



The AIDSRelief Rwanda Partnership:
Transitioning to the Ministry of Health



CRS is the official international humanitarian agency of the Catholic community in the United States. The agency alleviates suffering and provides assistance to people in need in nearly 100 countries, without regard to race, religion or nationality. CRS has had a presence in Rwanda since 1963. Since the 1980s, the agency has promoted self-help initiatives by introducing projects that encourage local communities to participate in the identification and resolution of their own development problems. As Rwanda works towards reducing poverty, strengthening civil society and reconciling its past, CRS engages in development activities in health, HIV and AIDS, nutrition, agriculture, microfinance, and peacebuilding.

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Cover photo:

Bungwe Health Center lab technician Bosco Karasira prepares to test blood samples for HIV. Photo by Rick D’Elia for CRS

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Acronyms

ART	Antiretroviral therapy
CDC	U.S. Centers for Disease Control and Prevention
CNLS	National AIDS Control Commission (Rwanda)
CRS	Catholic Relief Services
DH	District hospital
HRSA	Health Resources and Services Administration (U.S.)
IHDPC	Institute of HIV/AIDS and Disease Prevention & Control (Rwanda)
IHV	Institute for Human Virology
IT	Information technology
MOH	Ministry of Health
NGO	Nongovernmental organization
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLO	Patient level outcome
SCA	Site Capacity Assessment [tool]
TRAC Plus	Center for Treatment and Research on AIDS, Malaria, Tuberculosis, and Other Epidemics (Rwanda)
TTF	Transition Task Force
USG	United States Government

Introduction

Working as the AIDSRelief consortium in Rwanda from 2005, Catholic Relief Services (CRS), Futures Group, and the University of Maryland School of Medicine Institute for Human Virology (IHV) expanded antiretroviral therapy (ART) to nearly 12,000 patients who continue to receive life-saving care and treatment, including nearly 5,000 people who were on antiretroviral therapy (ART) as of August 2011. 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 sites* from AIDSRelief to the Government of Rwanda Ministry of Health. The government now maintains those ART sites and their affiliated patients as part of the national health system. Rooted in CRS's commitment to capacity strengthening and equitable partnerships as a means to promote local ownership and sustainability, AIDSRelief was designed to transition management of the program to a local partner. The donor mandated that the transition should occur by February 2012. Rwanda is the only AIDSRelief country program in which the sole local partner for transition is a government body.

The Partnership and Capacity Strengthening unit at CRS developed this learning document with the AIDSRelief Rwanda team to highlight project lessons and successes and make relevant information available to others seeking adaptable or replicable strategies.

Background

AIDSRelief: Country Programs for a Global Response

In 2004, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) funded AIDSRelief, a CRS-led consortium, to rapidly

*Also called local partner treatment facilities, or LPTFs.

scale up HIV care and treatment for the poor and underserved in nine countries (adding a tenth, Ethiopia, in 2009), including Rwanda. Each AIDSRelief country program is built upon the AIDSRelief model of care (see Figure 1), adapted to each country's unique context and needs.

PEPFAR: From Emergency Response to Sustainable Development

PEPFAR was launched in 2004 as a \$15 billion, five-year response to the global AIDS epidemic. PEPFAR provided funding and technical expertise through agencies such as CRS to make ART available in 15 focus countries including Rwanda. With the U.S. government's reauthorization of PEPFAR in 2008, programming shifted from an externally led emergency response to an increasing emphasis on strengthening health systems and building a sustainable response owned by each host country.

The AIDSRelief model of care has three pillars (clinical, strategic information, and site management) and relies on health systems strengthening to provide comprehensive and high-quality HIV care and treatment. The model posited that a strong system depends on the strength of each facility, its network, and its links with the public health sector and the community. Because such a systems-strengthening understanding and approach is a fundamental shift for many health institutions in resource-poor settings, AIDSRelief provides direct assistance to partners in the development of financial, material, technical, and human resources. AIDSRelief staff accompany partner staff and management through a continuous process of capacity strengthening and program quality improvement.

