities we support, we organized sensitization and education sessions for families of HIV-positive women enrolled in PMTCT services. The health facilities we support also encouraged testing of

male partners of women receiving ANC or PMTCT services. This quarter, **6,302 (81%)** male partners of women receiving PMTCT services were tested for HIV. Of these men, **113 (1.8%)** were found to be HIV-positive, referred to treatment services and advised to join PLHIV cooperatives or support groups.



In total, **29** service providers completed training on the new national PMTCT protocol this quarter. These were the same new providers in Gicumbi and Rulindo trained in TC. Subsequent supportive supervision visits focused on post-training follow-up, particularly overseeing the services provided to HIV-positive pregnant women and HIV-exposed children.

Next quarter, the HCSP will continue to provide supportive supervision to ensure the correct application of the new national PMTCT protocol.

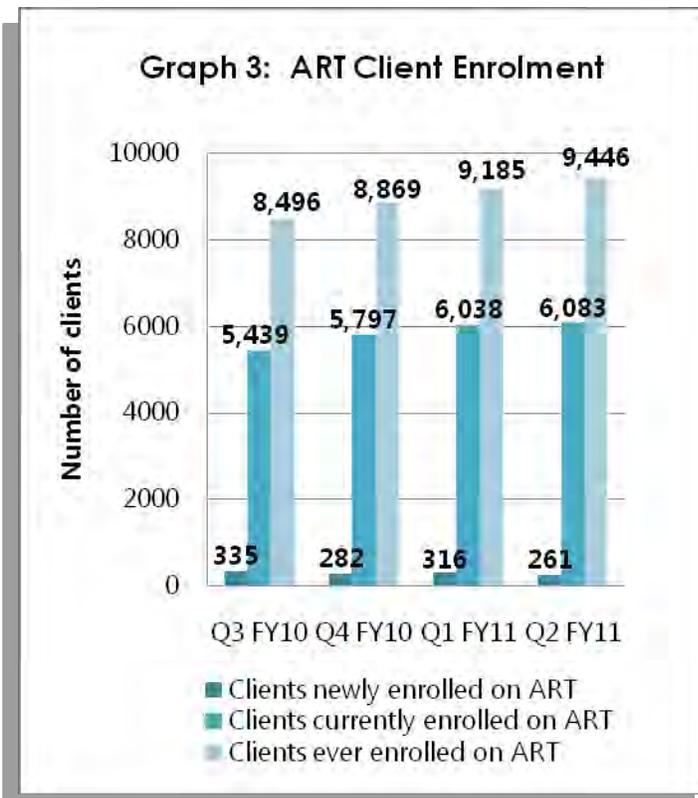
HIV Treatment and Antiretroviral Therapy Services

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	100%
Adults and children with advanced HIV infection newly enrolled on ART	316	261			577	2,130	27%
Adults	287	243			530	1,810	29%
Children	29	18			47	320	15%
Adults and children with advanced HIV infection receiving ART therapy	6,038	6,083			6,083	7,569	80%
Adults	5,503	5,571			5,571	6,434	87%
Children	535	512			512	1,135	45%
Adults and children with advanced HIV infection who ever started on ART	9,185	9,446			9,446	10,626	89%
Adults	8,318	8,561			8,561	9,032	95%
Children	867	885			885	1,594	56%
Adults and children known to be alive on ART 12 months after initiation of ART	247	452			699	1,426	49%
Adults	211	422			633	1,212	52%
Children	36	30			66	214	31%
Number of persons trained in ART	12	0			12	404	3%

The HCSP supports a total of **25** ART sites (3 hospitals, 22 health centers). Each of these sites offers an ART package that includes HIV treatment, CD4 counts, clinical chemistry and hematology tests, and viral load tests at one year; and integrates TB, nutrition, palliative care, GBV, nutrition and FP services.

During this quarter, **243** adults and **18** children with advanced HIV infection newly initiated ART. Thus far, we have reached only 27% of our COP10 target. As HCSP-supported sites increase their efforts to identify new sero-positive clients and put them on treatment, we will 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 of HIV-positive clients, delaying the start of ART – a possible reason for low target achievement thus far of this indicator. Screened HIV-positive clients who were not yet eligible for ART received regular follow-up and evaluation.



At the end of this quarter, **5,571** adults and **512** children with advanced HIV infections were receiving ART. In total, **9,446** individuals have ever received ART at HCSP-supported sites, including **8,561 (91%)** adults and **885 (9%)** children under 15. Moreover, of all clients who newly initiated ART in the January-March 2011 period, **452** 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 two in year three have since transferred to sites outside of our intervention zone.

One of our two field team leaders, a physician, visited Nyagatare and Kibagabaga Hospitals in March to present the latest scientific evidence linking Tenofovir with renal insufficiency. He transferred skills in creatinine clearance testing and monitoring to district physicians, who will in turn transfer the same skills to health center service providers under their supervision. Our guidance was in response to the introduction of Tenofovir in the national protocol for care and treatment, and we will provide the same mentorship to Byumba and Rutongo Hospital physicians next quarter. Our clinical services officers will also support health center service providers to perform routine creatinine clearance tests correctly and according to national guidelines.

With regard to training, our focus this quarter continued to be the mentoring and certification of individuals for whom we have supported ART task shifting training. In January, in collaboration with TRAC Plus and the University of Maryland, we worked with district-level task shifting mentors, both physicians and nurses, to develop their skills in overseeing task shifting in health centers. We then continued to support the TRAC Plus and district mentor teams to certify **31** nurses in Gasabo, **38** in Gicumbi, **37** in Nyagatare and **33** in Rulindo. Two of our technical staff members have also been certified. Next quarter we will pursue certification for the rest of our technical team. We will also work with the sites we support to ensure that nurses trained in task shifting are placed in health center ART service areas. We expect the number of service providers trained in

ART to significantly increase in quarter four, following additional task shifting trainings planned in the districts we support.

