REPUBLIC OF RWANDA

MINISTRY OF HEALTH
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HEALTH SECTOR ANNUAL REPORT

July 2013-June 2014

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ACCRONYMS

EAC	East African Community
ACT	Artemisinin Combined Treatment
DQA	Data Quality Assessment
OI	Opportunistic Infections
ACILT	African Centre for Integrated Laboratory Training
AIDS	Acquired Immunodeficiency Syndrome
AMPATH	Academic Model Providing Access to Healthcare
ANC	Antenatal Care
ARI	Acute Respiratory Infections
ART	Antiretroviral Treatment
BECS	Blood Establishment Computer Management Software
BoD	Board of Directors
C-BNP	Community Based Nutrition Programmes
CCM	Country Coordinating Mechanism
CD4	Cluster of Differentiation 4
CDC	The Centres for Disease Control and Prevention
CHU	Centre Hospitalier Universitaire
CHUB	Centre Hospitalo-Universitaire de Butare
CHUK	Centre Hospitalo-Universitaire de Kigali
CHWs	Community Health workers
C-IMCI	Community Based IMCI
CVD	Cardiovascular disease
DGPHIS	Directorate General of Planning and Health Information System
DH	District Hospital
DHMT	District Health Management Teams
DHU	District Health Unit
DP&R	Disaster Preparedness and Response
EAC	East African Community
EDPRS	Economic Development and Poverty Reduction Strategy
EH	Environmental Health
EID	Epidemic Infectious Diseases
ELISA	Enzyme-Linked Immunosorbent Assay
eLMIS	Electronic Logistics Management Information System (eLMIS)
EMTCT	Elimination of Mother-to-Child HIV Transmission
EPI	Expanded Programme for Immunization
FP	Family Planning
FSW	Female Sex Workers
GBV	Gender Based Violence
GF	Global Fund
HBB	Helping Baby Breath
HBV	Hepatitis B virus
HC	Health Center
HCC	Health Communication Center
HCV	Hepatitis C virus

HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papilloma Virus
HRH	Human Resources for Health
HSSP III	Health Sector Strategic Plan III 2012-2018
ICATT	Integrated Management of Childhood Illness Computerized Adaption and Training Tool
ICU	Intensive Care Unit
IHDPC	Institute of HIV, Disease Prevention and Control
IHR	International Health Regulation
IMCI	Integrated Management of Childhood Illnesses
ISS	Integrated Supported Supervision
ITN	Insecticide Treated nets
KPH	Kacyiru Police Hospital
LMIS	Logistics Management Information System
MCH	Maternal and Child Health
MDA	Maternal Death Audit
MDGs	Millenium Development Goals
MMC	Medical Maintenance Center
MoH	Ministry of Health
MSM	Men who Sex with Men
MUAC	Mid-Upper Arm Circumference
MVA	Manuel Vacuum Aspiration
NCBT	National Centre for Blood Transfusion
NCD	Non-Communicable Disease
NCDA	Neonatal and Child Death Audits
NCNM	National Council of Nurses and Midwives
NCPD	National Council of Persons with Disabilities
NHRA	National Health Research Agenda
NIP	National Immunization Program
NRL	Natioanl Reference Laboratory
NSEM	National multi-sectoral Strategy to Eliminate Malnutrition
NSP	National Strategic Plan
PAC	Post Abortion Care
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement
QMS	Quality Management Systems
RAIHIS	Rwanda AIDS Indicator and HIV Incidence Survey
RBC	Rwanda Biomedical Center
RDHS	Rwanda Demographic and Health Survey
RHA	Rwanda Housing Authority
RMH	Rwanda Military Hospital
RMIS	Rwanda Health Management and Information System
RSSB	Rwanda Social Security Board

SAMU	Service d'Assistance Médicale d'Urgence
SGBV	Sexual and Gender-Based Violence
SOPs	Standard Operating Procedures
STIs	Sexually Transmitted Infections
SWAp	Sector Wider Approach
TB	Tuberculosis
TOT	Training of Trainers
TWG	Technical Working Group
USA	United States of America
UTC	Université de Technologie de Compiègne, France
UTHK	University Teaching Hospital of Kigali
VPD	Vaccine Preventable Diseases
WHO	World Health Organization

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FOREWORD

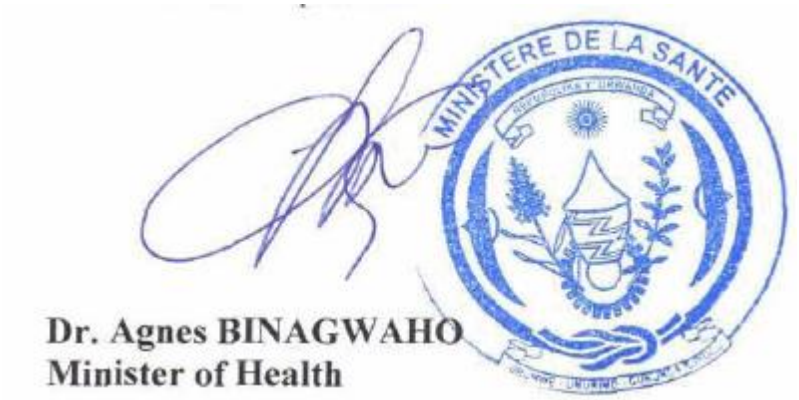
The period June 2013-July 2014 was the second financial year of the Health Sector Strategic Plan III (HSSP III: 2012-2018) implementation. Most of the achievements registered during this period are a result of consolidated outcomes from the HSSP III implementation in year one. Realisation trends across all programs during year one and two indicate that the gains made have significantly contributed to transforming Rwanda's socioeconomic development geared towards making it a lower-middle-income country by 2020.

The implementation of HSSPIII is driven by two guiding principles: a client-oriented service delivery and systems-focused strategic programs. The move to focus on client-oriented service delivery is intended to improve accessibility to quality primary healthcare services, as well as to consolidate, expand and improve services for the prevention, treatment and disease control not forgetting health promotion.

Systems mainly focused on strategic programs with intent to provide an enabling environment for effective and efficient service delivery. This was done through strengthening the health sector's institutional capacity, increasing the availability and quality of human resources, ensuring financial and geographical accessibility to health services for all, sustainable and equitable financing of the health sector, ensuring the universal availability and rational use at all levels of quality drugs, vaccines and consumables, ensuring the highest attainable quality of health services at all levels; and strengthening specialised services, national referral hospitals and research capacity.

Better service delivery and strategic programs cannot correctly be managed in the absence of well-established structures for governance and leadership at all levels. For this particular reason, the Ministry of Health undertook a number of initiatives and made key decisions aimed at supporting decentralized entities to increase effectiveness and efficiency in planning, implementation, monitoring and evaluation in order to respond community in a timely manner.

Through our usual collaboration with our development partners and stakeholders, we are confident that all these efforts will yield more good results that will strengthen the ongoing decentralization process.



Dr. Agnes BINAGWAHO
Minister of Health

EXECUTIVE SUMMARY

In the fiscal year 2013-2014, the health sector continued to implement the Health Sector Strategic Plan III (HSSP III: 2012-2018) through its operational plan, with a focus on the health sector priorities: Maternal and Child Health, Family planning, prevention, treatment and control of Comunicable and non Communicable diseases, Human resources for health, availability of drugs and other consumables, geographical and financial accessibility.

In addition to routine activities for the prevention, treatment and control of disease, 23 main output indicators were selected to guide the Health Sector Performance throughout 2013-2014, and fastrack the progress of the following priorities within the Health Sector: (a) Reduction of maternal and child mortality, (b) increase of the proportion of married women using modern contraceptive methods, (c) reduction of the burden of communicable and non-communicable diseases, (d) ensuring quality and availability of human resources for health, (e) ensuring universal availability and accessibility of drugs and consumables, (f) improving financial and geographical accessibility to health services, and (g) improving the quality of health care services delivered in health facilities.

This report highlights key achievements registered by the Ministry of Health, affiliated institutions, implementing agencies both at central and decentralized levels in 2013-2014. Generally, the Health Sector accomplishments and programs routine data for 2013-2014 confirm that Rwanda maintains its progress towards the realization of health-related MDGs and national health targets as well.

INTRODUCTION

This report highlights key achievements registered under the implementation of the Health Sector Strategic Plan III (HSSP III: 2012-2018), for the fiscal year July 2013-June 2014. The HSSP III outlines key strategic interventions to be implemented by the Rwanda's health sector for the period 2012-2018 to ensure the improvement of the health status of the population and contribution to the realization of national priorities as stated in the Rwanda's development agenda; the Rwanda Vision 2020.

The implementation of HSSP III is translated into annual operational plans which correspond to the fiscal and operational plans of all sectors of the Government of Rwanda.

For the Fiscal Year June 2013-July 2014, the health sector continued to implement interventions aimed at reducing maternal and child mortality; increasing the proportion of married women using modern contraceptives; reducing the burden of communicable and non-communicable diseases; ensuring quality and availability of human resources for health; ensuring universal availability and accessibility of drugs and consumables; improving financial and geographical accessibility to health services; and improving the quality of health care services delivered in health facilities.

ACHIEVEMENTS IN 2013-2014

The key achievements highlighted in this annual report have been grouped under the four components of HSSP III: Programs, Health Support Systems, Health Service Delivery and Governance.

1. PROGRAMS

Under HSSP III, the overall objective for programs is to improve access to and quality of essential health services. Programs are grouped into 3 main catergories: Maternal and Child Health Programs, Disease Control and Prevention Programs, and Health Promotion & Environmental Health programs.

1.1. Maternal and Child Health Programs

The improvement of maternal and child health (MCH) is among top priorities of the health sector in Rwanda; a move which is also in line with the Millennium Development Goals to reduce maternal and child mortality (MDG 5 and MDG 4), as well as the Rwanda 2020 Vison. Currently, MCH programs are made up of a number of interventions implemented across Health Facilities and the Community. The key inteventions implemented under MCH programs include: Integrated Management of Childhood Illness (IMCI), Expanded Program for Immunization (EPI), Family Planning (FP), handling of Sexual and Gender-Based Violence (SGBV) cases, promotion of adolescent sexual reproductive health and rights, and improving the nutrition status.