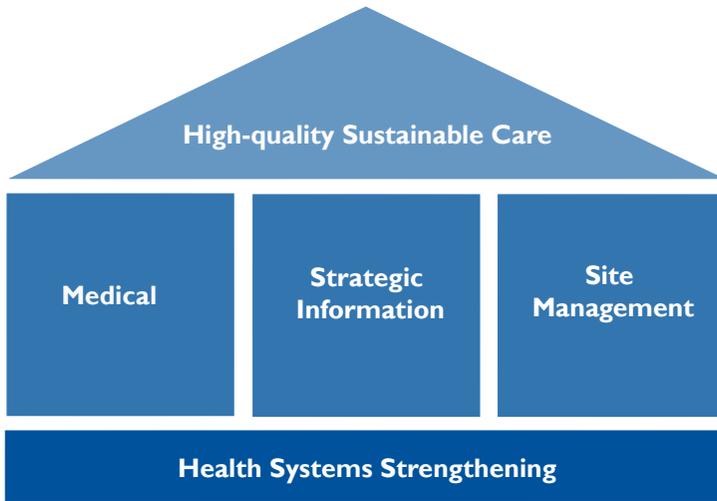


Figure 1: The AIDSRelief Model of Care

HIV in Rwanda

Prior to the launch of PEPFAR and the national roll out of ART in 2004, Rwanda faced staggering mortality rates. At least 10,000 people died each year since the early 1990s¹ while treatment was either unavailable or prohibitively expensive. In 2004 alone, nearly 15,000 Rwandans lost their lives to HIV.² Since 2004, and with the help of bilateral and multilateral partners, Rwanda has achieved substantial growth in HIV care, support, and treatment services in public and private settings. ART coverage has increased dramatically—in 2009 about 90 percent of ART-eligible patients (defined by current WHO guidelines as those with CD4 counts of less than 350) received treatment.³

The Government of Rwanda is wholly committed to the cause, setting aggressive national goals⁴ that are closely linked with the country's Economic Development and Poverty Reduction Strategy, 2008–2012:

1. Halve the incidence of HIV in the general population by 2012
2. Significantly reduce morbidity and mortality among people living with HIV
3. Ensure that people infected and affected by HIV have equal opportunities

Clinical Outcomes as a Measure of Success

Conducted through retrospective chart reviews and evaluation of patient data, patient level outcome (PLO) surveys are a key tool in continuous quality improvement under AIDSRelief. In 2008, a survey of more than 400 patients in Rwanda who had started ART nine to 15 months prior to review revealed that AIDSRelief Rwanda was able to attain dramatic treatment success even in very remote areas and despite limited access to laboratory monitoring tools.[†]

- Of AIDSRelief patients surveyed, 91 percent had undetectable viral loads. Patients with low viral loads are less infectious and thus present a reduced risk of onward transmission, embodying “treatment as prevention” efforts in Rwanda.
- Only two percent of AIDSRelief Rwanda patients are lost to follow-up as of August 31, 2011. This excellent retention rate rivals rates in industrialized countries with robust health systems, suggests patient satisfaction, and bodes very well for adherence and treatment outcomes in Rwanda.

[†] AIDSRelief Rwanda conducted a final PLO survey in August 2011. The final data analysis was not available at time of publication.

The Rwandan Health System and AIDSRelief

As in many resource-constrained countries, the Rwandan health system is composed of public facilities as well as those run by faith-based missions,

nongovernmental organizations (NGOs), and private clinicians working for profit. Different countries have varying degrees of collaboration among these different entities; in Rwanda, they are governed as one network. NGOs and faith-based institutions manage day-to-day operations but adhere to Government of Rwanda standards and guidelines and participate in district-wide planning to help ensure comprehensive, efficient, and wide-reaching services for the people

of Rwanda. In Rwanda's

decentralized system, funding flows from the government and external donors through the central government to facilities, but districts 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:

1. Provide technical assistance to local- and district-level health facilities to roll out and scale up HIV care and treatment services



Bungwe Health Center lab technician Bosco Karasira draws blood from Mundekezi Therese for an HIV test at the VCT clinic. Photo by Rick D'Elia for CRS.

2. Provide technical assistance to the MOH at district and central levels to enhance the government's capacity to provide clinical leadership

At the facility level, AIDSRelief strengthened staff and institutional capacity in grants management, strategic information, and clinical support by jointly identifying needs and providing direct, hands-on support to facility staff. As the program's focus expanded to emphasize transition, AIDSRelief staff and the district hospital staff who are responsible for facility oversight jointly conducted supervision, mentoring, and technical assistance at facilities. This accompaniment approach concurrently reinforced technical skills among facility staff, and training and oversight skills among district hospital staff who now mentor and supervise facility staff.

At the central level, AIDSRelief used similar approaches to support Rwanda's Institute of HIV/AIDS and Disease Prevention & Control (IHDPC, formerly TRAC Plus[‡]) in its supervision of and mentorship program for district hospitals nationwide. With technical support from AIDSRelief, IHDPC developed and revised research protocols and national curriculums for in-service and pre-service training.