In year three, we learned of ART client documentation difficulties, in particular at the district hospitals we support. A number of hospital clients had moved of their own accord to other health facilities nearer their homes and were recorded at the hospitals as lost to follow-up. The HCSP has since reinforced our collaboration with sites, community health workers, PLHIV cooperatives and the Rwanda Network of PLHIV (RRP+) to trace hundreds of patients to date and give them official transfers. We began this work at Byumba and Nyagatare Hospitals. **Two** ART clients remain lost to follow-up at Nyagatare Hospital. We continue to work closely with Kibagabaga Hospital, where **34** ART clients are currently lost to follow-up. Across all the sites we support, **16** clients were recovered this quarter. Despite our progress, we recognize the difficulties faced by the sites. For instance, health facilities located close to the Ugandan border experience substantial cross-border movement of the population, complicating client follow up and home visits. We will continue to encourage home visits and provide supportive supervision to ensure adequate documentation of the problem and accurate data for decision making.

The HCSP recognizes pediatric ARV treatment as a priority for the remaining year and a half of the program. Currently, children constitute approximately 9% of all clients on ARV at our supported sites. While this is in line with national figures and the experiences of other partners in Rwanda, we wish to increase the number HIV-positive children enrolled in treatment, and encourage the return to care of more children lost to follow-up. With this aim, we will continue to emphasize PITC at all service entry points, family-centered services, peer support groups and collaboration with PLHIV cooperatives in community sensitization. Next quarter, we will conduct a five-day training session in pediatric psychosocial care for one provider from each of the ART sites we support together with a provider from Rutongo Hospital. Originally planned for this quarter, the training was postponed to April in large part due to the launch of the national palliative care policy, discussed below. The training will emphasize children’s specific needs with regard to HIV counseling, status disclosure and psychosocial support.

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	11,389	10,731			11,389	15,518	73%

PEPFAR Indicator	Quarterly results				COP10 result	COP10 target	% of target achieved
	Oct – Dec 10	Jan – Mar 11	Apr – Jun 11	Jul – Sep 11			
clinical service							
Adults	10,172	9,773			10,172	13,190	77%
Children	1,217	958			1,217	2,328	52%
Number of HIV-positive persons receiving Cotrimoxazole (CTX) prophylaxis	10,738	10,632			10,738	15,518	69%
Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	771	833			833	1,030	81%
Number of HIV-positive patients who were screened for TB in HIV care or treatment settings	12,145	10,731			12,145	15,518	78%
Number of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	53	56			109	155	70%
Number of infants—born to HIV-positive women—who received an HIV test within 12 months of birth	108	116			224	680	33%
Number of infants—born to HIV-positive women—who are started on CTX prophylaxis within two months of birth	143	108			251	680	37%
Number of persons trained in any HIV service	549	113			662	404	164%
Umbrella Care Indicators							
Eligible adults and children provided with a minimum of one care service	10,704	10,902			12,335	15,518	79%
Adults	9,816	9,848			11,130	13,190	84%
Children	888	1,054			1,205	2,328	52%

Clinical care includes not only ART services, but also other services such as integrated TB/HIV care; prevention and treatment of opportunistic infections and STIs; nutritional support and infant weaning; and care delivered by community volunteers to clients in their homes. During this quarter, **113** providers were trained in HIV-related clinical services. Service providers at the sites we support attribute to these trainings a noticeable decline in the number of cases of opportunistic infections compared with previous quarters. We consider such testimony an indication that the quality of services offered to HIV-positive clients continues to improve.

In addition, the HCSP paid for community health insurance *mutuelles* for **461** indigent PLHIV and their families this quarter.

Between January 1 and March 31, **9,773** HIV-positive adults (**36%** males and **64%** females) and **958** HIV-positive children (**48%** males and **52%** females) received a minimum of one clinical service at an HCSP-supported site. Of these, **10,632 (99%)** received Cotrimoxazole (CTX) prophylaxis.

As well, 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, **10,731** HIV-positive patients were screened for TB in HIV care and treatment settings and **56** initiated TB treatment. Also, **179** registered TB patients received HIV TC and results.

The HCSP does not collect data on the number of live births each quarter. Even so, as mentioned above, we know that **136** HIV-positive pregnant women followed at the sites we support also *delivered* at the sites we support. In total, **116** infants underwent DBS-PCR testing at six weeks of age, among whom **4 (3.4%)** tested HIV-positive and were referred for treatment and follow-up. This quarter, **108** 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 has begun setting up a community-based mothers support program. Modeled after the work of the well-known South African organization Mothers2Mothers, our program will engage HIV-positive mothers as lay counselors for new mothers receiving PMTCT services, and other women. Training for these mother counselors is well underway. This quarter, we trained one counselor each from **13** health facilities in Gicumbi and **11** health facilities in Nyagatare. Sites that did not participate in these training sessions included health centers at Cyondo, which currently has only two HIV-positive mothers enrolled; Rushaki, whose PMTCT services are supported by the Global Fund; Miyove Prison, which does not offer PMTCT services; and Bwisige, which currently has no HIV-positive mothers enrolled. Gasabo and Rulindo training sessions will follow next quarter.

Palliative care

Palliative care 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. Palliative care 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 palliative care services at **42** supported sites, where a total of **10,902** HIV patients (**90%** adults and **10%** children) received palliative care this quarter.