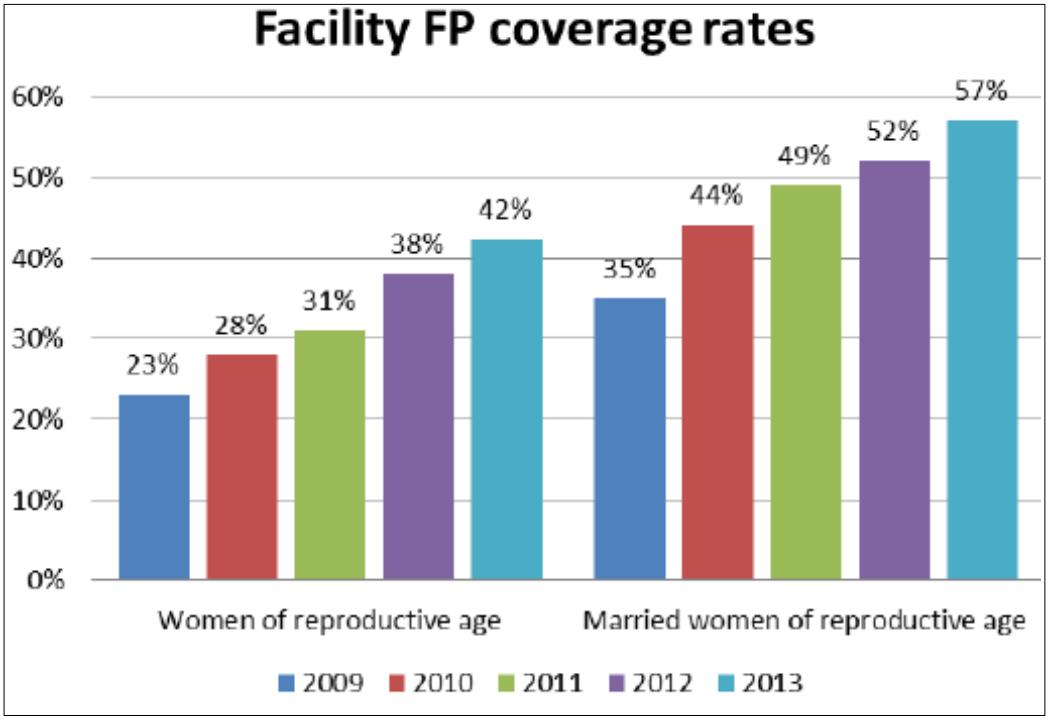
1.1.1. Maternal Health

Routine data collected by Rwanda Health Information Systems up to December 2013 showed hat indicators related to maternal health continue to improve steadily[2]:

a. **Family Planning(FP)**: at the end of 2013, a total of 1,147,009 (42%) of women of reproductive age were registered as continuing users of contraceptive methods in health centers and districts hospitals, which represents an increase of 4% since 2012.

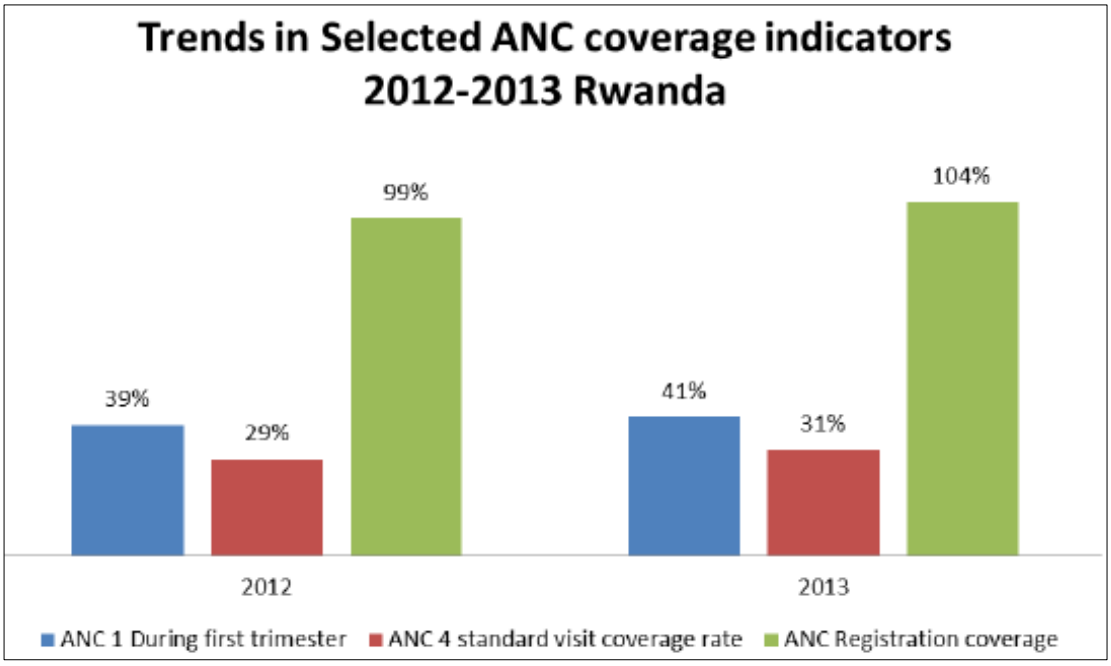
Antenatal Care: almost all pregnant women consult ANC services at least once during their pregnancies. However the proportion of women who consult ANC services in the first trimester of their pregnancy and complete 4 ANC visits throughout the pregnancy is still low. The proportion of women who attended 4 ANC visits increased slightly from 29% in 2012 to 31% in 2013; and the proportion of women who attended their 1st visit in the 1st trimester also increased from 39% in 2012 to 41% in 2013.

Figure 1: Facilities FP coverages rates



Source: Ministry of Health: Annual Health Statistical Booklet 2013

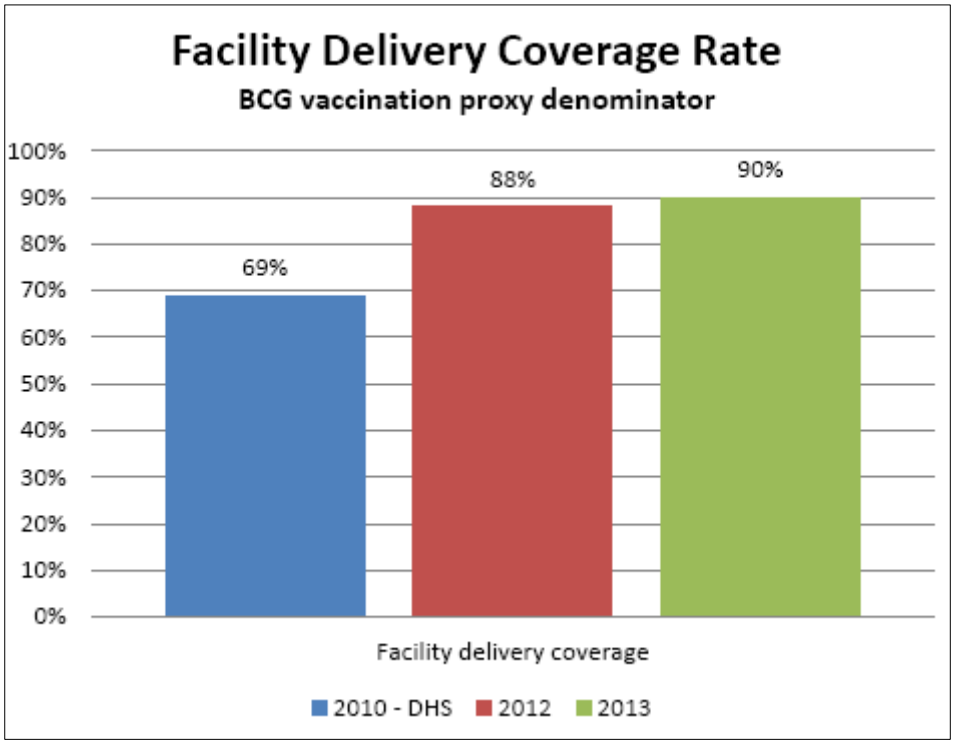
Figure 2: ANC Coverage Indicators 2012-2013-Rwanda



Source: Ministry of Health: Annual Health Statistical Booklet 2013

Assisted deliveries: over the past 4 years, Rwanda experienced a significant increase of deliveries at health facilities. By December 2013, the facility delivery coverage rate reached 90% at the national level, which represents an increase of 2% since 2012. Community sensitization on the benefits of delivering in health facilities, improvement in financial and geographical accessibility to health services accessibility has been very key in increasing the proportion of women delivering in health facilities.

Figure 3: Facility Delivery Coverage Rate

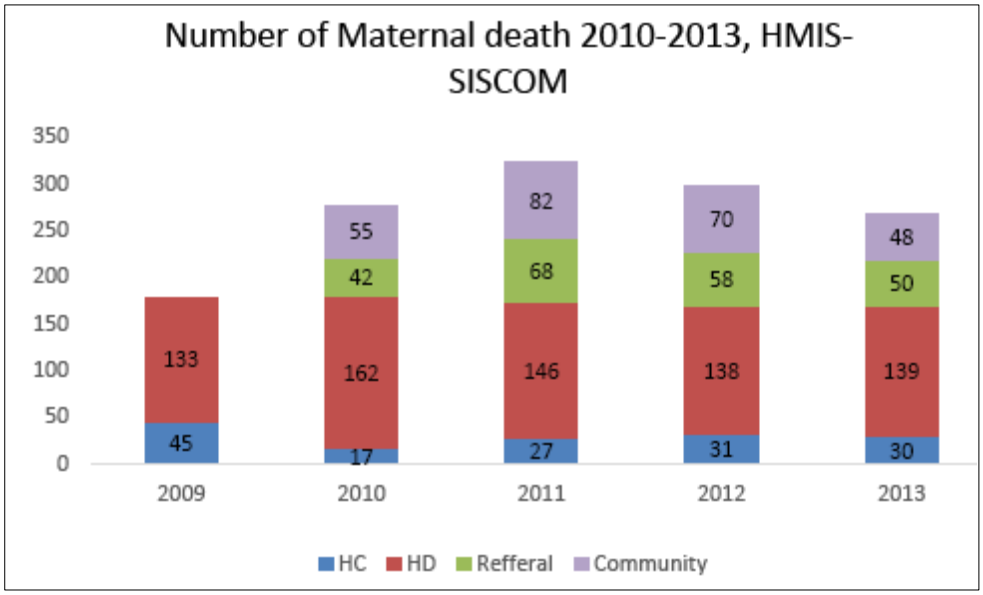


Source: Ministry of Health: Annual Health Statistical Booklet 2013

b. Maternal Deaths:

- During 2013 a total of 267 maternal deaths were reported from health facilities and by community healthworkers. The biggest number of maternal death was reported in District hospitals.
- Since 2011, the number of maternal deaths appears to have been reduced significantly. This may be explained by the fact that because more pregnant women with high risk pregnancies are transferred to District Hospital in time by CHWs and health centers for appropriate care.

