

Providing Treatment,
Restoring Hope



AIDS  **RELIEF**™

RWANDA

FINAL REPORT 2004-2012

AIDSRelief, a five-member consortium funded through the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), supported rapid scale up of HIV care and treatment services for poor and underserved people in ten countries across Africa, the Caribbean, and Latin America. Over nine years, the program served more than 700,000 people, including more than 390,000 who enrolled on antiretroviral therapy through 276 treatment centers.

AIDSRelief countries

Africa



AIDSRelief worked largely through rural facilities and established basic packages of care and treatment that exceeded what many thought possible in a resource-constrained environment. Instead of merely offering HIV tests and dispensing medicine, AIDSRelief helped broad cadres of health workers to identify and manage treatment failure or other adverse drug events; to diagnose, treat, and prevent opportunistic infections such as tuberculosis or pneumonia; and to provide patients with adherence counseling and support, empowering them to effectively manage their own treatment.

AIDSRelief consortium partners included Catholic Relief Services as prime grantee; the University of Maryland School of Medicine Institute of Human Virology as technical lead for clinical care and treatment; Futures Group as lead agency for strategic information; IMA World Health and Catholic Medical Mission Board as implementing partners; and Children’s AIDS Fund as a key sub-grantee, operating sites in three countries.

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The project described was supported by grant number U51HA02521 from the Health Resources and Services Administration (HRSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA, CDC, or the United States government.





From 2004 through 2011, AIDSRelief Rwanda expanded HIV care and treatment support to nearly 12,000 patients including nearly 6,700 who enrolled on lifesaving antiretroviral therapy (ART) at 20 health facilities in the Nyamasheke and Burera districts. Consortium members Catholic Relief Services, University of Maryland School of Medicine Institute of Human Virology, and Futures Group worked hand-in-hand with Rwanda's Ministry of Health and local health facilities to strengthen the skills and systems needed to support high-quality care. A deep commitment to partnership underscored AIDSRelief's relationships and capacity strengthening

activities, which culminated in late 2011 when the Ministry of Health won a new grant to receive PEPFAR funds directly and assume full responsibility for managing the program. Rwanda was the only AIDSRelief country to transition solely to a government partner.

The program's comprehensive package covered not only strengthening HIV clinical capacity, but also program operations and management support for district and national health structures. This report outlines key outcomes and lessons learned during the eight-year program; it also describes approaches and methods that contributed to the program's success.

HIGHLIGHTS INCLUDE:

- » AIDSRelief directed its capacity strengthening efforts at the national, district, and facility levels, in line with Rwanda's existing health delivery structure. Extensive clinical technical assistance was not only targeted to district level hospitals but also focused on providing support to lower-level health centers through mentoring and referral links for complicated cases.
- » Community-based treatment support expanded services from clinic to community and contributed to excellent results. Of the patients started on ART through AIDSRelief in Rwanda, 92.6% were retained in treatment. Only 1.4% were lost to follow up and mortality was just 5.9%¹.
- » More than 180,000 HIV tests were performed each year, including tests for 15,000 pregnant women. Of the pregnant women who tested positive for HIV, 81% went on to receive treatment that virtually eliminates the chance of transmitting the virus to their children.
- » As part of program monitoring and quality improvement, two patient-level outcomes evaluations were conducted over the six years of the program. Each time, average viral suppression—the gold standard for measuring treatment success—exceeded 80%².
- » Training and mentoring focused not only on clinical issues but also on comprehensive laboratory and pharmacy management, monitoring and evaluation, and organizational management. From 2008 to 2012, nearly 18,000 participants attended off- and on-site training sessions.
- » A focus on strategic information prioritized comprehensive and timely access to clean, complete, and accurate data. Teams used data to make informed decisions and address gaps in program operations and services.

¹ Rates are derived from survival (time to event) analysis. At each time period, the probability of 'survival' is calculated. These 'survival probabilities' are then cumulated (multiplied) over several time periods. For instance, 12 month retention is a cumulation of survival probabilities over 12 one-month periods. Since mortality and LTFU are the reverse of retention, the rates are calculated as 100% minus the survival probability.