Partnership and capacity strengthening for change

Recognizing that people and organizations in their own context are best suited to identify and address their own development needs, CRS has spent more than 60 years developing sound programs with an array of local partnerships marked by mutual

[‡] In 2011, the Government of Rwanda restructured its health-related agencies. IHDPC is the body that currently oversees clinical research, guideline development, and strategic information at a national level; TRAC Plus (Center for Treatment and Research on AIDS, Malaria, Tuberculosis, and Other Epidemics) previously held those responsibilities. The RBC's current policy responsibilities were previously held by *Commission Nationale de Lutte contre de SIDA* (CNLS), Rwanda's National AIDS Control Commission.

respect and equity. Furthermore, this experience has revealed that all organizations can learn to function better as institutions and healthy local institutions help ensure that positive changes outlast project funding, staffing, and material or technical support. Critical to a successful transition of expertise or responsibility, partnership and capacity strengthening are mutually reinforcing and often concurrent and overlapping processes. These tenets inspired AIDSRelief's program design and commitment to change: a transition from externally driven, vertical HIV treatment activities to locally owned, high-quality, integrated ART services delivered within a strengthened health system.

CRS regards **capacity strengthening** as essential to any organization's health. It includes **capacity building**, which focuses on individuals or teams, enhancing or developing new knowledge, skills, and attitudes in order for people or teams to function better; **institutional strengthening**, focusing on an organization, enhancing or developing its systems and structures to function more effectively, work towards sustainability, and achieve goals; and **accompaniment**, consistent coaching and mentoring that allows new skills to be mastered or new organizational systems to become standard operating procedures.

For such a complex transition to be successful, all stakeholders must commit in word and deed. The entity taking on new roles and responsibilities must be willing to own the process and systems, to devote human and material resources to the cause, and to strengthen its capacity to thrive in the new roles. Equally important is that "outgoing" organizations like AIDSRelief's consortium members must step back, trust the process of capacity strengthening and transition, and give their partners the room to learn and succeed on their own.

Rwanda's dedication to transition is noteworthy. The Government of Rwanda—including central- and district-level MOH, as well as mayor's offices in each district—had the political will to take full responsibility for the AIDSRelief-supported health facilities and pushed the process forward and emphasized the government's willingness to take over project responsibilities. AIDSRelief staff were devoted to the program they had nurtured, but also were committed to the vision of a strong, Rwandan-owned health system providing comprehensive and high quality HIV care and treatment to its people.

Shortly before program closeout, members of the AIDSRelief Rwanda team looked back on their implementation experiences and found that certain dimensions of partnership and capacity strengthening stood out in their experience. These dimensions frame the discussion that follows: development of a **shared vision**, demonstrated **commitment to transition, right relationships** embodying the partnership principles, and **accompaniment**.

Developing & actualizing a shared vision

In any partnership or collaboration, a shared vision is critical to reaching common goals. That the shared goal was lifelong, high-quality HIV care and support for thousands of patients raised the stakes and made a shared vision critical in Rwanda. AIDSRelief and the Government of Rwanda strived to follow best practices by engaging stakeholders early and frequently, at every level, and within every function of the program.

Once collaborators arrive at a common vision, actualization requires careful and participatory work planning, implementation, and ongoing monitoring and evaluation of progress. Changing contexts and mid-term assessments might reveal gaps in knowledge, skills, and attitudes, or mistaken assumptions made during planning, in which case teams must come together and recalibrate strategies or plans while remaining focused on the vision. The situation in Rwanda was no exception.

Planning for Success

To make the goal of transition a reality, stakeholders from the USG donor agencies (CDC and HRSA), AIDSRelief, and the MOH developed detailed work plans for the 2009–2011 transition period. Using qualitative experience and data from clinical and site quality assessments, the teams identified gaps or areas for improvement in each site and function; strengthened knowledge, skills, and attitudes; established or reinforced systems; monitored their progress; and revised plans to changing needs or contexts. AIDSRelief staff supported facility and central and district MOH staff in each of these processes, providing technical assistance and capacity strengthening (through trainings, accompaniment, and mentorship) as necessary. As the transition to MOH agencies progressed, AIDSRelief staff took an increasingly smaller role in each of these processes, providing technical advice at the request of MOH staff.

District hospitals now lead work planning for ART sites, supervising and mentoring facility staff in the process. Prior to this process, districts and facilities may have received or even developed work plans, but did not consistently execute those plans. Now, with full participation in the process, plans are need-based, and are implemented and monitored. District hospitals and health facilities also set their own targets for their work plans, emphasizing ownership and tapping into plentiful local expertise to determine how to reach those targets.