During the first three and a half years of the HCSP, IntraHealth and Mildmay provided technical leadership in the development of Rwanda's first palliative care policy, guidelines and strategic plan. Our support to the MOH in this process bore fruit when the Minister of Health signed all three documents on January 18, putting them into immediate effect. Rwanda is now one of only a few African countries to adopt a national palliative care policy. Since document signature, we have been in regular and frequent dialogue with the MOH, providing them with technical, financial and logistical support to launch the policy. On March 31, the MOH hosted a policy dissemination workshop in Kigali, where approximately 85 health sector partners gathered to learn about the policy, guidelines and strategic plan, and discuss policy implementation. Five key recommendations emerged from the workshop: enable nurses and midwives to prescribe and dispense morphine; inform all health facilities of policy guidelines and ensure their compliance; emphasize impeccable palliative care assessment, particularly in classifying pain; support the MOH to coordinate stakeholders and oversee a clear implementation plan; and create a national pool of palliative care trainers.



The national palliative care policy dissemination workshop on March 31, clockwise from top left: Dr. Eugene Ruberanziza, MOH expert in charge of communicable and non-communicable diseases; Diane Mukasahaha, HCSP palliative care officer; workshop participants.

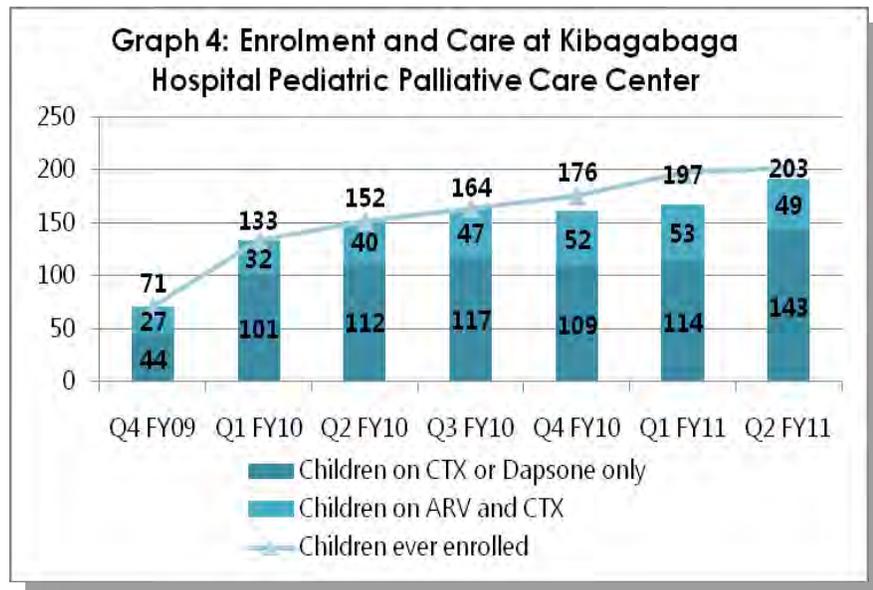
Although service provider training in palliative care was pre-empted by urgent activities related to launching the national policy, in the last week of March, the HCSP nonetheless instigated a training session in home-based palliative care for **37** Nyagatare community health workers. Next quarter, in collaboration with district trainers, the HCSP will organize on-the-job palliative care training for service providers at three new HCSP-supported sites: Mimuri, Ruhenda and Muhondo Health Centers. We will also respond to the fifth policy dissemination workshop recommendation next quarter by coordinating training for national-level palliative care trainers.

The Pediatric Palliative Care Center at Kibagabaga Hospital continued to progress this quarter. A new pediatrician joined the team in March, making possible the provision of pediatric clinical services, in addition to psychosocial services, seven days a week. As of

March 31, **203** children were ever enrolled, **143** on CTX or Dapsone only, and **49** on both ARV and CTX. None were malnourished, and average adherence was estimated at 99%. While **4** children were transferred to another facility and **1** died, **6** HIV-exposed children under 18 months were discharged as a result of their confirmed negative status. These 11 children explain the gap in Graph 4, below, between children ever enrolled and children on treatment.

Psychosocial support comprises an important aspect of the comprehensive care provided at the center. This quarter, **88** children and **76** parents and guardians participated in support groups at the center.

Spurred on by the success of its pediatric palliative care work, the hospital established a new adult palliative care ward in August 2010. By March 31, it was caring for **55** patients living with HIV, cancer, heart disorders and progressive neurological disorders,



among other illnesses. Hospital staff are organized into a multidisciplinary team whose weekly meetings are routinely attended by HCSP staff. The team uses a series of tools for inter-departmental and hospital-community referrals to ensure a holistic approach to caring for adults and children with chronic illnesses.

In February and March, the HCSP organized weeklong clinical placements for two physiotherapist members of the multidisciplinary team. One visited the University Teaching Hospital of Kigali to learn about electrotherapy for rehabilitation, and the other went to Gahini District Hospital in Gatsibo District, which is specialized in physiotherapy and rehabilitation for adults and children. The Kibagabaga Hospital physiotherapy department has since developed a rehabilitation plan for pediatric and adult patients. This plan will no doubt benefit a large number of clients living with conditions such as paralysis or cerebral palsy, both common in PLHIV.

In light of its achievements, Kibagabaga Hospital mentors neighboring health centers, sharing its own best practices, to enable them to initiate and manage their own

palliative care units. A focus for the HCSP is to support the hospital in extending its multidisciplinary, family-centered palliative care approach to all HCSP-supported ART sites. Our field team leaders are also overseeing the establishment of multidisciplinary teams first in our supported hospitals, and then in the health centers we support, to coordinate holistic care. We plan to take advantage of the multidisciplinary teams' weekly meetings to provide clinical updates and informal trainings such as those done this quarter at Nyagatare and Kibagabaga Hospitals on creatinine clearance testing, described above.