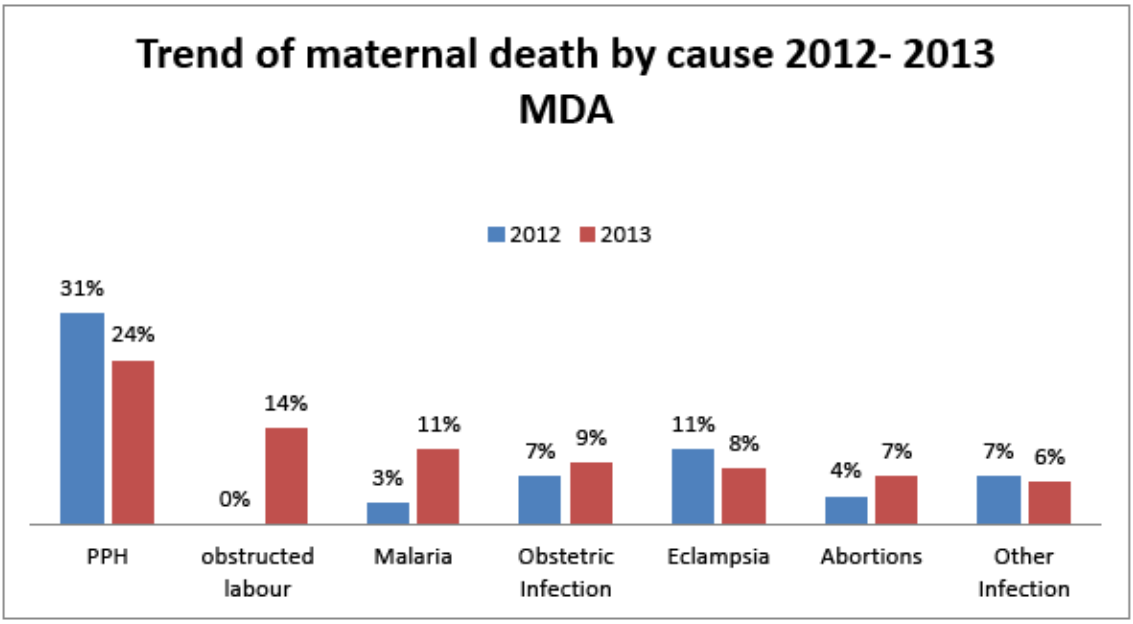
Figure 4: Number of Maternal Deaths 2010-2013



Source: Ministry of Health: Annual Health Statistical Booklet 2013

- Since 2009, the Ministry of Health introduced maternal deaths audits (MDA) in all public and private health facilities. MDA is an important approach to get much information about maternal mortality. It is based on hospital data that are collected through audit sessions.
- A total 218 maternal death were audited in 2013; which represents 92 % of all 267 maternal deaths that were registered across 2013. MDA report for 2013 shows that about 50% of the deceased women were aged between 26-35 years; and were 3% aged 18 and below. The average age of the deceased women was 29.5 years of age and the youngest was 16 while the oldest was aged 43. About 94 % of the women were married and only 5% of them were single. Almost half of them had had more than three pregnancies (47%) while 7% were at their first pregnancy. Only 8% had never given birth before.
- The leading cause of maternal death is Post-Partum Hemorrhage (24%) followed by obstructed labor (14%) and malaria (11%). Obstetrical infections and eclampsia are still among the top five main causes of maternal death with 9% and 8% respectively.

Figure 5: Causes of maternal Deaths: 2012-2013



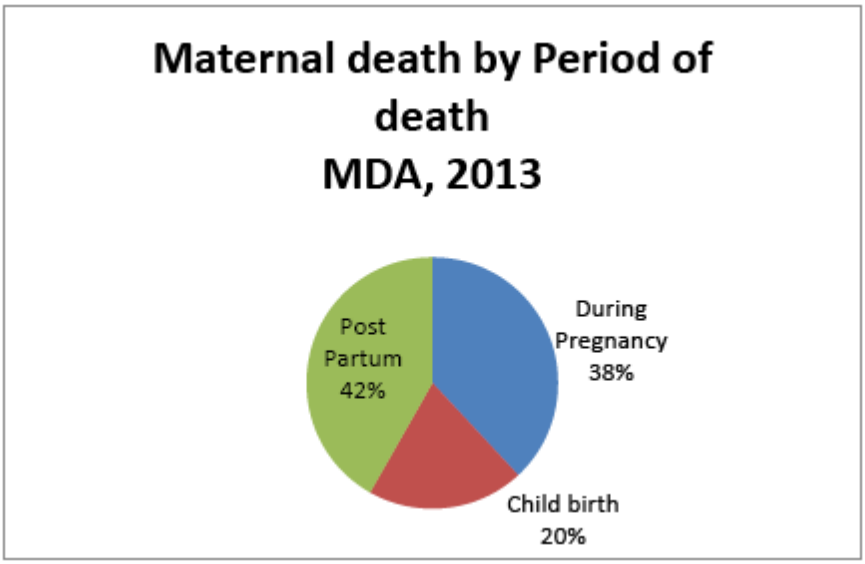
Source: Ministry of Health: Annual Health Statistical Booklet 2013

Table 1: Causes of maternal death

Causes	Number	Percentage
PPH	53	24%
Obstructed labor	31	14%
Malaria	24	11%
Obstetric Infection	19	9%
Eclampsia	17	8%
Abortions	15	7%
Other Infection	13	6%
Anesthesia Complication	8	4%
Others	8	4%
HIV	5	2%
Cancer	5	2%
Amniotic embolism	5	2%
Anemia	4	2%
Cardiopathy	4	2%
Pulmonary embolism	4	2%
Unknown	3	1%
Total	218	100%

Source: Ministry of Health: Annual Health Statistical Booklet 2013

Figure 6: Maternal death, by period of death



Source: Ministry of Health: Annual Health Statistical Booklet 2013

c. Post Abortion Care (PAC)

Effective post abortion care is essential in saving women lives experiencing post abortion complications. To introduce a comprehensive post abortion care approach, different documents including the National protocol, reference manual and other training materials have been developed. The development of these tools was followed by the training of healthcare providers on comprehensive post abortion care using medical and surgical methods. Trainings organized in 2013-2014 brought together healthcare providers from Gatsibo, Kayonza, Rutsiro, Kamonyi, Rwamagana, Nyamagabe, and Gakenke districts. Each district was represented by 2 healthcare providers per health center and 3 healthcare providers per District hospital.

These trainings increased the number of district implementing comprehensive PAC from 4 to 11 districts. The remaining districts are implementing PAC using either the Manuel Vacumm Aspiration (Nyarugenge, Gasabo, Gicumbi, Nyagatare and Rulindo), or Misoprostol (Bugesera, Nyabihu and Kicukiro). In the near futre, comprehensive PAC will be rolled out in all districts.

A total 3000 kits of Manuel Vacuum Aspiration (MVA) to be used for post abortion care were distributed in all hospitals, and the later will be dispatching the kits to health centers once they are trained in comprehensive PAC.

d. Post Partum Hemorrhage Prevention at Community Level

This program is new. Before the Fiscal year 2013-2014, it was implemented in seven districts only: Rubavu, Musanze, Gakenke, Nyanza, Gisagara, Nyabihu and Kayonza. During the fiscal year 2013-2014, 4 additional districts (Rutsiro, Nyagatare Ngororero and Rusizi) were trained on the initiation of Post Partum Hemorrhage Prevention at Community Level. In these two districts, a total of 80 health providers were trained as trainers. They trained a total of 2111 Community health workers for the implentation of the program at community level. The trained districts received also misoprostol tablets for the implementation of the program.

e. Implemntation of Exemptions for Abortion in the Penal Code of 2012

According to the Rwanda's Organic Law N° 01/2012/OL of 02/05/2012 Organic law instituting the Penal Code, as published in the *Official Gazette*, special issue, June 14, 2012, there is no criminal liability for a woman who commits abortion and a medical doctor who helps a woman to abort if one of the following conditions is met:

- when a woman has become pregnant as a result of rape;
- when a woman has been subjected to forced marriage;
- when a woman has become pregnant due to incest in the second degree;
- when the continuation of pregnancy seriously jeopardizes the health of the unborn baby or that of the pregnant woman.

To comply with the law, the Ministry of Health started implementing a program that will be helping Hospital to implement the above-mentionned exemptions. The initial phase of the program started with 8 hospitals: CHUK, RMH, KPH, Muhima, Ruhengeli, Kabutare, Gihundwe and Nyagatare.

1.1.2. Child Health

In Rwanda, the five major killers of children are: Acute Respiratory Infections (ARI), malaria, diarrheal diseases, HIV, and malnutrition. Some of strategies put forward by the health sector to reduce child mortality include the use of Community Health Wortkers (CHWs) to enhance immunization services and strengthen Integrated Management of Childhood Illness (IMCI) services and community IMCI (C-IMCI). These strategies are coupled with neonatal and child mortality surveillance.

- **Integrated Management of Childhood Illness (IMCI)**

Despite significant progress regarding the reduction of child mortality in Rwanda, there are still much to do to improve child health. Throughout July 2013-June 2014, the health sector continued to run essential programs for the child health, focusing efforts on the reduction of neonatal death. In this move, approaches for Integrated Management of Childhood Illnesses (IMCI) were closely followed up in 6 districts which have been reporting higher rates of neonatal deaths. In these 6 Districts, an Integrated Management of Childhood Illness Computerized Adaption and Training Tool (ICATT) was introduced, and healthcare providers from all their health facilities were trainerd on the use of the tool. The introduction of ICATT in Health Facilities was complemented by a training of healthcare providers in Helping Baby Breath (HBB). Quarterly supportive supervision to district hospitals were also organized to support them in the improvement of the reporting and monitoring system of child health interventions in Health facilities under their catchment areas.

- **Neonatal and child mortality surveillance**

Neonatal and child mortality surveillance is done through the Neonatal and Child Death Audits (NCDA). NCDA started in January 2011 with a few districts. All District Hospitals (42) and referral hospitals (2) are currently conducting NCDA.

Neonatal deaths surveillance consists in notification, on weekly basis, and auditing of neonatal and child deaths. Since October 2012, reporting is webbased. This allows to conduct death surveillance by comparing reported deaths in a weekly surveillance and in HMIS, and then through a counter verification conducted during supportive supervisions. Health facilities audited 923 neonatal deaths, 2,632 cases in 2012, and 2,889 cases in 2013.

a. Neonatal mortality

For the period 2013-2014, a report on neonatal deaths that occurred in health facilities in 2013 was produced. Some results from that report are described below.

- **Demographic information of deceased newborns:** 61.4% of all deceased newborns had low weight, 88.3% died at district Hospitals and 62.3% of were born at Hospitals; which means that over 26% of newborns who died at District Hospitals were referred from Health centers.

Table 2: Demographic information of deceased newborns

1.Sex of Newborn	Percentage
Female	48.8
Male	51.2
2.Birth weight	
> 2500 Gr	39.6
1000Gr- 1499Gr	20.7
1500 Gr - 2500 Gr	29.9
500Gr-999 Gr	9.8
3.Place of Birth	
At Home	5
On Route to HF	3.7
Health Center	25
District Hospital	62.3
Referral Hospital	3.6
4. Place of Death	
Health Center	3.6
District Hospital	88.3
Reference Hospital	8.1

Source: Ministry of Health: Annual Health Statistical Booklet 2013

- **Clinical description of deceased newborns:** more than a half of deceased newborns (52.6%) were premature babies, 61.4% had low weight, 50.4% didn't cry at birth and only 21.3% had cried at 5 minutes. Newborns from normal delivery represented 62.8%, while 71.2% of them were hypothermic at the admission in neonatology services.