Meeting Changing Needs

In 2009, the Rwanda Ministry of Health created a Transition Task Force (TTF) tasked with developing guidance and parameters for transition and helping to ensure a common vision and approach at the central, district and facility level. TTF membership was representative of national stakeholders including MOH, transitioning implementing partners and CDC Rwanda. This was a significant step toward thoughtful, purposeful creation

of the transition roadmap and planning for specific transition milestones and capacity strengthening activities. As the transition progressed, the TTF and its subgroups served as a critical forum for transparently monitoring progress against planned activities and agreed-upon quality of care indicators at transitioned sites over time. This collective approach greatly contributed to the stakeholders' ability to conceptualize transition and then make it happen.

During the early stages of TTF working sessions and meetings, district hospitals and health centers did not have direct participation. This left district and facility staff uninformed for a short time regarding changes to the original AIDSRelief scope of work and the new ways of operating during transition. For example, district hospital staff and leadership knew that transition in a decentralized health system meant increased responsibility for care and treatment oversight in their respective zones, but they were not as familiar with the vision developed by the Transition Task Force with MOH leadership, timeline for transition, or capacity strengthening plans and goals.

To engage district hospitals and health centers, AIDSRelief, CDC, and the MOH convened transition orientation meetings to familiarize districts and transitioning facilities with their new responsibilities and new funding mechanisms. The meetings also provided a venue for districts and transitioning facilities to ask questions and provide feedback on transition plans. As program responsibilities shifted from AIDSRelief to MOH, the purpose of these joint meetings evolved to meet the changing needs at central, district, and facility levels.

The transition orientation meetings became quarterly planning and evaluation sessions, and district hospitals began to convene and lead these meetings, set agendas, and take notes even before the end of AIDSRelief. At the new meetings, AIDSRelief, CDC, district hospital, and facility representatives discussed and prioritized technical assistance needs at the health centers, jointly

identified areas for building district hospital mentorship skills, and set calendars for the delivery of technical assistance at either district or health center levels. District hospitals continue to convene these meetings, exemplifying an established system that will support sustainability.

Remaining Focused through Challenges

District hospital staff who supervise facilities work across several national health initiatives in Rwanda's integrated health system and can face significant resource constraints. Demands on supervisory staff often exceed the time they have available and vehicles—

crucial for visiting rural facilities—are in short supply. To help serve facilities and patients, and to efficiently use the limited time district hospital supervisory staff have available, AIDSRelief and district hospital staff combined their supervisory and program support visits. By planning together, districts were able to prioritize facility needs and stretch time and financial

resources. These joint visits also served as capacity strengthening exercises since AIDSRelief and district staff could learn from one another in the process.

As part of AIDSRelief's close-out equipment disposition plan, the Ministry requested that district hospitals receive former program vehicles to facilitate oversight and support visits to facilities. At the



Bungwe Health Center lab technician Bosco Karasira tests blood for the human immunodeficiency virus. Photo by Rick D'Elia for CRS.

time of publication, this plan was pending donor approval, but nevertheless demonstrated the Ministry's understanding of and commitment to the district hospitals' role in ensuring service quality.

A New Understanding: Mentorship versus Supervision

Managers in any setting may not distinguish between supervision or supportive supervision and mentoring. In the AIDSRelief model, they are distinct but complementary activities. Through joint site visits and other interactions with AIDSRelief, the Government of Rwanda and even another PEPFAR implementing partner have recognized the distinction and the value. During Transition Task Force clinical subgroup meetings, the Government of Rwanda began

making the verbal distinction between mentorship and supportive supervision at health facilities.

Joint teams of AIDSRelief and central MOH staff who provided mentorship to district hospitals nationwide

continued after

program close out and are now called "mentorship teams." MOH staff on those mentorship teams are now required to spend time consulting patients in HIV treatment clinics, which demonstrates the Ministry's new understanding that clinical mentorship requires that one practice clinical skills in order to most effectively teach those skills. There is now a distinction between transferring clinical knowledge versus "checkbox supervision."

Supportive supervision is a method of oversight that relies on periodic visits and checklist assessments administered on key areas by an expert clinician.

Mentoring involves personalized support, by an expert clinician working side by side with site staff, on clinical matters such as resolution of complicated cases.

Commitment to transition

Transition can be difficult and each stakeholder’s dedication to the shared vision is critical. Under AIDSRelief, the donor, program, host country government, and facilities were wholly committed to a successful transition. An important measure of commitment was physical presence and willingness to work together to address the inevitable challenges that arose. The donor cultivated a productive relationship with the Government of Rwanda, facilitating problem-solving efforts when called upon. AIDSRelief representatives attended and were fully engaged

at all Transition Task Force and subgroup meetings hosted by the Government of Rwanda. Staff and management at

“It was a shared, partnership decision to get this [transition] right.” —AIDSRelief staff

treatment sites embraced their new responsibilities, maintaining quality patient care throughout the process.