² Based on an analysis of summaries for patients who had started ART a mean of 12 months prior to review. The analysis included retrospective chart review, viral loads, and patient adherence surveys. Analysis in 2007 indicated 91.2% viral suppression; the 2011 analysis indicated 81.5%

OUR CALL TO ACTION

The Government of Rwanda is dedicated to the mitigation of HIV's impact, setting aggressive national goals³ that are closely linked with the country's Economic Development and Poverty Reduction Strategy. The country has made great strides toward its commitments to halve the incidence of HIV in the general population by 2012, significantly reduce morbidity and mortality among people living with HIV, and ensure that people infected and affected by HIV have opportunities equal to those who are not. HIV prevalence has declined to less than 3% since the epidemic peaked in the mid-1990s, and nearly 90% of eligible HIV patients are receiving ART.

Only eight years ago, the picture for HIV-infected Rwandans was far less hopeful. There were very few providers qualified to prescribe life-saving drugs, and they generally had very little knowledge about treatment options and comprehensive patient care. At least 10,000 people died each year beginning in the early 1990s⁴ because treatment was either unavailable or prohibitively expensive. In 2004 alone, nearly 15,000 Rwandans lost their

AIDSRelief Supported Health Facilities 2004-2012

Bungwe Health Center
Bushenge District Hospital
Gatare Health Center
Gisakura Health Center
Hanika Health Center
Kamonyi Health Center
Karambi Health Center
Karengera Health Center
Kibingo Health Center
Kibogora District Hospital
Kibogora Health Center
Mugera Health Center
Muhura Health Center Mukoma Health Center
Muyange Health Center
Mwezi Health Center
Nyamasheke Health Center
Rangiro Health Center
Ruheru Health Center
Rushaki Health Center
Yove Health Center



lives to HIV.⁵ Access to voluntary counseling and testing was very limited, as was the technology to test infants born to HIV-infected mothers.

The advent of PEPFAR and national rollout of ART in 2004 brought tremendous resources, but health organizations and providers largely lacked the systems, structures, and staff to manage these new resources and the clinical skills to manage the complexities of ART.

³ Government of Rwanda. *National Strategic Plan on HIV & AIDS 2009–2012*.

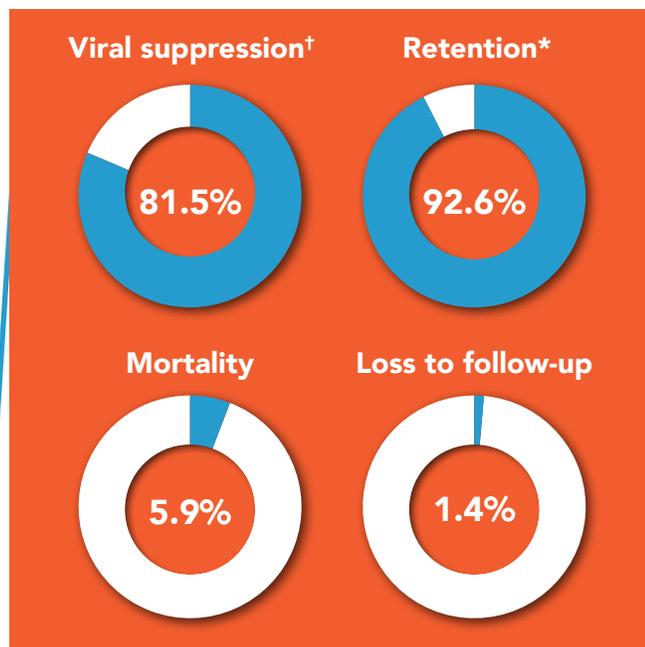
⁴ UNAIDS. AIDSinfo country fact sheet, Rwanda. Available at <http://www.unaids.org/en/dataanalysis/tools/aidsinfo/countryfactsheets/>.

⁵ UNAIDS. AIDSinfo country fact sheet, Rwanda. Available at <http://www.unaids.org/en/dataanalysis/tools/aidsinfo/countryfactsheets/>.

THE AIDSRELIEF RESPONSE: IMPACT & LASTING CHANGE

The AIDSRelief consortium worked with the Government of Rwanda to expand services to nearly 12,000 patients who continue to receive life-saving care and treatment, including nearly 6,700 patients who received ART. Of the patients started on ART through AIDSRelief in Rwanda, more than 92% have remained on treatment. More than 180,000 HIV tests were performed each year, including tests for 15,000 pregnant women. Of the pregnant women who tested positive for HIV, 81% went on to receive treatment that virtually eliminates the chance of transmitting the virus to their children.