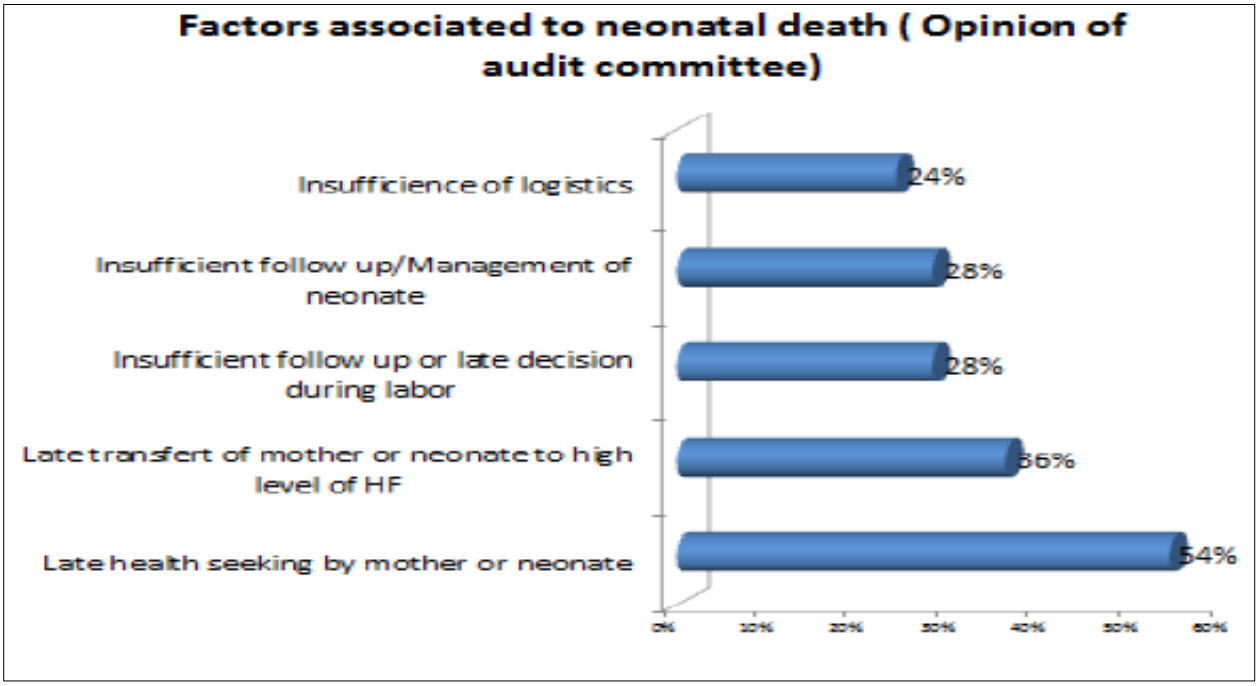
Table 3: Clinical description of deceased newborns

Indicator	Percentage
1.Age of Pregnancy	
Prematurity	52.6
2.Cry at Birth (APGAR >6)	
No	50.4
Yes	26.6
No documented	22.8
3.Cry at 5 th Minute (APGAR >6)	
No	49.6
Yes	21.3
No documented	29.1
4.Mode of Delivery	
C-Section	23.9
Other abnormal Delivery	13.2
Normal Delivery	62.8
5. Temperature on admission in Neonatology services	
< 36.5 C	71.2
36.5-37.5 C	14.8
>37.5 C	3.1
Non recorded	10.9

Source: Ministry of Health: Annual Health Statistical Booklet 2013

- **Avoidable Factors associated to neonatal deaths:** according opinions of audit committee in Hospitals, it was observed that late health care seeking by mothers for delivery or neonatal care was the first avoidable factor associated to neonatal death. Insufficient follow up after delivery or late decision during labor was reported in 28% of cases by audit committee.

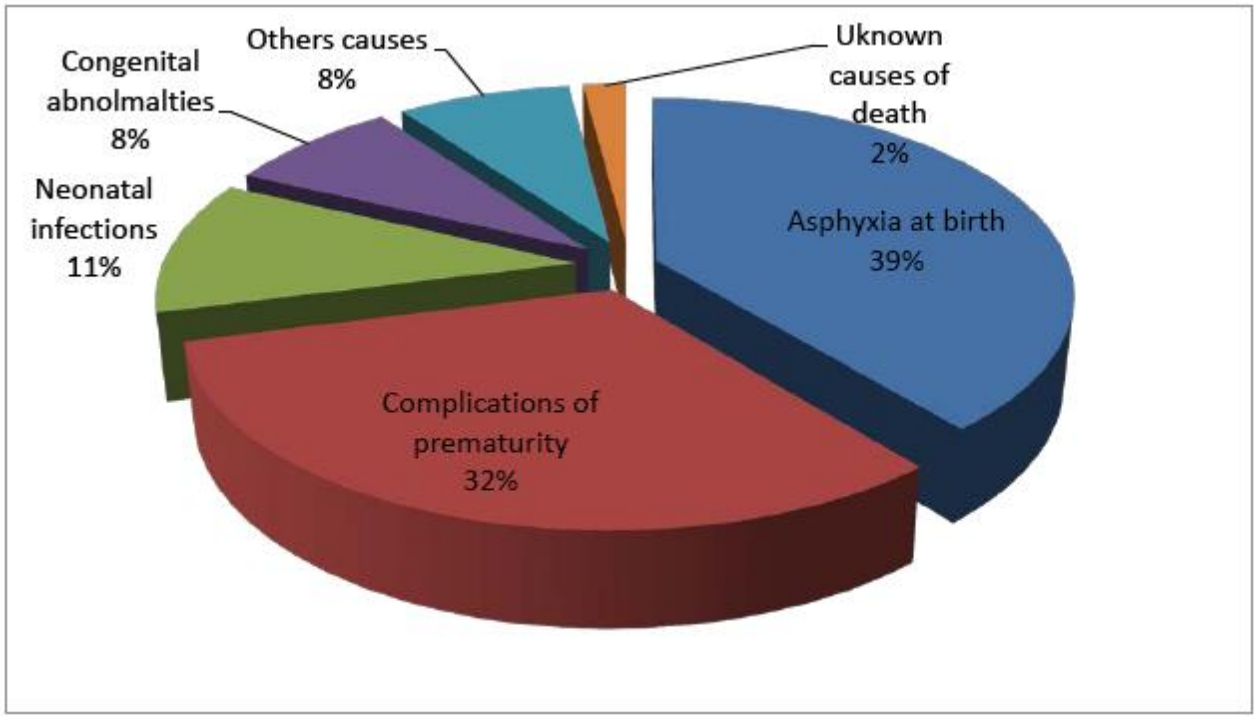
Figure 7: Factors associated with neonatal death



Source: Ministry of Health: Annual Health Statistical Booklet 2013

- **Causes of neonatal deaths:** neonatal asphyxia is still the first cause of neonatal deaths (39%), followed by complications of prematurity (32%) and neonatal infections (11%). Congenital abnormalities represent 8%.

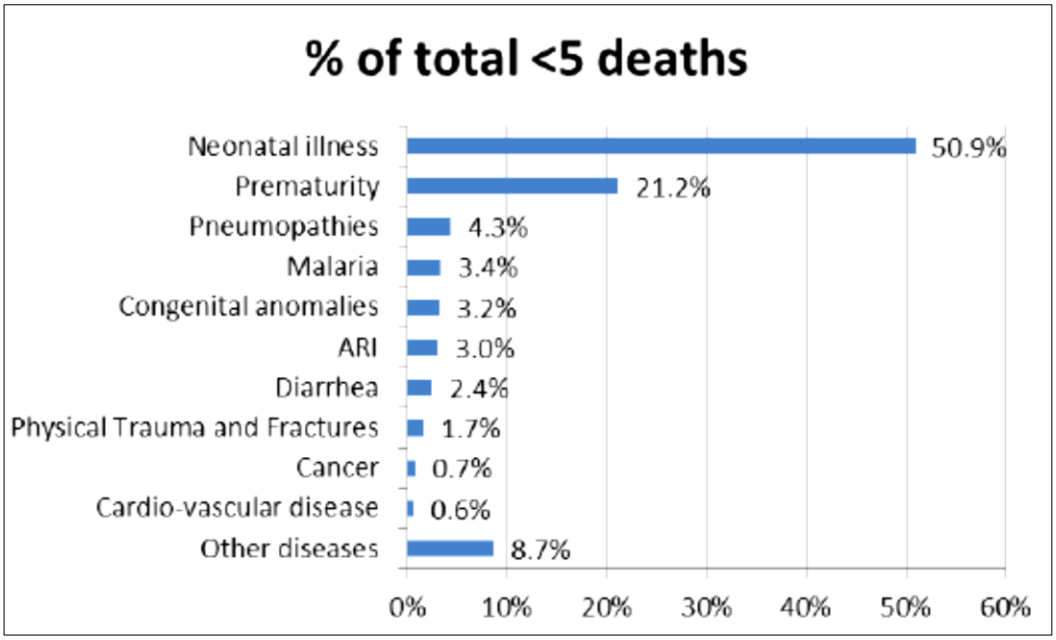
Figure 8: Causes of neonatal death



Source: Ministry of Health: Annual Health Statistical Booklet 2013

b. Child mortality

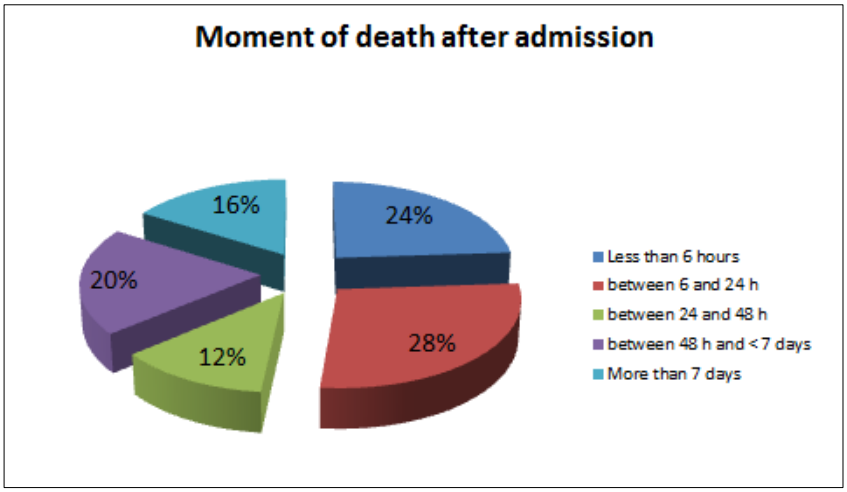
By December 2013, the total number of deaths for children under 5 years in health facilities was 5,882. The most frequent causes of death in health facilities were Neonatal illness representing 51%, prematurity 21%, pneumopathies 4% and gynecological problems 4%.



Source: Ministry of Health: Annual Health Statistical Booklet 2013

Results from child deaths audit show that 64% of children die within 48 hours after admission in hospitals and 24% of them in less than 6 hours after admision.This mean that childeren reached hositals with critical health conditions.

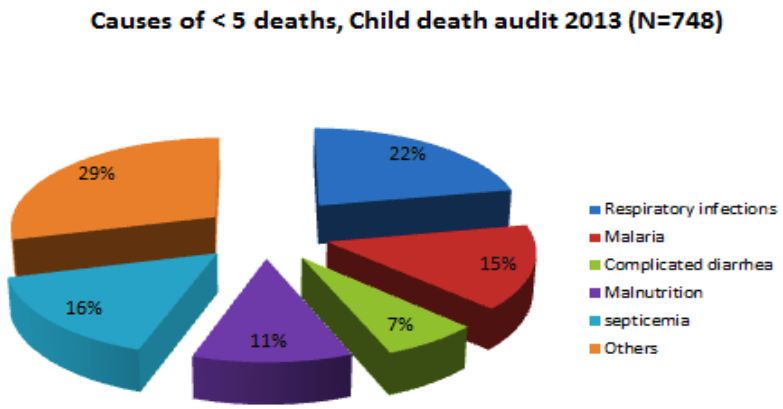
Figure 9 Moment of death after admission



Source: Ministry of Health: Annual Health Statistical Booklet 2013

The top five main causes of child deaths include respiratory infections, septicemia, malaria, pathologies associated with malnutrition, and complicated diarrhoea.