Developing Systems for Timely Fund Disbursements

Even flawless planning sometimes fails to address every circumstance or need. Under AIDSRelief, this meant that the first treatment sites to transition struggled, but also blazed the trail for others. Throughout the three-year transition period, stakeholders strengthened their systems. During the second half of that period, stakeholders also learned from challenges encountered by the first sites to transfer to the MOH from AIDSRelief support. This continuous improvement made transition smoother for each subsequent wave of sites that received funding through MOH instead of AIDSRelief.

Transitioning from AIDSRelief to the MOH in March 2010, the first six sites faced a five-month funding delay and a number of operational difficulties as a result. To their credit,

the sites maintained quality of care as measured by routine site assessments during this period. However, the funding delay revealed gaps in financial and operational systems at the donor, program, and ministry levels. Each entity stepped up to acknowledge any responsibility for the delay and to improve their financial and operational systems for disbursement, subgranting, budget development, and approval processes.

The sites that transitioned in October 2010 received funding for salaries on time, but faced a delay in activity funding that was resolved after several months. The March 2011 sites also faced minor delays, but they were significantly less than first group. The last site to transition did so in October 2011. This was also the start of a new fiscal year, meaning all sites needed revised work plans, budgets, and subagreements. MOH jointly developed their work plans and budgets with district government (who coordinate all development activities in their area), district hospitals, and AIDSRelief. Plans, budgets, central- and district-level approvals, and disbursements were on schedule as of the first week of the fiscal year. This dramatic improvement was possible because all stakeholders united as equals and remained committed to their shared vision of sustainable Rwandan ownership and quality patient care.

Understanding and Staffing for New Responsibilities

Post-transition, the Government of Rwanda took on a new role as the prime recipient of a substantial U.S. government grant for HIV care and treatment, but this first required new staff and new functions. To support this end, seven AIDSRelief staff members were transferred from the Rusizi suboffice to Kigali in March 2011 with the objective of accompanying their new counterparts in the central MOH.

Recognizing that accompaniment of central MOH staff by AIDSRelief staff was important for knowledge exchange, CDC facilitated communications between the program and

the Ministry in support of the collaboration. The Government of Rwanda came to better understand its new role as prime of a U.S. government cooperative agreement, yet struggled somewhat to recruit staff for the new responsibilities. Because of the willingness of the donor to advocate for the program and the unyielding commitment of the Government of Rwanda, the MOH filled most of the open positions and functions, making AIDSRelief accompaniment of the MOH possible. New and existing staff were also notably quick learners, benefitting from the support in spite of the relatively short timeframe.



Bungwe clinic staff meet with doctors to decide which patients will begin ART. They also present difficult cases for the doctors' consideration. Photo by Rick D'Elia for CRS.

Meaningful partnerships & right relationships

In a project as complex as AIDSRelief, poor relationships can undermine the most technically sound design and implementation. Relationships must be strong and equitable at each level of the system and among each group of stakeholders, including within the program or consortium itself.

CRS, IHV, and Futures Group comprised the AIDSRelief Rwanda consortium, the technical backbone of a model of care shaped by the complementary expertise of each organization. While

these differences were assets, challenges arose in unifying a team comprised of distinct agencies with distinct missions, organizational cultures, and priorities. Strong leadership, deep professional respect, and an appreciation for the merit of each interdependent technical area helped build a unified team.

Outside of the consortium, relationships were equally important to the success of AIDSRelief as a program. At the facility level and among IHDPC members, relationships grew naturally from technical exchange and existing relationships. AIDSRelief clinical staff and Government of Rwanda clinicians jointly conducted operational research and regularly shared evidence and experience to ensure that Rwandan decision-makers were positioned for success.

Key representatives from the Government and from AIDSRelief also worked side-by-side to develop the 2010 plan that drove

“Internal unity makes support of external partnerships possible.”

—AIDSRelief staff

transition activities. Strong relationships with district leadership were critical to AIDSRelief’s success, particularly in Rwanda’s decentralized system. By being present and highly responsive to the needs of district leaders, AIDSRelief suboffice staff created invaluable alliances with district hospitals and administrators.



Uwizeyimana Florence gives a married couple happy news about their HIV status. Photo by Rick D’Elia for CRS.

All of these relationships were hallmarked by transparency, open communication, and tangible trust, which evolved naturally from evidence including clinical outcomes.