In February, Mildmay used non-HCSP funds to send our palliative care officer to the Mildmay International Leaders Meeting at Mildmay headquarters in the United Kingdom. While there, she received practical training in women's support groups at the Sussex Beacon, one of two clinical care centers in England specialized in HIV and AIDS. Next quarter, following the Sussex Beacon model, she will work with Kibagabaga Hospital to institute a cooperative and support group for mothers of children enrolled at the pediatric center.

The director of Kibagabaga Hospital, Dr. Ntizimira, will also benefit from international training next quarter when he begins a course on palliative care at Harvard University in April. In recognition of the value Dr. Ntizimira's successful completion of the course will add to national expertise in palliative care, the HCSP has covered course tuition costs. Classroom study at Harvard University takes place during one week in April and one week in November, between which students carry out individual study projects. Dr. Ntizimira's study project will be implemented at Kibagabaga Hospital.

Also next quarter, the HCSP will arrange a week-long clinical placement at Mildmay Uganda in May for the new pediatrician and the medical chief of staff at Kibagabaga Hospital. We will also continue with our regular supportive supervision to palliative care service providers.

Nutrition Support

Proper nutrition is a central part of human health, and it 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 income-generating activities (IGAs) to benefit PLHIV cooperatives at our supported health facilities. Among all HCSP-supported sites, **42** have established gardens. Unfortunately, due to lack of suitable space, Kibagabaga Hospital is unable to set up a garden. The other two facilities

still without kitchen gardens, Nyagatare Hospital and Karangazi Health Center, have committed to creating theirs in the coming months.

During January and February, we organized training sessions on nutritional management of PLHIV for **34** service providers from Ruhenda, Bushara and Giti Health Centers. New TC/PMTCT sites, Mulindi and Muhondo Health Centers, will receive the same training next quarter. Refresher training on the same theme was given for two providers each from other sites we support in Gicumbi, for a total of **26** trained.

In March, the HCSP also worked with district hospitals to coordinate training in IGA management for PLHIV cooperative members. In Gicumbi, **46** cooperative members representing all health centers we support in that district, except Miyove Prison, received the training. In Nyagatare, **39** were trained. IGA management training in Rulindo district could not take place due to other commitments on the part of the trainer, the district official in charge of cooperatives, so was postponed to April. Training in Gasabo will also take place next quarter.

As part of the Ibyiringiro Project led by Catholic Relief Services (CRS), the HCSP oversees complementary nutrition programs in **37** sites: **35** HCSP-supported PMTCT sites and **2** sites (Rurenge and Matimba Health Centers) supported by Global Fund. During this quarter, activities reached **553** HIV-exposed infants aged 6 to 18 months, as well as **327** pregnant and lactating women. The HCSP nutrition officer contributed to all steering committee activities, notably supportive supervision visits to other partners' supported facilities to evaluate provider competency in nutritional counseling and care, including correct documentation and filing of client data, and stock management. Evaluations conducted by other partners at the sites we support have shown considerable improvement in the ability of providers to correctly fill out patient forms.

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, **924** ART patients were supported by Food for ART. Also this quarter, thanks to the extension of our agreement with WFP, we began accepting funding requests from PLHIV cooperatives to implement nutrition-related IGAs. Next quarter, we will analyze the requests and dispense funds as rapidly as possible. By the end of March, 17 requests had been received.

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 of sensitization, education and training. During nutrition education and PMTCT training sessions, we emphasize the importance of treating water

with SurEau, and monitor health centers to ensure that they receive and use it in sufficient quantities. We also emphasize 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 IGAs at **42** of our supported sites: **23** sites raising livestock only; **7** sites growing crops only; **10** sites raising livestock and growing crops; and **2** sites selling handicrafts. The HCSP nutrition officer also directly engaged with PLHIV cooperatives to support them not only in establishing gardens but also in managing their IGAs. For example, she visited cooperatives at Tanda, Bushara, Cyondo, Rushaki and Giti Health Centers to provide technical assistance and recommendations for improvement of their IGAs.

As of the end of this quarter, **8,903** PLHIV had their own kitchen gardens. All the gardens grow vegetables, and a small number have begun to produce pineapples and sugar cane as well. 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, such as cooperative members from Rukozo, Cyabayaga, Rushaki, Munyinya, Kigogo, Muyanza and Gikomero Health Centers, have begun to pay their own *mutuelles* fees.

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 contributed to preparations for the implementation of the new national strategy to eliminate malnutrition; reviewed and field-tested nutritional counseling tools for adherence to the latest WHO recommendations; and participated in national weaning food program steering committee meetings.

Next quarter, in addition to ongoing nutrition activities, such as supportive supervision and IGA support, the HCSP will provide technical and financial support to train service providers in Gasabo and Rulindo on the nutritional management of PLHIV. We will also participate in nutrition TWG meetings to revise national guidelines on nutritional management for PLHIV.

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			

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	100%
Number of lab personnel trained	0	28			28	45	62%

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.