Figure 10: Causes of <5 deaths



Source: Ministry of Health: Annual Health Statistical Booklet 2013

1.1.3. Nutrition

In 2010, the Government of Rwanda designed a 3-year (2010-2013) National multi-sectoral Strategy to Eliminate Malnutrition (NSEM). In 2013-2014, this strategy was updated and a new Rwanda National Policy on Food and Nutrition was designed, along with the National Strategic Plan on Food and Nutrition for the period 2013-2018.

In the same framework, the 3rd National Summit on Food and Nutrition was held from 18 to 20 February 2014 in Kigali. The overall theme of the Summit was "Promoting the First 1000 Days to Prevent Child Stunting through Multisectoral and Decentralized Action". The summit came up with 9 recommendations that will guide the implementation of National Strategic Plan on Food and Nutrition for the period 2013-2018. Recommendations were formulated as follows:

- Adequate household food security and nutrition and nutrition across the lifecycle are basic human rights;
- The nation's policy dialogue and strategic directions for programming in food and nutrition should continue to be fully evidence based;

- The timely identification, management and prevention of all forms of malnutrition should continue to be addressed through well selected packages of evidence-based, cost effective, locally appropriate and locally adapted interventions and promotion. These include, in particular, acute malnutrition, chronic malnutrition, micronutrient deficiencies, nutrition and HIV/AIDS, nutrition related non-communicable diseases, and over nutrition especially over-nutrition;
- The 1000 Days in the Land of 1000 Hills national communication initiative needs to achieve goals beyond behavior change campaign toward a social change whereby the 1st 1000 Days and the Prevention of Child stunting are fully owned at all central and decentralized levels and becomes part of family values across Rwanda;
- No children born after the launch of the 1000 day campaign by the Honorable Prime Minister should be stunted. This should be included in the Imihigo ;
- Scale up strategies for improved/ increased Household Food Security is essential to succeed in substantially reducing stunting among children under two years of age;
- Social protection mechanisms for vulnerable populations need to be more effectively emphasized;
- Continued monitoring of coordinated multisector food and nutrition programmes and interventions is needed at all levels. Areas for support and continued development should include institutionalized surveillance systems, using appropriate, cost effective technologies and software as well as effective knowledge management and continuous learning;
- Overall, Food and Nutrition Capacity Development should be based on Gap analysis and a plan that includes short and longer term strategies for Resources Mobilization, human resources capacity at all levels and supplies and logistics.

1.1.4. Adolescent Sexual Reproductive Health&Rights

Addressing Sexual and Reproductive Health needs for young people requires a multi-sectoral approach with collaboration of all stakeholders. The health sector needs to be in a position to ensure that the information that is provided through Health Facilities is technically sound and is consistent with other messages that adolescents are receiving about sexual and reproductive health, including HIV, and that strategies that are being implemented are

evidence based. With this regards, the Ministry of Health is implementing different programs to ensure its targets and expected result are timely met.

In 2013-2014, activities for the promotion of adolescent sexual reproductive health & rights were focused on the training of healthcare providers and teachers of primary and secondary schools, community mobilization, sensitization of in and out of school adolescents, and the implementation of the 12+ program as an extra-curriculum program that puts together young adolescent girls aged 12-16 and teach them about sexual reproductive health.

1.1.5. Gender Based Violence

- Two grant proposals for scaling-up ***Isange One Stop Centers*** were elaborated; and the two proposals have been approved by World Bank and Royal Netherland Embassy for funding.
- A refresher Training of district trainers in psychosocial support and clinical management of SGBV were organized for 100 healthcare providers from 10 districts hospitals: Kilinda, Mugonero, Kibuye, Masaka, Murunda, Kibagabaga, Rwamagana, Kibungo, Kirehe, and Nyamata.
- A training for service providers in Multidisciplinary Investigation and Intervention Model Team has been organized, and 45 service providers from Murunda District Hospital have been trained
- 100 local authorities from Rutsiro District have been sensitized on the availability of GBV services in their respective area.

1.2. Disease Prevention and Control

Disease prevention and control in the health sector falls under the technical mission and responsibilities of the Institute of HIV, Disease Prevention and Control (IHDPC) Department in Rwanda Biomedical Center (RBC). IHDPC is responsible for the coordination of all activities aimed at the national response to HIV/AIDS and other diseases, including noncommunicable diseases. It is made up of seven disease-specific divisions: noncommunicable diseases division, HIV and other blood borne infections division, mental health division, tuberculosis and other respiratory diseases division, vaccine preventable

diseases division, malaria and other parasitic diseases division, and epidemic infectious diseases division.

1.2.1. Non Communicable Diseases Division

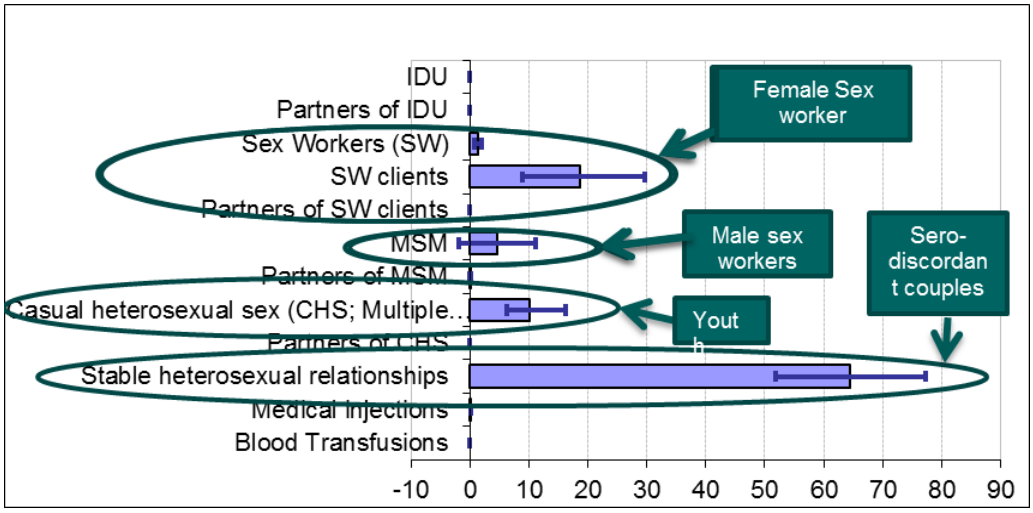
The Non Communicable Diseases (NCD) Division manages interventions and programs for prevention, care and treatment of Cancer, Cardiovascular and Chronic Respiratory Diseases as well as Injuries and Disabilities. The following are achievements registered by the division in 2013-2014:

- The development of National NCD Integrated Strategic Plan with inputs from different clusters formed depending on the group of non-communicable diseases, namely cancer diseases, CVD and Diabetes, injuries, eye and oral health. A draft plan with associated costs is available and is being reviewed by the TWG before its approval by relevant authorities;
- A rapid assessment was conducted in district hospitals and health centers from November 2013 to February 2014 to assess the readiness of different health facilities to diagnose and treat NCDs. Results of the assessment revealed gaps in equipment, human resources (quality and quantity), medication and finances;
- Given the fact that cervical cancer was found to be the common cancer among women diagnosed at referral hospitals, a program to screen cervical cancer among women aged 35 years and above has been put in place. By September 2013, a total of 7,520 women had been screened for cervical cancer in five districts hospitals (Muhima, Butaro, Rwinkwavu, Ruhengeri and Gahini). Among the screened women, 874 (11.62%) tested positive for Human Papilloma Virus (HPV). Of the positive women, 151(17.27%) women were treated for pre-cancerous lesions, 15 biopsies were collected from suspect cancer lesions and 8 hysterectomies were performed on women with advanced cancer;
- Guidelines, protocols and appropriate clinical data collection tools were developed and given to Health Facilities;
- Drugs for Asthma treatment (salbutamol and beclomethasone) were distributed in all health facilities of Kigali and Southern Province. Materials for cancer screening were also distribured to eight hospitals.

1.2.2. HIV and Other Blood Borne Infections Division

The biggest achievement for HIV and Other Blood Borne Infections Division in 2013-2014 is the development of the Rwanda National HIV strategic plan (NSP) 2013-2018. The NSP 2013-2018 identified key populations that will be a focus in the five years; and has set an ambitious target to reduce new infections by two-thirds by June 2018 (from 6,000 new infections annually to 2,000). To reach this target, the country is implementing a combination of HIV prevention programs focusing on key drivers of the HIV epidemic.

Figure 11 Distribution of new infections by mode of transmission



Source: Rwanda NSP 2013-2018

Other key achievements have also been obverved in many areas, including HIV prevention; HIV care, support, and treatment; HIV monitoring and evaluation activities; and Hepatitis B screening and vaccination.

a. HIV prevention

- The scale up of HIV counselling and testing services: From June 2013 to July 2014, 17 new health facilities started offering HIV counselling and testing services. This brought the total number of facilities offering HTC services to 510. As a result, over 3 million tests were done, 0.8% tested positive.
- The scale of Male circumcision as a major component of HIV Prevention program: In the reporting period, 129,580 males were circumcised using surgical and non-surgical methods.