AIDSRelief by the Numbers



[†] Based on an analysis of summaries for patients who had started ART a mean of 12 months prior to review. The analysis included retrospective chart review, viral loads, and patient adherence surveys.

^{*} Rates are derived from survival (time to event) analysis. At each time period, the probability of 'survival' is calculated. These 'survival probabilities' are then cumulated (multiplied) over several time periods. For instance, 12 month retention is a cumulation of survival probabilities over 12 one-month periods. Since mortality and LTFU are the reverse of retention, the rates are calculated as 100% minus the survival probability.

By the end of 2011, AIDSRelief Rwanda had leveraged effective partnerships and needs-based capacity strengthening to facilitate the transition of all 20 program-supported ART sites from AIDSRelief to the Ministry of Health. The government now maintains those sites and their affiliated patients as part of the national health system.

How did this happen?

A Systems Strengthening Model

AIDSRelief Rwanda was comprised of three of the five AIDSRelief global consortium members: Catholic Relief Services (CRS), Futures Group, and the University of Maryland School of Medicine Institute of Human Virology (IHV). The consortium partners worked together to implement a care and treatment model that emphasized its core components equally: clinical care, strategic information, and site management. This model was supported by a foundation of health systems strengthening activities designed to ensure excellent patient outcomes that can be sustained over time by local providers, a goal that is wholly dependent on a functional health system.

CRS was the prime grantee and provided overall program coordination and oversight for grant administration and compliance, in addition to coordinating representation of the grant to United States and Rwanda government agencies as well as other stakeholders. IHV served as the clinical lead for AIDSRelief in developing and implementing activities that built local partners' capacity to provide comprehensive, high-quality HIV care and treatment within the framework of national policies and guidelines. Futures managed strategic information through data collection and analysis; monitoring; and, generation of reports for donors, government, and other key stakeholders, and development and implementation electronic health records and other health informatics applications.

A NETWORK OF TREATMENT SITES

Using principles laid out in the WHO's six building blocks of health systems strengthening⁶ and the AIDS-Relief model of care, the project worked closely with the Government of Rwanda and through a network of health care facilities to provide exceptional care and treatment to HIV-infected patients. Because these facilities were established parts of the health system prior to AIDSRelief, they also served—and continue to serve—as entry points into district management, communities, and families.

The Rwandan Health System

As in many resource-constrained countries, Rwanda's health system is composed of public facilities as well as those run by faith-based missions, NGOs, and private clinicians working for profit. Different countries have varying degrees of collaboration among these entities; in Rwanda, they are governed as one network. All players adhere to government standards and guidelines and participate in district-wide planning to help ensure comprehensive, efficient, and wide-reaching services. In Rwanda's decentralized system, funding flows from the government and external donors through the central government to facilities, while district governments lead facility-by-facility planning and management.

Another distinction of the Rwandan system is the dual role of district hospitals. They deliver HIV and other services while also supervising and mentoring health centers that provide care and treatment at the local level. This structure helped define AIDSRelief's two-pronged scope of work:

- » Provide technical assistance to local- and district-level health facilities to roll out and scale up HIV care and treatment services
- » Provide technical assistance at district and central levels to enhance the government's capacity to provide clinical leadership

Site Selection and Scale Up

To ensure more streamlined coordination and evaluation of HIV programs supported by international partners, in 2007 the government established a "one implementer, one district" policy. As a result, AIDS-Relief worked almost exclusively in the Nyamasheke district in addition to supporting one site in Burera because no U.S. government partners were working in that area and AIDSRelief (through CRS) had an existing relationship with the faith-based facilities.

Prior to launching treatment services, AIDSRelief staff visited each facility and used standardized tools to develop a site profile using data including catchment area and patient load; staffing levels; and available infrastructure, equipment, and services. Based on these assessment findings, AIDSRelief teams worked with their counterparts at each facility to develop tailored site action plans that addressed both infrastructure and clinical supports needed in order to provide complete and high-quality HIV services to their patients.

Before the launch of AIDSRelief, five facilities in Nyamasheke provided ART and very basic treatment support to only the sickest patients. At the time of program transition to the Ministry of Health, 18 facilities provided complete care; two others offered counseling, testing, and maternal-child HIV services.

⁶ WHO defines the blocks as health service delivery, health workforce, health information systems, access to essential medicines, health systems financing, and leadership and governance. Community is widely regarded as the "seventh building block."