HIV and AIDS tests in HCSP-supported facilities:

- * Rapid HIV tests
- * DBS collection for PCR
- * PCR and viral load sampling
- * RPR for syphilis
- * Zeel Nielsen for TB
- * Blood grouping
- * Biochemistry and hematology
- * CD4 count

We support **45** laboratories with the capacity to perform clinical laboratory tests, including all tests necessary for HIV and AIDS clinical services. Supportive supervision visits this quarter concentrated on new TC/PMTCT and ART sites, as well as Muhambo, Cyondo and Bugaragara Health Centers, where new laboratory

technicians were recently recruited. All HCSP-supported sites are trained to use the new HIV rapid testing algorithm, and all but one are trained in DBS collection for PCR.²

In February, the HCSP laboratory officer collaborated with NRL trainers to train one laboratory technician from each of Byumba and Kibagabaga Hospitals and Kiyanza, Gihogwe, Jali, Rukomo and Bushara Health Centers on how to use the Humalyzer 3500 and Humacount 5, clinical chemistry and hematology analyzers, respectively. These machines will be installed on-site next quarter. Training and installation will also take place at Rurenge Health Center next quarter.

The HCSP also trained one laboratory technician from each of **22** health facilities in Gicumbi – including those not supported by the HCSP – on the spermogram. Sperm and semen analysis services for men who have undergone vasectomy are now fully available

² Miyove Prison has not launched PMTCT services.

at health centers throughout this district. However, in response to an MOH request at the end of February, we will also give spermogram training to nurses to enhance the quality of their vasectomy counseling, meaning that a second training session for nurses will be held in Gicumbi next quarter. It was for this reason that spermogram training also planned in Rulindo this quarter was postponed to the next, when nurses and laboratory technicians will be trained together.



Members of the HCSP technical team pose with their trainer in logistics and commodity management.

Additional trainings in logistics and commodity management for one laboratory technician per site had to be postponed from this quarter to May, given other commitments on the part of the district and NRL trainers. Except in Gasabo, which does not have one, all district pharmacists in our supported districts have been trained in logistics and commodity management. What is more, in March, the entire HCSP technical team received this training from TRAC Plus and the NRL. Next quarter, we will extend the training to the districts and sites we support. We are waiting to learn whether the NRL will support this activity financially, or whether we will do so with our own funds.

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	43	26			69	82	84%
Number of persons trained in PEP provision	600	85			600	404	149%

PEP is given when an HIV-negative individual is exposed to HIV. 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 for PEP reporting. During this quarter, **85** providers were trained to provide PEP.

Between January and March 2011, **26** individuals were provided with PEP. This brings us to 84% of 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. As community awareness and health center 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 Prevention with Positives interventions (PwP)	10,402	9,626			10,402	12,415	84%
Number of service providers trained in PwP	208	277			485	404	120%

The HCSP undertook several PwP activities during the quarter. These included mentorship of PLHIV cooperatives and their members; financing, monitoring and technical support of IGAs; strengthening of peer support groups; sensitization regarding FP and double 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, **277** service providers were trained to provide PwP services, and **9,626** PLHIV were reached with a minimum package of PwP interventions.

PERFORMANCE-BASED FINANCING

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

The HCSP continued financial support to the DHUs in each of the four supported districts to facilitate coordination of PBF activities. In addition, we regularly participated in national-level PBF meetings such as the CAAC (*Cellule d'Appui à l'Approche Contractuelle*), the PBF extended team, the PBF TWG and district-level PBF steering committees. Throughout the quarter, under the coordination of the district hospitals, we actively participated in the quantitative and qualitative evaluation of PBF indicators in

the four districts. Evaluation results have been transmitted to the CAAC to prepare quarterly payments based on the quantity and quality of HIV services provided during the period.

Whereas payment for this quarter’s performance will not be made until May, last quarter’s performance scores are indicative of the latest performance trends. The lowest and highest quality scores per district are shown in Table 9, below.

Table 9: Most Recent PBF Performance Scores, October - December 2010

District	Lowest Quality Score (%)	Highest Quality Score (%)
Gasabo	78	86
Gicumbi	73	97
Rulindo	88	94
Nyagatare	68	89

The HCSP and district supervisors use PBF-generated data to prioritize supportive supervision and technical assistance needs at the health facility level. For example, Rutare Health Center received the lowest quality score in Gicumbi District (53%) in the third quarter of year three. Together with Byumba District Hospital and sector representatives, we organized meetings with Rutare Health Center leadership and providers to address problems on-site. Thanks to these efforts, Rutare Health Center achieved a quality score of 82% in the July-to-September period. The following quarter, the score fell slightly to 79%. We continue to monitor this closely.

Nyagatare Health Center has also struggled to raise its quality scores, and achieved the lowest score in Nyagatare District (68%) between October and December. The reason for this became clear during a February district-level PBF steering committee meeting: the center is evaluated poorly for not offering certain services – notably in maternity – that are not needed given that Nyagatare District Hospital is located next door. The committee and the HCSP will make a special visit in May to evaluate the health center according to PBF indicators and devise strategies to improve indicator scores.

As well, although Gihogwe and Kajevuba Health Centers achieved the lowest quality scores in their districts last quarter, they have also both seen improvement. Between quarter four in year three and quarter one in year four, Gihogwe Health Center moved from 70% to 78%, and Kajevuba from 84% to 88%.

During this quarter, it was brought to our attention that United States Government policy forbids the payment of an FP-related PBF indicator that we and other USAID-funded clinical services partners have been routinely paying. It measures the number of women receiving modern contraceptive methods. We immediately stopped payment of

the indicator. We and other partners will learn more about this subject during an FP compliance training that USAID will host next quarter.

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, the HCSP has had to intensify our training and support to site-level data managers to ensure correct collection, management and reporting of service data. In February, we trained **25** data managers and **25** health facility managers – representing each of the ART sites we support. A number of sites whose data managers began this quarter or last quarter also received additional mentorship and technical assistance, particularly in the use of IQChart, the TRACNet system and the new TC/PMTCT tools. The new data manager at Rubungo Health Center, for example, received extra support as he settles into his role. We were also very involved with post-training follow-up, troubleshooting, and correcting reports with sites.