Strategic Information: A Paradigm Shift

While a program's data collection and reporting can easily be perceived as an administrative burden, AIDSRelief's approach to strategic information emphasized the



Improved data quality and analysis assist clinicians in making informed decisions about patient care. Photo by David Snyder/CRS.

application of that data in all facets of patient care and site management. By linking clinicians and data managers through combined trainings (formal and informal), assessments, and evaluation meetings, AIDSRelief helped create a process through which clinicians and data managers now see the value and interconnectedness of each other's work and can associate that work directly with patient outcomes and improved teamwork.

Prior to AIDSRelief, most facility staff did not differentiate between **reporting** and data use. In this context, reporting is a passive activity of sharing data with the MOH or donors in order to meet a request or contractual obligation.

Data use is proactive in that staff analyze and leverage data to support a decision or activity.

AIDSRelief advocated for facility and district

staff to have adequate time and resources to collect and analyze their data, improving data quality and analyses. Together, these efforts helped create a culture of timely, data-driven information use that has transformed management and patient care.

“Data illuminated the situation for health facility staff. [It created] a full picture they hadn't seen before.”

—AIDSRelief staff

Underlying data-driven information use is quality monitoring and evaluation (M&E). Under AIDSRelief, technical staff conducted formal trainings for and worked alongside MOH staff to strengthen M&E skills. To reinforce these skills, the program then focused on skills application. As the MOH gradually took on additional reporting responsibilities, AIDSRelief played a smaller role and focused on data checks and quality assurance of reports prepared solely by M&E staff at central, district, and local levels.

Over the course of the project, AIDSRelief developed abstracts for national and international conferences highlighting the success of facilities in Rwanda. This motivated AIDSRelief staff who were being recognized for their work and emphasized the value of quality data to conference audiences, including central and district level Government of Rwanda staff.

A Leader Stands Behind

As the AIDSRelief transition gained momentum, district-level MOH leaders developed a sense of urgency and grew eager to take on their new roles. When the project began, a sense that AIDSRelief was in control of technical assistance may have been reassuring to many but during transition this would have been a liability. To curtail AIDSRelief involvement and create space for the Government of Rwanda to engage, AIDSRelief project leaders imposed limitations on how much AIDSRelief could “do.” For example, by limiting the number of trips AIDSRelief teams could make during a certain period, district hospital and AIDSRelief teams from different technical specialties had to plan carefully and combine resources for site visits.

This sort of support and accompaniment also helped facilities take the lead technically. In the early days of transition, facility clinicians called AIDSRelief staff to ask for advice on how to handle patients who were not responding well to treatment. Now facilities and district hospitals consistently make decisions about complex patient management with confidence and improved

accuracy. Other capable, empowered staff also stepped up. Because of staffing shortages throughout the region, many facilities only have physicians in-house on a set day a few times a month. These physicians previously spent that time reviewing files to identify patients who were not responding well to treatment. Now physicians arrive to find that nurses who have received additional training and authority through MOH task-shifting initiatives identify these patients prior to the doctor's arrival, improving efficiency and patient care. Strategic information and laboratory staff at district and local levels also took on greater responsibility and decision making with great success.

While AIDSRelief staff stepped back, they remained available as a resource to Government of Rwanda partners. In one example, district hospital staff identified the need to train new clinical staff in areas of high turnover (i.e., rural areas), and led the training from beginning to end. At the request of district leadership, AIDSRelief staff provided support by helping to identify training needs, to develop training materials, and to facilitate sessions. In a similar case, district hospitals identified grant management as an area in which health centers could use additional capacity. With AIDSRelief support, the district hospital led a very successful training session, helping improve grants management among facilities. Signs of the Government of Rwanda ownership come in something as simple but meaningful as an invitation to events or trainings that bear the mayor's stamp instead of an AIDSRelief logo.

“When you give people responsibility, support, and resources, most people will step up. [They] want to help and improve.”
—AIDSRelief staff

Accompaniment & “Letting Go”

In any environment, camaraderie comes from working side-by-side with one’s counterparts. The experience helps cultivate relationships, foster trust, and allow for a meaningful, two-way exchange of knowledge, skills, and experience by complementing formal and informal training with ongoing support, coaching, and mentoring. This concept is reflected in the principle of **accompaniment**.

At facility and district levels, AIDSRelief and Government of Rwanda staff worked together. In the first half of 2011, nine AIDSRelief team members from the Rusizi suboffice were moved to Kigali to work side-by-side with their technical (clinical, strategic information, and grants management) counterparts at central MOH offices. The staff that remained in the suboffice focused their efforts on capacity strengthening at district hospitals, rather than at the health center level. All work targeted specific capacity strengthening needs (identified through formal capacity assessments or at the request of a facility or MOH leadership), whether at central or district level, to further support transition.