Clinical excellence: Recognizing the needs of providers and patients

As HIV programs continue shifting from emergency response to long-term care, it is imperative to assess treatment outcomes and provide technical support so that program scale-up does not come at the expense of service quality. Consistent with the Government of Rwanda's target of near-zero HIV transmission and a dramatic reduction in HIV-related morbidity and mortality, AIDSRelief delivered exceptional patient outcomes. To make this possible, providers needed material resources such as adequate infrastructure, equipment, and commodities;

up-to-date skills and knowledge; and an enabling policy environment.

Additionally, patients receiving any sort of treatment are far from passive recipients of care, and myriad social factors influence their health-related behaviors and decisions. This is arguably even more true of patients facing a complicated, often stigmatizing disease that requires life-long care and treatment. Through AIDSRelief's unique treatment model, the program prepared and informed patients so that they could make sound decisions for their health and bolstered support for those decisions through family-focused care and community-based treatment support. >>

AIDSRelief Impact: Early Infant Diagnosis

ARVs and drugs to prevent and treat opportunistic infections in infants are highly effective, but without treatment 50% of HIV-infected children will die by their second birthday (mortality is 80% by age five).¹ When infants are diagnosed and start treatment in the first three months of life, mortality can decline by 75%.²

The high rate of early infant diagnosis (EID) in AIDSRelief-supported facilities is a testament to dramatic improvements in laboratory systems. HIV diagnosis in infants younger than six months requires a highly specialized test to distinguish between the presence of a mother's antibodies in her infant and an

actual HIV infection. In Rwanda, this test is offered at the national reference laboratory in Kigali. The laboratory is a day's travel by road from Nyamasheke, making sample collection and transportation critical to the program's success. AIDSRelief trained and mentored 20 nurses and 20 laboratory technicians in sample collection for EID. Prior to AIDSRelief, three sites in Nyamasheke were conducting EID; at the end of 2011, 20 sites offered this vital service.

In AIDSRelief-supported facilities in Rwanda, 94% of HIV-exposed children were tested for HIV within 12 months of birth, and 88% received a confirmation test at 18 months. Eleven of the 20 AIDSRelief-supported sites tested 100% of exposed children younger than one year old. Furthermore, 96% of HIV-exposed infants received prophylactic cotrimoxazole within two months of birth.

1 Newell ML, Brahmbhatt H, Ghys PD (2004) Child mortality and HIV infection in Africa: a review. *AIDS* 18 Suppl 2: S27-34.

2 Violari A, Cotton MF, Gibb DM, Babiker AG, et al. (2008) Early antiretroviral therapy and mortality among HIV-infected infants. *N Engl J Med* 359: 2233-44.

81% of all HIV-infected pregnant women received ARV prophylaxis and 94% of HIV-exposed children were tested for HIV within 12 months of birth.

Maternal-Child HIV Care

AIDSRelief approached prevention of mother-to-child transmission (PMTCT) services through the lens of maternal-child HIV care, supporting Rwanda's integrated approach to emphasizing PMTCT within ART service. More than one hundred health workers were trained in the provision of PMTCT services, and ART nurses benefited from training on the national protocol and continuous on-site mentoring. AIDSRelief also trained and mentored 40 staff in early infant diagnosis techniques and provided

further technical assistance with dried blood spot (DBS) and polymerase chain reaction (PCR) sample collection.

In addition, trained community health workers closely followed the health status of infants and mothers on treatment, while health facility staff ensured intake of mothers and children. As a result, 81% of all HIV-infected pregnant women received ARV prophylaxis and 94% of HIV-exposed children were tested for HIV within 12 months of birth.

Tuberculosis/HIV

AIDSRelief promoted integration of tuberculosis (TB) services into HIV care and treatment by establishing one-stop services at each TB detection center. To ensure early identification, isolation, and treatment of TB cases, AIDSRelief refitted TB isolation rooms for effective infection control and encouraged facility staff to offer patients TB screening on a regular basis.

AIDSRelief introduced a fine needle aspiration (FNA) program at the National Reference Laboratory, Kigali University Teaching Hospital, and Butare University Teaching Hospital. Nearly 200 district-level health care workers were trained in FNA techniques and equipped with diagnostic materials.