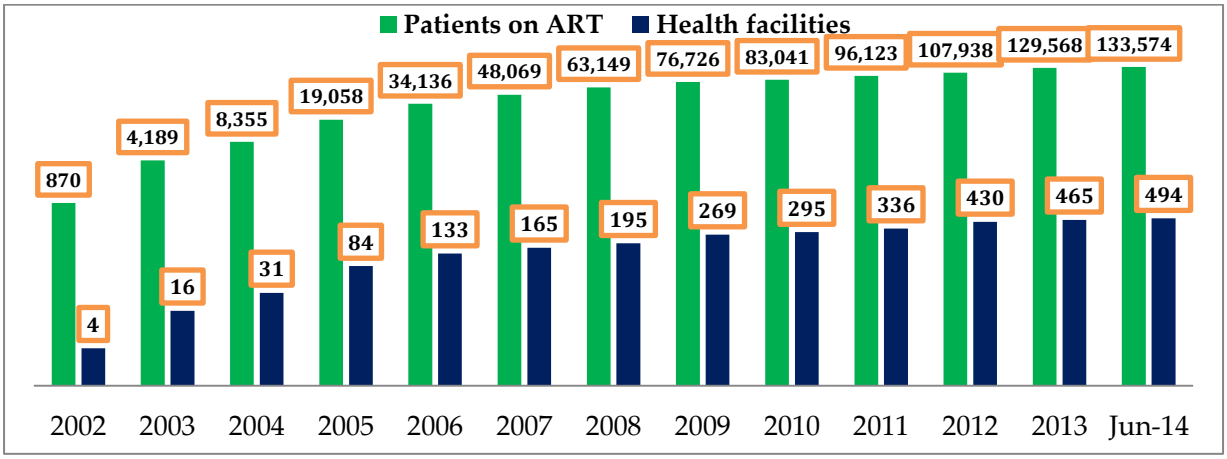
- The country continued to implement strategies towards the elimination of mother-to-child HIV transmission (EMTCT) with a target to keep the new paediatric HIV infections below 2% by 2015. In this move, a package of services that include community support to PMTCT, HIV counselling and testing, linkage to care and treatment, initiation of ART and adherence support to medication, infant feeding and counselling on Family planning approaches as well as safer sex education is being implemented in all 490 PMTCT sites across the country.
- Between July 2013 and June 2014, more than 350,000 pregnant women were tested for HIV in antenatal care (ANC) services. Also 84% of their partners were tested were counselled and tested for HIV. 3,842 HIV-positive pregnant women tested in ANC received ART based on the Option B+ guidelines.
- Easy access to early infant HIV diagnosis (EID) was made a priority for the EMTCT program. Currently, 100% of health facilities offering PMTCT services have access to Early Infant Diagnosis; and ART prophylaxis is provided to all HIV exposed infants. Between July 2013 and June 2014, 7,213 infants received ART prophylaxis.
- Results from a cohort of infants born to HIV-positive mothers followed in PMTCT programs showed that 1.83% became infected representing a significant reduction of HIV transmission from mother to child.
- Throughout July 2013-June 2014, a total of 5,269 discordant couples were enrolled in the follow-up program; 22,184 Female Sex Workers(FSW) and 617 Men who have Sex Men (MSM) were reached with targeted prevention interventions;
- Consolidated guidelines based on the new WHO recommendations that will lead to early initiation of ART for positive partners in sero-discordant couples, FSW, and MSM, regardless of any other eligibility criteria, were developed and validated.
- Between July 2013 and June 2014, 11,273,800 male condoms and 45,020 female condoms were distributed through the public sector, while 12,112,976 male condoms were distributed through social marketing efforts.

b. HIV care, support, and treatment

In the National HIV Program, care, support, and treatment components are intended to provide people living with HIV (PLHIV) with services that enable them to live a normal life. These services include clinical and biological assessment for ART eligibility and disease progression; prevention and treatment of opportunistic infections (OI), especially TB, STIs, cervical cancer, Cryptococcus, Viral hepatitis and other blood borne infections.

- By June 2014 the total 133,574 of adults and adolescents were receiving ART and majority of them were on the first line. From July 2013 to June 2014, a total of 2,212 children were enrolled in the pre-ART program, bringing the total number of children receiving ART to 7,853.

Figure 12 Evolution of health facilities providing versus infected patients receiving ART



Source : RBC Annual Report 2013-2014

- All PLHIV are systematically screened for TB at enrolment and during follow-up visits every 6 months. All TB suspected patients are diagnosed using different methods, including sputum, chest X-ray and GeneXpert. For the period July 2013-June 2014, the number of PLHIVscreened for TB at enrolment reached 15,361, and 1,743 of them (11.4%) tested TB-positive.

c. Hepatitis B screening and vaccination

In the NSP 2013-2018, systematic screening of Hepatitis B virus (HBV) and Hepatitis C virus (HCV) among HIV-positive people is strongly recommended to allow early initiation of ART to cure Hepatitis B or improve clinical evolution of liver disease due to HBV and HCV, or vaccination for those screened HBV-negative. For this purpose, 60,000 HIV-positive people countrywide were screened for Hepatitis B and received HBV vaccine.

d. HIV monitoring and evaluation activities

The monitoring and evaluation system set up for the NSP 2013-2018 hit the ground running with in the first year of implementation. Several studies and operations researches were implemented, others are on-going.

- The Rwanda AIDS Indicator and HIV Incidence Survey (RAIHIS) is being conducted for the first time and results will show the level of new infections.
- A special follow up of the Results Based Financing (RBF) indicators was put in place resulting in more than 95% achievement of all indicator targets set for this reporting period.

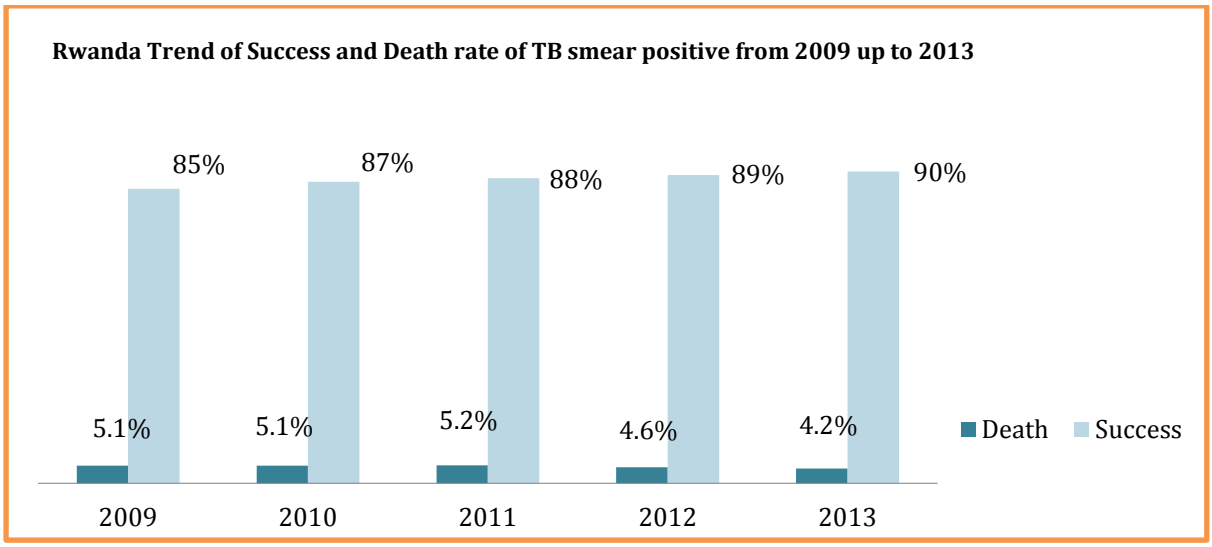
1.2.3. Mental Health (MH)

The Mental Health Division is responsible for the implementation of the National Mental Health Policy. During this fiscal year, the Division continued to scale up mental health services in health facilities, through rainings and mentorships of Healthcare providers. Campaigns were also conducted to people's awareness on mental health diseases and drgus abuse.

1.2.4. Tuberculosis and Other Respiratory Diseases

- Thanks to various strategies put in place to deal with TB, therapeutic TB success has been increasing, resulting in reduction of deaths due to TB.

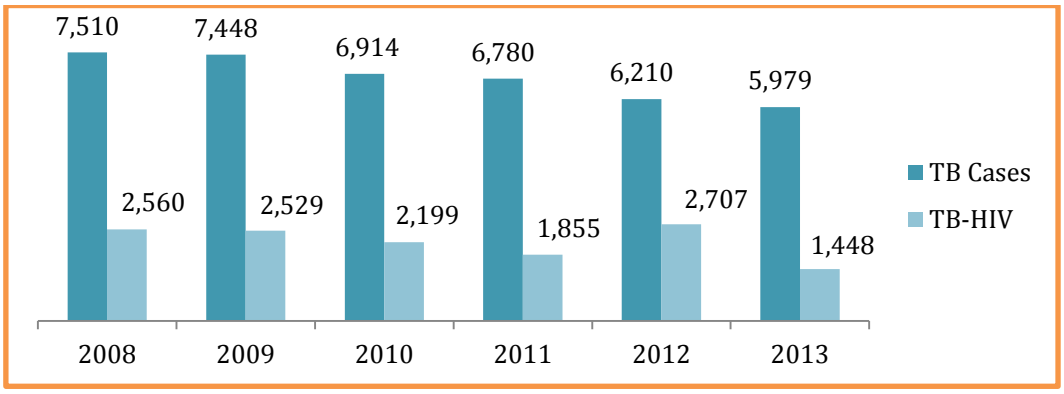
Figure 13 Trend of Success and Death rate of TB smear positive from 2009 up to 2013



Source : RBC Annual Report 2013-2014

- Case finding and management for TB-HIV co-infected patients also kept improving.

Figure 14: HIV testing among TB Cases 2008-2013



Source : RBC Annual Report 2013-2014

- Rwanda has introduced new technologies with international standards:
  - 2010 Xpert MTB/RIF was introduced with sensitivity of 40% compared to Ziehl-Nelson microscopy.
  - RBC has implemented the use of a truck with incorporated radiologic equipment to facilitated mobile out reaches.

1.2.5. Vaccine Preventable Diseases (VPD)

One of strategies recommended for effective management of VPD is to strengthen the supply chain management capacity of the National Immunization Program (NIP) so as to effectively sustain optimal stock levels of Expanded Program on Immunizations (EPI)/Vaccine Preventable Diseases (VPD) commodities at all levels of the health system.

In this regard, two key activities are consistently implemented,-Renting dry store and training of 84 Biomedical Technicians in basic maintenance of sound cold chain integrity and other medical equipment in the 42 district hospitals-, to avoid stockouts of key vaccines and decrease vaccine wastage rate. In addition to these two key activities, they key achievements for VPD in 2013-2014 are the following:

- There was no stockout for all antigens at any level (central level and in all health centres) in the reporting period; and pentavalent vaccine wastage rate was at 1% while the baseline was 3%.
- 100% of all health facilities were able to offer immunization services with good quality of service delivery, including: cold box/vaccine carriers with ice packs, functioning refrigerators and thermometers.
- Integrated supervision and evaluation meetings allowed maintaining completeness and timeliness of monthly reports at 100% at all levels (districts and health facilities). This allowed the central level to monitor on time performance indicators especially immunization coverage in all districts.
- The organization of coordination meetings with community health workers helped in tracing of defaulters and contributed to maintaining immunization coverage at high level (DTP3 coverage of 102% and measles coverage of 103%) and to decrease the dropout rate between DPT 1 and DPT3 (2%).

1.2.6. Malaria and Other Parasitic Diseases

For the fiscal year 2013- 2014, malaria control and prevention continued to be a key priority of the health sector.

a. Prevention activities

- Distribution of LLINs through mass campaigns and maternal child services:
  - A total of 3,365,235 Long Lasting Insecticide Net (LLINs) were distributed to households in 25 districts with high burden of malaria;
  - In the same framework, 666,103 LLINs were distributed to under five children and pregnant women through the ANC and EPI services. 222,034 LLINs were also distributed to primipara pregnant women and 444,069 were distributed to under one year children.
- At the national level, ITN ownership has slightly increased within the past three years from 82 percent measured in 2010 to 84 percent measured in the recent RMIS survey. A decrease in ITN ownership of 9 percentage points occurred within the East province. On the other hand, the greatest increase occurred in the North province, 15 percent points within the past two years (from 70 percent in RDHS 2010 to 85 percent in RMIS 2013).

b. Malaria pre-elimination activities

- Malaria cases surveillance was launched in March 2014 in Burera, Musanze, Nyabihu, Nyagatare, Ngororero and Gisagara Districts; with an aim to develop malaria pre-elimination guidelines and training of health providers on malaria pre-elimination strategy. Malaria cases surveillance include (1) Malaria cases investigation (2) Search for malaria case among residents living with the patient (3) Classify malaria cases (4) Search for malaria foci, and (5) Classify malaria foci.

c. Uncomplicated malaria cases treatment and testing

- From July 2013 to June 2014, health facilities received a total of 1,205,444 simple malaria cases. Overal, 1,103,448 (91.5%) were received by patients in public health centers, 3,724 (0.3%) in district and referral hospitals, and 14,694 (1.2%) in private health facilities. A total of 83,578 (6.9%) malaria cases were treated by community health workers (CHWs) through community-integrated management of childhood illnesses (C-IMCI).