As the sites we support confront difficulties with the new government data collection tools and reporting system, we inform TRAC Plus about where the difficulties lie and make suggestions about how they can be addressed. TRAC Plus has said it hopes to incorporate the feedback received from IntraHealth and other partners and propose a final, improved set of tools next quarter.



HCSP trainers and ART facility managers following an M&E training held in Gicumbi in February 2011

This quarter, although the current version of IQChart in use at the sites we support does not yet take into account the changes being made to TRAC Plus tools, our M&E team instigated a series of trainings for all HCSP technical staff on how to manage and exploit IQChart data. In the same vein, Futures Group has opted not to delay training on the latest version of IQChart any further and plans to train programmers and users from IntraHealth, the Elizabeth Glaser Pediatric AIDS Foundation, the International Center for AIDS Care and Treatment Programs and CRS/AIDS Relief in May. The HCSP will provide financial support for this partner training session. Afterwards, we will train our site-level data managers. Once the enhancements to TRAC Plus tools and systems are complete, IQChart will be modified accordingly one final time.

We closely monitor facility-level clinical service data to ensure their reliability and validity. From March 14-31, we conducted a data quality audit at 23 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 10: Health Centers Included in March 2011 Data Quality Audit

District	Health Centers
Gasabo	Gihogwe, Gikomero, Kayanga
Gicumbi	Giti, Gisiza, Kigogo, Byumba, Mukono, Bwisige, Rutare, Tanda
Nyagatare	Karangazi, Matimba, Cyabayaga, Ntoma, Cyondo, Muhambo, Kabuga, Bugaragara
Rulindo	Kajevuba, Murambi, Remera-Mbogo, Kiyanza

We also uncovered a number of weaknesses that we are already following up on 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; irregular data entry into IQChart; and failure to separate client-initiated testing and counseling (CITC) data from PITC data. While these weaknesses exist to varying degrees among the audited sites, certain sites such as Rutare, Kigogo and Tanda Health Centers emerged as those with the greatest room for improvement. Another round of data quality auditing will take place next quarter at Kibagabaga Hospital, Bushara and Rwahi Health Centers, and Miyove Prison.

We hope to minimize future shortcomings by running error checks weekly on-site and monthly at the HCSP office, and supplying data managers with reference documents, namely written standard operating procedures for data entry, a standardized patient data flow chart and a report compilation checklist. We began developing these tools at the end of year three and anticipate their completion next quarter.



Our M&E officer working with the data manager at Kajevuba Health Center.

In February, the new M&E and research technical advisor from IntraHealth headquarters visited Rwanda to familiarize herself with the program and provide documentation, training and ongoing M&E support. She reviewed the HCSP's M&E plans, procedures and systems, and had the opportunity to visit Kajevuba Health Center and Kibagabaga Hospital, where she observed facility-level systems for data collection and reporting.

Throughout the quarter, our M&E team participated in a number of additional meetings and trainings, such as a two-day training in February held by Futures Group/MEASURE Evaluation on routine data quality assessment; a March orientation to TRACNet data quality and use; and national M&E TWG meetings to develop the Key Annual Report on HIV and AIDS for July 2009-June 2010, and the TRACNet data quality improvement plan.

OTHER PROGRAM AREAS

FP/HIV Integration and Maternal and Child Health

Table 11: 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	45	102%
Unique clients provided with FP/RH counseling services	76,866	78,238			155,104	171,857	90%
Number of people who received FP/RH messages	76,866	78,238			155,104	160,574	97%
Service providers trained in FP/RH	54	61			115	164	70%
Number of women who attended their first ANC visit	7,106	7,627			14,733	22,000	67%
Number of deliveries attended by a skilled birth attendant	3,318	4,778			8,096	24,037	34%
Infants under 12 months who received DPT3 (Diphtheria, Pertussis, Tetanus) vaccinations	4,873	4,360			9,233	22,000	42%
Children under five who received Vitamin A	60,123	2,466			62,589	122,000	51%
Service providers trained in maternal and neonatal health	20	23			43	164	26%
Service providers trained in child health and nutrition	0	90			90	164	55%

The FP/MCH coordinator picked up this quarter where she left off in December, collaborating with national- and district-level trainers to coordinate trainings, follow up with previous training participants, and certify those service providers who have proven their practical mastery of training material. Furthermore, specialized training materials³

³ These materials include child birth simulators; model fetal baby with umbilical cord and placenta for vacuum delivery; lumbar puncture trainer; fetal model; placenta/cord/amnion/chorion model; cervical dilation easel display; infant intubation head; reproductive implant training arm (Rita); model uterus; family planning education kit.

received from the United States last quarter, including child birth simulators and family planning education kits, were distributed to the health facilities we support for easy use on site.

Training sessions for site-level FP trainers concluded this quarter. The HCSP provided financial, technical and logistical support for these trainings. In addition to the 16 service providers from Rulindo who were certified as site trainers last quarter, **20** Gicumbi service providers were trained in January, and **21** and **20** Gasabo and Nyagatare service providers, respectively, were trained in February. The HCSP will continue to provide technical assistance as these site trainers pass on their FP skills to colleagues through formal training sessions and on-the-job training.

Also in February, at the request of the MOH, the HCSP contributed USD \$33,482 to vasectomy sensitization and training. With our support, the MOH conducted a sensitization campaign in the districts of Rulindo, Karongi and Rubavu over two days. Several men from these districts then volunteered to undergo the procedure later in the month during the training of **11** national vasectomy trainers (five physicians and six nurses). Members from this national training team trained **2** Rulindo district trainers shortly afterwards. Next quarter, we will obtain vasectomy kits for Gicumbi and Rulindo Districts. Alongside Nyabihu District, they were part of a pilot vasectomy project initiated in 2008 by IntraHealth's Capacity Project that was a forerunner of vasectomy services in the country. Vasectomy kits for Gasabo and Nyagatare will be procured once sufficient numbers of health personnel in those districts are trained.