HIV Testing and Counseling

AIDSRelief supported Rwanda's national counseling and testing models (provider-initiated testing and voluntary counselling and testing mobile service) by working side-by-side with facility staff to reach the entire population of targeted communities. Overall, more than 180,000 HIV tests were performed at AIDS-Relief supported sites each year, including tests for 15,000 pregnant women.

In total, AIDSRelief activated and/or reactivated voluntary counselling and testing services at 18 health facilities as part of a complete package of HIV care and treatment services.



Infrastructure, Equipment, and Commodities

AIDSRelief helped ensure that providers had the tools required for their jobs, from sharing knowledge about the most current HIV science to supplying necessary commodities in the event of a stock-out. Depending on a facility's needs, AIDSRelief funded and managed refittings and equipment purchases such as the establishment of infection control measures in laboratories or waiting areas that serve TB patients, private areas for patients receiving HIV testing or adherence support, and more readily accessible CD4 machines for monitoring patients.

Full integration of laboratory services into clinical care was key to improving the quality of patient care. AIDSRelief supported procurement of automated biochemistry and hematology machines by liaising with the National Reference Laboratory (NRL) and Supply Chain Management System (SCMS)⁷. The program also supported the NRL in implementing cryptococcal antigen (CrAg) tests with the use of lateral flow assay technique and assessed the feasibility of transporting plasma for viral load testing.

Continuous technical assistance was provided to scale up early infant diagnosis through sample collection, packaging, and transportation to the NRL in Kigali. Ninety-four percent of collected samples were sent to the NRL for testing, and 88.6% of those received results. Fewer than 11.4% of samples were rejected by NRL.

The central pharmacy of Rwanda, CAMERWA, provided AIDSRelief-supported facilities with commodities such as medication and laboratory reagents; in the event of stock-outs, AIDSRelief sometimes provided sites with funding to purchase key commodities. While such action was necessary to maintain service provision at the time, this was not a long-term solution and AIDSRelief staff worked with facility staff to improve supply chain systems and eliminate the need for stop-gap subsidies.

AIDSRelief advocated for, hired, and trained a district pharmacist in Nyamasheke to coordinate supply chain systems within the district, helping to set up the decentralized system of pharmaceutical management. Nineteen health facilities now benefit from uninterrupted drug and commodity supplies and receive coordinated support from the district level.

A Small Test of Change

After identifying a challenge through observation or data analysis, AIDSRelief and facility staff discussed why the challenge might have come about and how it could be addressed. By making incremental modifications to a process or system—a “small test of change”—teams could isolate simple variations to the status quo that make an impact before rolling out an expensive or complicated response that might not work.

In March 2009, a routine monthly report revealed that a striking number of patients in AIDSRelief-supported facilities were missing their CD4 appointments. Staff brainstormed reasons why this might happen and ways to quickly address those reasons; they then used the “small test of change” process to determine the best responses to the challenge.

Sites started using calendars specifically for CD4 appointments so that community support treatment staff could better follow up with patients. Clinicians also synchronized patient refill schedules and CD4 testing cycles so that patients could receive both services in a single visit and so that a waning supply of pills could serve to remind patients of an upcoming CD4 appointment. Within five months, the number of missed CD4 appointments had dropped by 8.3%. Each “small test of change” initiative was made standard practice and has contributed to the program's excellent patient outcomes.

AIDSRelief used the See-Try-Observe-Continue (STOC) model for small tests of change; the model is adapted from the Institute for Health Care Improvement's Plan-Do-Study-Act (PDSA) cycle developed by the Associates for Process Improvement.

⁷ SCMS coordinates pooled procurement across 19 PEPFAR-supported countries. It was established under PEPFAR in 2005 to ensure the availability of essential products (notably, HIV-related medicines) for programs in developing countries, and to strengthen national supply chain management systems.

Clinical Skills & Knowledge

Expanding clinical and laboratory capacity among providers was a key aspect of AIDSRelief's success in Rwanda. The onsite, shoulder-to-shoulder approach of accompaniment, needs-based technical assistance and continuing medical education helped to empower clinical teams to collect and evaluate patient health information for optimal care. Clinical teams continue to use these skills and to analyze aggregated patient data to identify challenges and to improve the quality of services at individual sites. Interdisciplinary technical assistance and the full integration of laboratory services into clinical care were also important to improving patient outcomes at each site.