- 3,529,310 malaria tests were performed at health facilities with 1,149,579 (32%) positives tests.
- 99.8% of malaria cases were treated with ACTs after confirmation with malaria tests and the proportional malaria morbidity was estimated at 12%.

d. Severe malaria and deaths

- From July 2013 to June 2014, a total of 10,904 severe malaria cases were hospitalized, including 4,811(44%) under five childrens and 163 (1.5%) pregnant women.
- A total number of 456 deaths due to malaria occurred in District Hospitals and among them 142 were fewer than five children. Proportional malaria mortality rate was estimated at 5.2% for the 2013/2014 fiscal year.

1.2.7. Epidemic Infectious Disease

In the area of Epidemic infectious disease, the fiscal year 2013-2014 was marked by the introduction of the new One Health concept, which is defined as the collaborative effort of multiple disciplines working locally, nationally, and globally to attain optimal health for people, animals and our environment.

a. Strategic planning

- A One Health Strategic Plan (2014-18) has been developed in collaboration between the ministry of agriculture, the Rwanda Development Board, Rwanda Agriculture Board, and other key stakeholders.
- Under the country initiative, during the 9th ordinary meeting of the EAC sectoral council of ministers of health held in zanzibar, Tanzania17th April 2014, institutionalization of the One Health approach in the East African community to prevent and control zoonotic diseases and other events of Public Health concern was adopted.
- In collaboration with the World Health Organization, the division has conducted national yellow fever risk assessment, and result showed that Rwanda is free from yellow fever.

- In view to comply with international health policy, the division collaborated with World Health Organization to conduct the first assessment of International Health Regulation (IHR). Findings will be used to develop a multi-sectorial action plan for controlling, containing and preventing diseases of national and international concerns.

b. Diseases Surveillance

- An innovative and functional Integrated Diseases Surveillance and Response system has been rolled out in 74% of private health facilities in the country.
- A new technology (multiplex PCR) for detection of other respiratory pathogens related to influenza virus species was also in the country.
- An epidemiological bulletin was released on a weeklys basis for public awareness and update on ongoing epidemic prone diseases trend and response

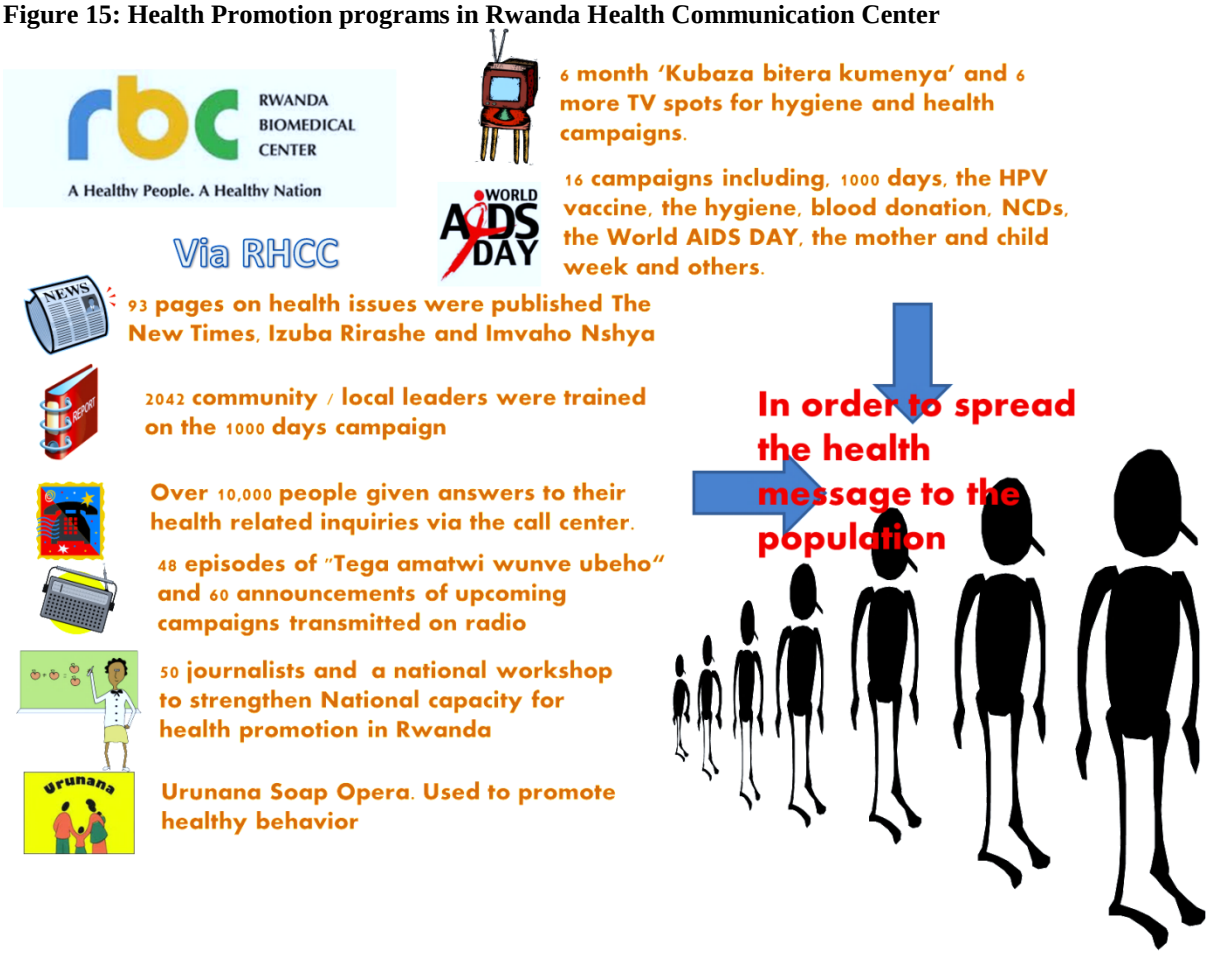
c. Outbreak preparedness and response

- The division has initiated the development a national preparedness and response plan;
- 27 outbreaks were detected countrywide and appropriately managed (prevention, containment);
- The construction of an isolation facility is ongoing at Rwanda Military Hospital.

1.3. Health Promotion and Environmental Health

The division of the Rwanda Health Communication Center is responsible for the Health communication for the population of Rwanda. Health Education, including spreading the message on RBC's work and mandate is its overarching goal and is accomplished with the use of a wide range of techniques and forums in order to ensure the best possible reach for the health messages concerned.

Figure 15: Health Promotion programs in Rwanda Health Communication Center



Source : RBC Annual Report 2013-2014

2. HEALTH SUPPORT SYSTEMS

In the spirit of HSSP III, the overall objective of Health Support Systems is to strengthen policies, resources and management mechanisms of health support systems to ensure optimal performance of the health programs at output, input, and process levels.

2.1. Planning, budgeting, and monitoring

The overall responsibility for health sector planning, budgeting and monitoring fall under under the Directorate General of Planning, M&E and Health Information System (DGPHIS). This Directorate General is also responsible for the coordination in terms of overall development of comprehensive health policies, sustainable strategic plans, monitoring and evaluation, Health Information Systems as well as the coordination of the Stakeholders' interventions in the Health Sector.

On top of overseeing the health sector planning and budgeting processes for the Fiscal Year 2014-2015, the DGPHIS, through the Partners/Sector Wider Approach (SWAp) desk, ensured the coordination of Health Sector partners regarding their planning, monitoring and evaluation. Local and International Development Partners were helped to align their interventions to national and Health Sector planning tools, including Vision 202, EDPRS, and HSSPIII.

To improve the coordination and management of decentralized health services, District Health Units (DHUs) and District Health Management Teams (DHMTs) were supported and mentored to improve their capacities in the monitoring of health activities in decentralized health facilities. District M&E officers were trained on how to conduct data quality assessment in their respective health facilities; and District Hospital Managers were trained on leadership and management. An assessment was also conducted on the performance, contribution and challenges of DHMT and BoD of DH in the management of decentralized health system.

2.2. Human Resources for Health

The quantity and quality of Human Resources are crucial in the provision quality healthcare. In the Rwanda vision 2020, the health sector is requested to design combined strategies that will contribute to the improvement of the quantity and quality of human resources for health, as well as to reach the target of having 1 medical doctor per 10000 inhabitants and 1 nurse per 1000 inhabitants by 2020. In this move, data from the Rwanda Statistical Year Book 2014 show there was 1 medical doctor per 15,806 inhabitants and 1 nurse per 1,203 inhabitants in 2013.

Many other initiatives related to training and capacities building of the health sector workforce were carried out in 2013-2014:

- A template for categorizing of nurses and midwives was developed in collaboration with National Council for Nursing And Midwifery (NCNM);
- 472 A2 Nurses from public health facilities were recruited for upgrading to A1 level through E- Learning program in general nursing , 296 A2 Nurses in Midwifery full time program;

- A bachelor's degree in midwifery program was launched on 7th October, 2013 in Nyarugenge Campus with 37 A1 nurses from Nursing and Midwifery schools, referral and teaching hospitals;
- In collaboration with Vision for Nation Foundation, 21 teachers from nursing and midwifery schools were trained on primary eye care and the essential didactics material for the demonstration and practice in skills lab were given to their respective schools;
- In collaboration with the University of Rwanda College of Medicine and Health Sciences, Tulane University and the Nursing Schools; and in line with the improvement of e-Learning Pedagogy, a total of 10 teachers from each of the five Nursing Schools were trained and awarded diplomas in the following courses:
    - Learning Technology
    - Designing for Engagement
    - Training on the use of e-Resources
- In collaboration with the High Council for Education, University of Rwanda College of Medicine and Health Sciences the E-Learning program curriculum was revised and submitted to the Ministry of Education for approval and this will lead to the graduation of the first cohort of e-Learning students.