In total this quarter, **83,592** clients – including men having undergone vasectomy – used a modern FP method.

The first wave of HCSP service provider training in emergency obstetric and neonatal care (EmONC) and maternal death audit also concluded this quarter with **15** Nyagatare providers certified in January. Shortly afterwards the second wave of training began and will finish next quarter. An additional **23** service providers were trained in Rulindo. 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, will follow.

Last quarter we coordinated an EmONC and maternal death audit training at Muhima Hospital for 20 service providers. After post-training follow-up, **15** providers were certified in the last week of March. The remaining five providers to be certified were away from the facility at that time and therefore will be certified next quarter.

As planned, a training session on the integrated management of neonatal and childhood illnesses (IMNCI), including a module on neonatal death audit, took place in Gasabo. **Thirty** service providers were trained. The same training session had also been planned in Gicumbi, but was postponed in anticipation of an updated course outline. The MOH is currently condensing its original curriculum, which devoted 12 days to IMNCI and 2 days to neonatal death audit, to 7 days, including 1 day for neonatal death audit. The HCSP is a member of the course review group. Although course content will change only slightly according to the most recent HIV and malaria protocols, the MOH requested that we suspend our planned IMNCI provider trainings in Gicumbi and Nyagatare until the new materials are ready. We have also planned to train IMNCI district supervisors in June, contingent upon the availability of the materials.



Our FP/MCH coordinator shares lessons with her colleagues from Helping Babies Breathe.

In February, the FP/MCH coordinator traveled to Addis Ababa, Ethiopia to participate in the Africa Regional Meeting on Interventions for Impact in Essential Obstetric and Newborn Care, as well as an orientation on Helping Babies Breathe, a neonatal resuscitation course designed for limited-resource settings. One of only seven other Rwandans in attendance the whole week, she returned home with a number of immediately applicable evidence-based strategies to incorporate into the training she oversees. She also briefed other HCSP technical staff on what she had learned.

Gender and Gender-based Violence

Table 12: 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	45	102%
GBV survivors who received care and support	174	255			429	324	132%
Health facility personnel trained in care and treatment of GBV survivors	438	164			602	552	109%

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 (MIGEPROF).

At minimum, 3 providers at each HCSP-supported health center and 15 providers at HCSP-supported hospitals have been trained to provide care to GBV survivors. In Gicumbi and Nyagatare, all personnel at HCSP-supported sites have been trained. This quarter we trained **15** health facility personnel – including non-medical staff – from Tanda Health Center in the care and management of GBV survivors. The HCSP coordinated training for district supervisors as well: between February and March, **8** district supervisors from Gasabo, **10** from Gicumbi, **12** from Nyagatare and **11** from Rulindo were trained to ensure that high quality care and treatment services for GBV survivors are well integrated into the full-service package.

In Rulindo, **23** community leaders and sector authorities and **135** anti-GBV committee members were sensitized to issues of gender and GBV. More will be sensitized next quarter. Furthermore, **46** and **39** PLHIV cooperative members in Gicumbi and Nyagatare, respectively, were sensitized over two days to issues of gender and GBV. Approximately 3 members of each PLHIV cooperative in Gasabo and Rulindo will receive the same orientation next quarter.

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 was planned for this quarter. We initiated contact with individual district police commanders in January, but preparations are still ongoing. As a result, the trainings were postponed to next quarter.

Thanks to intensive training, GBV services are well integrated into other clinical services at all **46** of the sites we support, including even Rutongo Hospital, where we only provide a district support package, and Miyove Prison. Throughout the quarter, **255** 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.

In partnership with Nyagatare District, the HCSP is laying the groundwork to establish a one-stop GBV service center at Nyagatare District Hospital. To date only two other such one-stop centers exist in Rwanda: the Isange one-stop center at Kacyiru Police Hospital, and the one-stop center at Gihundwe Hospital in Rusizi District. In February, the HCSP coordinated and financed a visit to the Gihundwe center by the director of Nyagatare Hospital, the IntraHealth field manager in Nyagatare, the HCSP's agreement officer's technical representative from USAID, and the HCSP gender/GBV officer. The visitors appreciated the opportunity to discuss with Gihundwe personnel the challenges of operating a one-stop GBV service center, and learn more about pediatric counseling and psychosocial support for GBV survivors. Meanwhile, Nyagatare Hospital has identified the space that will house the new one-stop center, and throughout next quarter, we will support renovations, procurement, recruitment and training of three new staff.

To mark the 100th International Women's Day on March 8, the HCSP accepted an invitation from Rulindo District to participate in activities in Masoro Sector. Worldwide, the theme for this year's celebrations was "Equal access to education, training, science and technology: pathway to decent work for women." Throughout Rwanda, authorities chose to accelerate progress towards this goal via Bye Bye Nyakatsi, an initiative to remove families from straw-thatched shelters and place them in more adequate housing. The first activity on March 8 brought Rulindo authorities, leaders and residents together with a delegation of HCSP staff to prepare the ground for a new house for a vulnerable woman and her family. Afterwards, a more formal ceremony and an all-girls soccer match were held.



On International Women's Day, the beneficiary couple look on as volunteers, including HCSP staff, clear the ground for their new home.

The information, education and communication materials developed with Raising Voices as part of the PEPFAR Special Initiative on Sexual and Gender-based Violence went to print this quarter, and we will disseminate them throughout the districts we support next quarter.