Enabling Policy Environment

In addition to reinforcing providers' clinical skills, AIDSRelief supported the Government of Rwanda in changing policy to improve patient care. Initially, the government had only one guideline for all aspects of HIV care; with in-depth AIDSRelief participation, the government developed guidelines for different facets of the complicated disease: care and treatment, pediatric treatment, prevention including PMTCT, sexually transmitted infections, and psychosocial care.

Additionally, AIDSRelief support and advocacy helped change policy that previously allowed only certain specialist physicians to prescribe ART. The new policy created a cadre of nurse prescribers (560 individuals, as of late 2011) whose training is highly specialized to ensure >>



quality care and patient management, but less lengthy and resource-intensive than that of physicians. This task shifting makes more providers available for treating patients and frees up specialist physicians to care for complicated cases. Complementing this change, AIDS-Relief staff helped government partners to design the new policy and the curriculum for nurse prescribers.

Treatment Preparation and Counseling

Prior to initiating treatment, every patient at AIDSRelief-supported sites underwent a minimum of three intense, structured counseling sessions to prepare them for the life-long commitment of treatment. Treatment preparation helps patients better understand the importance of adherence and the dedication required of and resources available to them as they embark on the therapeutic regimen. Patients were strongly encouraged to have a “treatment buddy”—a friend, family member, or other confidante who may or may not be HIV-positive themselves—attend treatment preparation sessions. After initiating treatment, patients participated in adherence counseling as a standard part of their regular ART prescription refill visits. Adherence sessions are an opportunity for counselors to answer patient questions, identify potential adherence challenges, and reinforce messages about effective treatment. Adherence counselors are often on ART themselves and can therefore provide a unique perspective to other patients.

Community Engagement

Treatment initiation and adherence were further supported by community-based treatment support—a cornerstone of AIDSRelief’s highly effective treatment model—that included home visits during which trained counselors answered questions from family members and assessed some of the challenges and opportunities each patient faced at home. In this setting, a counselor might notice that the family is struggling financially and refer them to income generation activities or supplemental nutrition programs in the community. A counselor might also identify a mother-in-law as a key influencer in the family and encourage her to support appropriate infant feeding for an HIV-positive mother.

Outside of patient homes, AIDSRelief community supporters engaged local authorities, influencers, and religious leaders of all faiths to combat stigma and misinformation (such as rumored treatment risks or harmful myths about HIV transmission), raise awareness about HIV and available services, and help cultivate a supportive environment for people living with HIV. Community supporters, often living with HIV themselves, also encouraged formal and informal support groups to help patients overcome challenges to adherence and were critical to tracing patients lost to follow-up or at risk for dropping out of treatment. AIDSRelief’s community support groups are unique in that their primary focus is on patient outcomes, including adherence, testing for opportunistic infections, and HIV testing and treatment for pregnant women. Other support groups support people living with HIV through nonclinical activities such as income generation or psychosocial support.





Strategic Information: Transforming Health Systems and Patient Care

To evaluate the successes or struggles of patients, facilities, and any program, comprehensive and timely access to clean, complete, and accurate data is a top priority. This focus on strategic information provided decision makers at the country management and clinical levels with quality data to make informed decisions. In keeping with AIDSRelief's commitment to excellent patient outcomes, informed decisions, and continuous quality improvement, strategic information was a focus from the earliest stages of program design.

IQChart for Monitoring and Evaluation

Developed by AIDSRelief and used in every PEPFAR-funded ART site in Rwanda, IQChart is an

electronic health management information system that allows for the comprehensive longitudinal follow-up of HIV-positive patients. IQChart was designed to assist providers in making informed decisions about patient care and monitoring and evaluating programs at all levels. It allows health facilities to collect, store, and analyze patient-level data and generate reports on a variety of customizable indicators. Furthermore, data can be disaggregated by any patient characteristic in the database.

AIDSRelief-supported sites were the first to use IQChart. PEPFAR implementing partners throughout Rwanda soon learned of its effectiveness and availability and voluntarily began using the system (the open-source software is available from Futures Group). While the Government of Rwanda has decided not to use IQChart for its nationwide system, >>

In early 2008, routine reports revealed that large numbers of ART patients had missed scheduled appointments for drug pick-ups. Site teams quickly organized a two-pronged response: 1) improve and assure the quality of data and 2) strengthen community support networks.

Data managers generated a list of names and contact information for each patient recorded as more than 20 days overdue for an appointment. Clinicians and community coordinators followed up with each patient individually to determine if they had actually missed appointments or if their records were incomplete. Staff then updated the records, ensuring that subsequent patient management decisions could be based on clean, verified data.