In this model, AIDSRelief staff who intimately knew the work shared their knowledge and experience, in the spirit of accompaniment, with the Government of Rwanda teams who took on new responsibilities in the transition. The joint teams worked shoulder-to-shoulder, and AIDSRelief staff gradually stepped back to allow the Government of Rwanda staff to take full responsibility. The Government continued to call on AIDSRelief for specialized technical assistance as necessary (e.g., youth HIV services, data demand and information use), and will have some access to IHV for highly specialized technical support for health systems strengthening in the future via a new U.S. government cooperative agreement.

Late in the project, AIDSRelief continued to provide both district hospitals and local facilities with technical assistance and problem

solving related to hardware and software maintenance because many facilities lacked staff to do this work. Seeing an opportunity, AIDSRelief took the initiative to train information



The strengthening of care delivery systems has been a steady priority in the transition of AIDSRelief to Rwandan ownership. Photo by David Snyder/CRS.

technology staff at district hospitals to maintain hardware and software for the IQChart health management information system. While the scopes of work for these staff do not currently include IQChart technical support to facilities, they are a logical resource and are trained and capable, should Government of Rwanda leadership shift responsibilities to them. As the program tapered off, central-, district-, and facility-level staff increasingly tapped into their own skills and experience for technical expertise, and turned to AIDSRelief only for complex consultations.

In part through these rich relationships with AIDSRelief staff, district hospital staff have grown confident and taken responsibility for their own programmatic reporting to U.S. government 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.

Financial Reporting and Grant Compliance

U.S. government grants come with stringent rules and regulations to ensure that taxpayer funds are used efficiently and as intended. For some grant recipients this level of reporting and regulation is unfamiliar, yet transition under the AIDSRelief grant required that local entities maintain or develop the

capacity to absorb and manage direct funding from the U.S. government. Central Government of Rwanda agencies are dependent on district and local entities for their participation as well (e.g., reporting and subgrant compliance), thus it was critical for Government staff at all levels to have the necessary skills, systems, and structures to succeed.

Through AIDSRelief, staff at district hospitals and local health facilities received and spent U.S. government funds and received annual training in U.S. government regulations, but with the transition, a deeper level of understanding and application was required. AIDSRelief would no longer serve as a fail-safe (e.g., checking data or financial reports prior to submission to the donor), and—given Rwanda’s commitment to decentralization—the MOH is likely to put additional compliance responsibility on both the district hospitals and health centers in the future.

To ensure that local entities could comply with these new obligations, AIDSRelief grant staff, CDC, and Government of Rwanda counterparts worked side-by-side to review regulations, develop systems and processes to support compliance, and to correct the inevitable mistakes that come with learning new policies and procedures. If a financial report revealed an irregularity, AIDSRelief staff (ultimately responsible for compliance through January 2012) walked through the regulations and the report to ensure that local staff understood and could address the challenge. This accompaniment approach helped the hard-working Government of Rwanda staff to become and remain U.S. government compliant with minimal involvement of AIDSRelief staff, and to receive substantial and direct funding from the U.S. government for HIV care and treatment.

Valuable Tool or Burdensome Task?

To measure site capacity among transitioned ART sites, the MOH has a baseline tool for transition that was applied by all implementing partners (including AIDSRelief) semi-annually at transitioned sites.

The tool provides a binary assessment that indicates the presence or absence of certain functions or resources in a facility. While this tool is relatively quick and easy to administer, AIDSRelief sites used an additional tool (the Site Capacity Assessment, or SCA) that measures additional capacities needed to meet the program standards of the AIDSRelief model. The SCA tool takes as long as two days to administer—a significant amount of time for resource-constrained staff—but provides users with detailed and incremental information about a site’s functionality and service quality. The SCA tool also has an action-planning component and facilities should be able to self-administer the tool after an initial assessment. These two characteristics allow health facility staff to become familiar with the meaning behind their scores, easily identify areas for improvement, and quickly create plans for quality improvement.

The Site Capacity Assessment (SCA) tool helps program managers to assess a health facility’s overall capacity of program operations to deliver quality HIV care and treatment. It identifies areas in need of strengthening as well as areas of excellent capacity that may be used to exemplify best practices. The tool’s components cover adult, youth and maternal child HIV care; nursing; community based treatment support; quality improvement programs; finance and compliance; health care management; pharmacy; laboratory; strategic information; and fundraising and advocacy. The tool automatically calculates the facility’s score for each component. Using the SCA tool scores, the SCA dashboard provides color coded maps, charts and tables to support program decision making at all levels—global, country and facility.