A testament to our achievements during the Special Initiative, which ended with year three, the Population Council invited only the HCSP and the MOH to represent Rwanda during a weeklong south-south exchange on emergency contraception that was held in Nairobi, Kenya from March 29 to 1 April. We were represented by the HCSP gender/GBV officer.

TRANSITION

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 move through the fourth year of the project, our capacity building efforts are moving away from trainings to intensive mentorship 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 three clinical services officers and the transition and field team leader, is tasked with ensuring the smooth transfer of sites currently supported by the HCSP to the Government of Rwanda (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 transition strategy.

Until a harmonized approach is found, we will use 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 palliative care, as well as against operational indicators relating to financial and administrative management, and M&E.

In March, the transition team attended Joint Action Development Forum meetings in the districts of Gasabo, Gicumbi and Rulindo. We will also participate in the Nyagatare meeting next quarter. These meetings ensure smooth coordination of interventions throughout the district and aim to create synergy for sustainability. IntraHealth currently serves as president of the Joint Action Development Forum in Rulindo.

Also in March, the HCSP initiated a series of trainings in leadership for health facility managers to strengthen their capacity in the management of health services and health facility resources (human, financial, material and data-based). Gasabo and Gicumbi trainings were completed this quarter, to be followed next quarter by sessions in Nyagatare and Rulindo.

HIGHLIGHTED CHALLENGES

In addition to the results and achievements described above, the HCSP and our partners managed some specific challenges during the quarter. This section summarizes some of the challenges not mentioned above.

- **Review of subgrantee payment procedures:** In light of habitually late cash requests and/or incomplete expense reports from several of the sites we support, and the delay in cash advances that results, the HCSP initiated a thorough review of subgrantee payment procedures last quarter. The intent of this review was not solely to clarify site-level procedures, but also to formally recognize the HCSP's shared responsibility with our site partners and delegate clear roles among program staff. Sites submitted cash requests for the months of December and January concurrently in order to begin this quarter with January's funds already in their bank accounts. There has since been a notable improvement in the timeliness of cash requests and expense reports, allowing us to transfer cash advances before the start of each month. Even so, our team leaders, clinical services officers and accountants continue to work closely with the health facilities and DHUs to maintain this trend.
- **Recruitment for key personnel positions within the HCSP:** Our new operations and support services team leader (OSSTL) began work in February, and rapidly became an effective member of our team. We have also identified a candidate for the position of senior technical advisor and formally submitted his name to USAID for approval.
- **Delayed procurement of materials and equipment:** The national process of finalizing the contents of GBV kits has taken longer than originally expected. As a result, in order not to hinder the provision of timely, high quality services to GBV survivors, we ordered examination tables and lamps, both necessary for adequate services, to distribute to the sites we support next quarter. Similarly, delays and stock outs at Supply Chain Management Systems obliged the HCSP to purchase four agitators and eight micropipettes for distribution to new TC/PMTCT sites (Mimuri, Ruhenda, Mulindi and Muhondo Health Centers) in March.
- **Damage to Rukomo Health Center caused by heavy rains:** The roofing over two hospitalization wards and the principal conference room at Rukomo Health Center was destroyed by very heavy rain in mid-March. Thankfully, a quick and effective response by health center management allowed for the roof to be repaired in less than two weeks. Until then, staff were able to make room for hospitalized patients elsewhere in the health center. The health center should be commended for its quick action in caring for approximately 40 students who were injured when the rain caused a nearby secondary school to collapse. All of the students recovered from their injuries.

NOTABLE ACCOMPLISHMENTS

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

- **Rwanda makes palliative care history in Africa:** The MOH signed the first national palliative care policy, including guidelines on morphine use, on January 18, and officially launched the dissemination of the policy, guidelines and strategic plan on March 31. Rwanda is now one of only a few countries in Africa to have a palliative care policy. IntraHealth and our partner Mildmay provided important support to the GOR to allow it to achieve this milestone in caring for patients living with chronic illness.
- **Improvements to internal program planning and management processes:** This quarter we initiated the most participatory needs-based work planning process that the HCSP has engaged in thus far. Having taken stock of site challenges during the mid-term evaluation meetings in each district, the HCSP team met over two days in March to further analyze existing needs and develop a matrix of objectives and expected results for year five. We began drafting activities corresponding with this matrix, and throughout quarter three will work with the sites we support and the MOH at central level to finalize our year five work plan. Our matrix and work plan will also inform subagreement work planning and budgeting in May and June. By harmonizing work plans at the HCSP, central MOH and site levels, we hope to create a tool that will be useful to all.
- **Collaboration with the Bank of Kigali to decentralize cash transfers:** We engaged in discussions with the Bank of Kigali this quarter to solve the longstanding problem of staff members' transporting large amounts of cash to the field for training and other activities. A system was established whereby the bank's main office in Kigali wires HCSP funds to its branch offices, allowing participants in HCSP-supported activities to collect per diems at banks in the field. This not only reduces long lines and delays in paying per diems, but also reduces the risks associated with carrying large sums of cash over significant distances. The new system will be implemented in April.
- **Integrated IntraHealth programming to leverage resources:** As part of a larger organizational strategy, IntraHealth/Rwanda took deliberate steps during the quarter to integrate programming across its two projects—the HCSP and a Hewlett Foundation-funded FP and MCH project. Instead of managing the projects vertically as two separate, distinct projects, leadership of both projects

consciously sought opportunities for collaboration and integration of activities. Such collaboration creates synergies and efficiencies, enhances impact, helps avoid duplication, and allows each project to achieve more with less. IntraHealth/Rwanda will continue to move in this direction in the coming weeks and months.

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