Because some "missed appointments" were actually the result of inaccurate data, AIDSRelief

conducted refresher training with relevant clinicians and staff to emphasize the importance of and procedure for accurately recording details of every patient visit and any transfers to different sites. Other patients had in fact missed their appointments and were at risk of dropping out of treatment. In response, AIDSRelief worked with facility staff to more clearly define the community support team members' roles, responsibilities, and activities and to better supervise and mentor community support staff.

In addition to improving data quality, addressing this challenge dramatically improved patient management and quality of care. In the three months following the first alarming report, the number of patients who were more than 90 days overdue for their appointments plummeted from 650 to 32. Three months after that, the number was 11.

AIDSRelief worked to ensure that supported sites can maintain IQChart until the transition to a new system occurs (even upgrading the system to include new indicators as necessary) and that data collected through IQChart can be readily transferred to the national system when the time comes. This ensures that patient care will not suffer because of the transition and that improvements in capacity among facility staff will not be lost. Arguably more importantly, AIDSRelief helped Rwandan stakeholders fully appreciate the value and importance of data use, regardless of the electronic system used to manage that data.



In part through rich relationships with AIDSRelief teams, district hospital staff have grown confident in taking responsibility for their own programmatic reporting to U.S. government donor agencies and subgranting to the health centers—unprecedented tasks for district hospitals. Strategic information staff at district hospitals are also compiling, cleaning, and validating reports at hospitals and facilities. As the Ministry of Health gradually took on additional strategic information and monitoring and evaluation responsibilities, AIDSRelief played a smaller role and focused on data checks and quality assurance of reports prepared solely by staff at the central, district, and local levels.

Data Demand

Data collection can easily be perceived as an administrative burden, but AIDSRelief’s approach emphasized the careful management and practical application of data in all facets of patient care and site management. Prior to AIDSRelief, most facility staff did not differentiate between reporting and data use; this was also true of many clinicians and data managers at the district and central levels. (In this context, reporting is a passive activity of sharing data with the government or donors in order to meet a request or contractual obligation. Data use is proactive in that staff regularly analyze and leverage data to support a decision or activity.)

AIDSRelief linked clinicians and data managers through combined training, assessments, evaluation meetings, and other activities for continuous quality improvement. The result of these efforts was a paradigm shift: Clinicians, data managers, and administrators grew to appreciate and seek out data to inform both clinical and administrative decisions. Furthermore, clinicians and data managers now collaborate, see the value and interconnectedness of each other’s work, and can associate analysis of valid data directly with patient outcomes and site management.



Each AIDSRelief country program was designed to transition management of the program to a local partner, but the early project years were necessarily focused on initiating patients on treatment. As transition moved to the forefront, AIDSRelief Rwanda continued to support the provision of quality care at health facilities while also considering their organizational capacity. Furthermore, AIDSRelief worked with the Government of Rwanda at the central, district, and local levels to position each entity to assume management responsibility for the program.

By bolstering systems and procedures and training and mentoring staff, AIDSRelief helped central government strengthen its capacity to effectively manage large U.S. government grants and subgrants; district hospitals to deliver high-quality mentoring, supervision, and oversight to facilities; and facilities to manage their own planning and budgets while delivering exceptional care and treatment.

Rwanda's dedication to transition is noteworthy. The Government of Rwanda—including central- and district-level offices, as well as mayors in each district—had the political will to take full responsibility for the AIDSRelief-supported health facilities and hastened the process while emphasizing a willingness to take over project responsibilities. To ensure smoother transition, the Government of Rwanda recruited seven AIDSRelief staff. Equally important, AIDSRelief's staff were committed to the vision of a strong, Rwandan-owned health system providing comprehensive and high-quality HIV care and treatment to its people.

This gradual shift from international management to local ownership culminated in 2011, when the Ministry of Health developed a competitive funding application that won a new grant from the U.S. Centers for Disease Control and Prevention (CDC). The Ministry now receives PEPFAR grant funds directly to oversee the care and treatment program.