Results from a SCA help stakeholders to strengthen and maintain program standards by efficiently and effectively targeting scarce expert technical assistance, and to make sound decisions at site, district, and central levels.

Since the SCA tool is reflective of the AIDSRelief model and results will be in final project reporting to U.S. government, AIDSRelief staff continued to conduct the SCA tool alongside the binary assessments during transition. AIDSRelief shared assessment results, listened to Government of Rwanda concerns about the SCA tool's time requirements, and trained interested stakeholders in application of the tool. As a result, some individuals outside of AIDSRelief see the value of the SCA tool for management of other public health programs nationwide. The Government of Rwanda is not currently using the tool, but may choose to make it part of future site assessment and management when appropriate; the principle of subsidiarity has helped AIDSRelief to "let go" and honor the government's decisions and solutions.

"Patience is the most important tool."

—AIDSRelief staff

Conclusion

Facing certain death from HIV-related illness less than a decade ago, tens of thousands of Rwandans are today healthy, thriving members of their communities in part because of programs like AIDSRelief. The AIDSRelief model of care helped to produce outstanding clinical results in the Rwanda program—nearly 12,000 people receiving care and treatment, a two percent lost-to-follow-up rate that rivals those of industrialized countries,⁵ and undetectable viral loads in 91 percent of ART patients surveyed. Equitable partnerships with host-country entities at all levels and needs-based capacity strengthening helped ensure that the MOH could take on new responsibility for clinical and grants management of AIDSRelief's 20 sites.

Without political will from the Government of Rwanda, this transition would not have been possible. Because of its absolute dedication, this profound change will last well beyond the AIDSRelief grant.

Since site-transition efforts began in 2010, the Government of Rwanda has developed the systems and structures to lead a U.S. government cooperative agreement substantially larger than any it has received before. Ministry officials at central and district levels support supervisors, mentors, and facility staff with need-based technical assistance, side-by-side accompaniment, accurate data collection and analysis, and sound financial and subgranting practices. Patients in rural ART sites receive high-quality, life-saving HIV services. The path was not always smooth, but a shared vision, commitment to transition, right relationships, and accompaniment helped AIDSRelief (as the original implementer) and the Government of Rwanda (as the transition partner) find their way together.

In an effort to achieve truly sustainable change, health and development donors worldwide have made a dramatic shift toward prioritizing host-country engagement in programming. Substantial capacity exists in Rwanda, and with equitable partnerships and targeted capacity strengthening the local ownership of high-quality programs became a wholly attainable goal.

1 UNAIDS. AIDSinfo country fact sheet, Rwanda. Available at <http://www.unaids.org/en/dataanalysis/tools/aidsinfo/countryfactsheets/>. Accessed September 20, 2011.

2 UNAIDS. AIDSinfo country fact sheet, Rwanda. Available at <http://www.unaids.org/en/dataanalysis/tools/aidsinfo/countryfactsheets/>. Accessed September 20, 2011.

3 UNAIDS. AIDSinfo country fact sheet, Rwanda. Available at <http://www.unaids.org/en/dataanalysis/tools/aidsinfo/countryfactsheets/>. Accessed September 20, 2011.

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

5 Rice BD, Delpech VC, Chadborn TR, Elford J. “Loss to follow-up among adults attending human immunodeficiency virus services in England, Wales, and Northern Ireland.” *Sex Transm Dis*. 2011 Aug;38(8):685-90. Keiser O, Orrell C, Egger M, Wood R, Brinkhof MWG, et al. 2008 Public-Health and Individual Approaches to Antiretroviral Therapy: Township South Africa and Switzerland Compared. *PLoS Med* 5(7): e148. doi:10.1371/journal.pmed.0050148

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CRS Partnership Principles

1. Share a vision for addressing people's immediate needs and the underlying causes of suffering and injustice.
2. Make decisions at a level as close as possible to the people who will be affected by them.
3. Strive for mutuality, recognizing that each partner brings skills, resources, knowledge, and capacities in a spirit of autonomy.
4. Foster equitable partnerships by mutually defining rights and responsibilities.
5. Respect differences and commit to listen and learn from each other.
6. Encourage transparency.
7. Engage with civil society, to help transform unjust structures and systems.
8. Commit to a long-term process of local organizational development.
9. Identify, understand, and strengthen community capacities, which are the primary source of solutions to local problems.
10. Promote sustainability by reinforcing partners' capacity to identify their vulnerabilities and build on their strengths.



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