AIDSRelief was designed to ensure that people living with HIV could access high-quality care and treatment and that local entities would be able to maintain these life-long services after the grant ended. By strengthening the capacity of Rwandan entities to provide excellent clinical care, to use strategic information for continuous quality improvement and evidence-based decision making, and to effectively manage grants and individual sites, AIDSRelief made these lofty goals a reality in Nyamasheke district. Furthermore, by working with the whole system in mind and encouraging integration, AIDSRelief helped ensure that the

emergency response to HIV did not devastate other health services. In fact, AIDSRelief's rollout and expansion of quality care for people living with HIV helped facilities to better serve all of their clients and operate more effectively.

Because of the intensive partnerships and capacity strengthening inherent in the program's design, facilities once supported by AIDSRelief are well-fortified and poised, with effective ongoing support from the Ministry of Health, to maintain and expand the level of care that patients now expect and have always deserved.

Cécile is talking to Séraphine, who is HIV positive, about her medication. Séraphine lost her husband to the virus, and she's now raising their six children in Bungwe, a village high in the hills of the Burera district in Northern Rwanda.

Cécile is a senior nurse at Bungwe Health Centre. Previously, when patients were ready to start ART or needed complex medical evaluations, Cécile and her patients had to wait for a district doctor's weekly visit. Now, Cécile can handle it by herself. She's had the training. This is just one of the changes since the center began receiving AIDSRelief support in 2005.

"I've learned a lot with the AIDSRelief program," says Cécile. "It's helped so much with patient care, with medication, counseling. They've trained us, mentored us, really helped us to work as a team. Treating HIV is a multidisciplinary affair—none of us can work alone."

What really strikes Cécile this morning is Séraphine's son, 12-year-old Jean-Claude. Today Cécile had to tell him that he is HIV positive like his mother. But Jean-Claude didn't



cry when he heard the news. He kept a bright smile on his face. He's been coming to the health center with his mother since she began treatment and knows how effective quality care and treatment can be and how his condition can be managed and his life can continue.

"Before, when you spoke to someone about HIV, it meant death," Cécile explains. "But now it no longer means death. We've been helped to treat patients as a human being like any other, not like someone who's going to die."

Jean-Claude told her this morning that he wants to become a doctor.

ACKNOWLEDGMENTS

We would like to acknowledge the extraordinary support that AIDSRelief Rwanda has received from our donor, our local partners, and the Rwandan clinical experts who shared their expertise to ensure that those most in need receive quality HIV care and treatment.

We are grateful for the financial and technical support from the program's donor, HRSA, through PEPFAR. We also appreciate the CDC team in Rwanda for their on-the-ground program oversight, guidance and support. In particular, Dr. Fernando Morales and Rose Kadende-Kaiser, Ph.D., provided extensive support throughout the entire transition process.

Transition would not have been possible without the tremendous dedication of the Government of Rwanda, including the Minister of Health, Dr. Agnes

Binagwaho, and her colleagues, Dr. Ida Kankindi and Dr. Sabin Nsanzimana, who played key leadership roles in coordinating the transition work of their respective teams in the Decentralization and Integration Unit and the Institute of HIV/AIDS and Disease Prevention and Control.

At the district level, we thank Dr. Damien Nsabimana, Dr. Alfred Twafiramungu, Jean Baptiste Habyarimana and Catherine Gatete, as well as staff from treatment sites and communities across Rwanda.

Lastly, we thank the author of this document, Rebecca Bennett, AIDSRelief staff and former staff for their input, and the reviewers whose thoughtful comments on early drafts were invaluable.

Patients Served by AIDSRelief in Ten Countries

Country	# Sites	Cumulative ever in care and treatment at transition	Cumulative ever on ART at transition	Current on ART at transition (incl. adults and pediatrics)	Current pediatrics on ART at transition
Ethiopia	5	4,125	2,179	1,062	144 (13.6%)
Guyana	3	2,443	1,519	1,083	74 (6.8%)
Haiti	11	14,644	6,473	4,469	306 (6.8%)
Kenya	31	141,734	88,615	60,549	6,320 (10.4%)
Nigeria	34	109,872	64,564	52,559	3,301 (6.3%)
Rwanda	20	11,928	6,698	4,850	670 (13.8%)
South Africa	28	73,293	35,038	21,204	1,518 (7.2%)
Tanzania	102	165,488	85,673	44,924	3,414 (7.6%)
Uganda	23	87,943	45,221	35,047	3,263 (9.3%)
Zambia	19	96,247	60,041	42,783	3,197 (7.5%)
Total	276	707,717	396,021	268,530	22,207 (8.3%)