2.3. Capacity Building

Like in any organization, capacity building has also played a pivotal role in strengthening the health system in Rwanda. During the fiscal year 2013-2014, more than 2 billion Rwandan francs were committed by RBC to address capacity gaps through training, coaching/mentorship and educational level upgrade of health professionals at both central and decentralized levels. Here are the key areas of capacity and results:

a. For Infectious diseases:

- A total of 78 trainers of trainees (TOTs) were trained on STIs guidelines, while 1,096 health providers were updated on the integrated HIV national guidelines. A total of 236 health providers were trained in Quality Improvement (QI).
- 63 Lab technicians from District Hospitals and health facilities with CD4 counts machines were trained on the screening of cryptococcal infections.

b. For Non Communicable diseases:

- In collaboration with Rwanda diabetic association and the National Council for

People with Disabilities (NCPD), a clinical mentorship was conducted in all district hospitals on diabetes management; and for the team performing the categorization of people with disabilities;

- A training of trainers on NCDs management (diabetes, cardiovascular, metabolic disease and chronic respiratory diseases) was organized for 42 staff from District Hospitals. A toatal of 18 district hospitals and 200 health centers of their catchment area were trained on the same topic;
- 371 health professionals from all District Hospitals, including 142 doctors, 82 nurses, 39 lab technicians, 3 pharmacists, and 2 pathologists were trained on cancer management.

c. For Mental Health,

- A consultant in CHUK and Ndera performed 50 mentorship sessions.
- 102 mentorships were carried out by Ndera Psychiatric hospital and CHUK in 42 District Hospitals.
- 45 mental health nurses from DHs received refresher training on trauma care during interventions and 70 general nurses working in Health Centers in Kigali City were trained on trauma.

d. Quality Control and Quality Management,

- The National Reference Laboratory (NRL) Division commissioned a training for 32 staff in Lab Diagnostic, Quality Assurance and Quality Control (QA/QC), Accreditation, Lab Information System and Safety. The trainings were provided by internationally recognized firms e.g. AMPATH in Kenya and ACILT in South Africa.
- One staff was trained in USA on Blood Establishment Computer Management Software (BECS), VPN-based connectivity software for blood management across all NCBT Blood Banks.
- 57 staff were trained in different areas of Quality Management System (QMS) e.g. SOPs in Mobilization and Laboratory, QMS implementing and Blood component production technology, and Adjustable automatic donor scales.

e. Medical Infrastructure

- 47 biomedical technicians from Referral and District hospitals were trained on Humacount 5, Humalyzer 3500, Visual, Hemoglobinometer, Autoclave, Sysmexpoch 100i, QBC machines, Microscopy, Centrifuge, Generator, Solar Energy system, Fridge, X-Ray machine and Oxygen plant.

- 2 technical staffs were trained on Hematology Analyzer from Sysmex industry, South Africa.
- 2technical staffs were trained on Autoclave machine from Matachana industry, Spain.
- 15 technicians from different heath facilities were graduated in Biomedical Engineering from IPRC Kigali. They awarded a Diploma in Biomedical Engineering.
- One staff is pursuing a master's degree in Biomedical Engineering in UTC (Université de Technologie de Compiègne, France).

2.4. Medical Products Management and Regulation

The effective procurement and distribution of medical products and pharmaceutical commodities play a key role in the proper functioning of health systems. In the fiscal 2013-2014, the Ministry of health sustained its effort to ensure the supply of pharmaceutical commodities to public health facilities including referral hospitals, district pharmacies, and other public sector institutions, such as the National Reference Laboratory.

A modern warehouse 2,673 square meters was constructed at Kigali Special Economic Zone. The new warehouse will lead to closure of 7 out of 10 rented warehouses; this will allow saving around 300 million Rwandan francs (62% of the original spending on renting warehouses).

Source: RBC Annual Report 2013-2014

In order to ensure efficient quantification of commodities at Health Facilities level and the ability to predict and procure adequate supplies timely, MoH set up the electronic based logistic management information system (eLMIS).

The system has the advantage of improving stock visibility at each level of the pharmaceutical supply chain and allows accurate forecasting and rational distribution of drugs and health commodities. By the end of the Fiscal Year 2013-2014, the system had been rolled out in 30 District Pharmacies, 42 Hospitals, 4 Referral Hospitals and all health centers in 16 Districts.

Regarding the medical products regulation, a number of orders and regional protocols were drafted:

- EAC Common Technical Document for Registration of Medicines Developed and approved for domestication;
- EAC Manuals, Guidelines, Requirements and SOPs for the four thematic areas
- Orders mentioned in the law on Narcotics and Psychotropic were drafted;
- Orders mentioned in the Law for regulation of an inspection of pharmaceutical, food and cosmetics were drafted;
- The list of controlled products in Rwanda and tools for reporting and monitoring the distribution of these products was elaborated;

Blood transfusion is another important component of medical products. Blood collection and screening for quality were carried in 2013-2014. As part of the ongoing blood collection and testing activities:

- Hemoglobin test started for all donors to avoid selecting a blood donor who has low Hb (anemia) with risk of developing dizziness or fainting after blood donation;
- Blood components were distributed to 60 health facilities both private and public. Blood usage was as follows: Internal medicine (31.1%), Ob-gyn (21.8%), Ped (17.5%), Emergency (9.6%), Neo-Nat (6%), Surgery (5.5%) and others (8.5%)
- The was a slight increase of quantities of blood units collected and results of screening for the major blood infections.

Table 4: Proportion of blood units collected since 2012 to June 2014

Year	Blood collected	HIV	HBs	HCV	Syph
2012	40,520	0.5	1.5	2.8	1.5
2013	43,074	0.5	1.2	1.6	0.3
2014	47,256	0.4	0.9	0.9	0.4

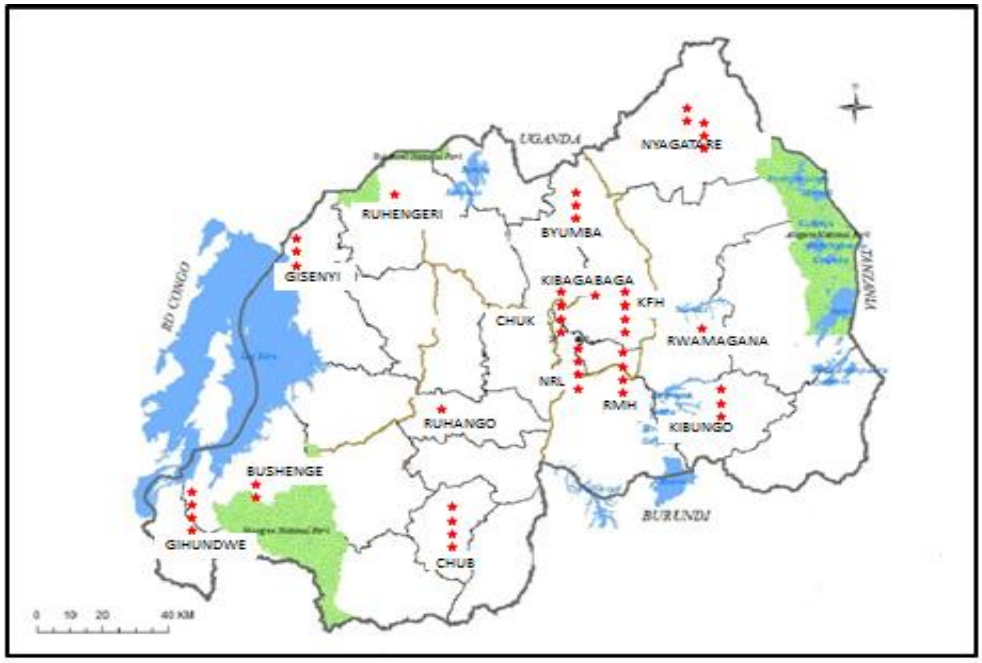
Source : RBC Annual Report 2013-2014

2.5. Diagnostic Services

In 2013-2014, the Ministry of Health continued to build the capacity of decentralized entities and started to spin off previous diagnostics tests that the National Reference Laboratory (NRL) was performing and moved to the decentralized labs. The decentralization for HIV QC occurred in the following Hospitals: Nyagatare, Ruhengeri, CHUB, Gisenyi, Gihundwe, Kibuye and Kibungo.

The NRL also purchased 10 GeneXpert machines for rapid TB and Rifampicin resistance detection as an ongoing effort to improve quality diagnosis and treatment of tuberculosis. The accreditation of Labs and their compliance with international norms and standard were also strengthened to ensure that the quality of products issued by our Labaratories is reliable. The NRL Division initiated the process of Labs accreditation and their compliance to standards. The map below shows the status of the lab accreditation under the guidance of NRL, the number of stars representing the level of accreditation:

Figure 16: Status of the lab accreditation under the guidance of NRL



Source : RBC Annual Report 2013-2014

2.6. Health Infrastructure Development

Medical equipment acquisition and maintenance:

- Preventive maintenance of medical equipment across 44 district hospitals and 436 health centers has been done three times in 2013-2014.
- Corrective maintenance has been conducted in MMC workshop and outside MMC in health facilities. More than 345 interventions have been completed successfully.
- MMC supported the identifications of technical specifications of equipments to be procured, technical evaluation of vendors bids, inspection of medical equipmens supplied by third parties before they are distributed to the beneficiaries, installation and commissioning of medical equipment

MMV supported the establishment of new Labs, medical equipment, health facilities construction and renovation. They supervised constructions of health facilities in order to ensure geographical and equitable accessibility to health services for all.

2.7. Health Financing

There are too many related achievements to list here but I will single one that I consider illustrative. In 2013/2014, the Global Fund (GF) chose Rwanda to be the first country with which to implement a Result Based Financing model by which funding is now channeled through sectoral support and contingent on the achievement of a few key indicators if health rather than through detailed program-specific commitments. This is a tremendous signal of trust in Rwandan systems and standards (confirmed by an in depth analysis of the Office of the Inspector General of the GF) and enables us to be more strategic and continuously optimize our allocation of resources to what will make the most difference to the health of the population in areas within the scope of the Global Fund.

Another important issue to highlight in health financing is the decision of the National Leadership Retreat to move the management of Community-Based Health Insurance from the Ministry of Health to Rwanda Social Security Board (RSSB). The move is aimed at improving the fund's financial accountability.

2.8. Quality Assurance, Standards, and Accreditation

During the Fiscal Year 2012-2013, healthcare facility accreditation was launched by the Ministry of Health as a strategy to create a sustainable process for implementing and measuring achievement of standards, and improving the quality of healthcare services at all levels of health facilities in Rwanda. In 2013-2014, the accreditation exercise was concentrated on the following aspects:

- **An Accreditation Baseline Assessment was conducted for 37 hospitals,** with the aim to assess the status of the hospitals in meeting accreditation standards that were disseminated and communicated to all hospitals. The survey process involved a variety of methods to elicit information from various sources to determine whether the intent of the standards has been met or not. The accreditation baseline assessment was conducted in the following 37 hospitals: Byumba, Gisenyi, Nemba, Ruli, Kinihira,Gihundwe,Nyagatare, Kibuye,Nyamata, Kabgayi, Kigeme, Kibogora, Mibirizi, Gakoma, Gitwe, Kirinda, Murunda, Mugonero, Muhororo, Kabaya, Remera-Rukoma, Gahini, Kiziguro, Ngarama, Masaka, Butaro, Kabutare, Kaduha, Kibagabaga, Kibilizi, Kirehe, Muhima, Munini, Nyanza, Rutongo, Rwinkwavu and Shyira.

- **An Accreditation progress assessment was conducted for 15 hospitals** to check on their status in meeting Rwanda Essential Hospital Accreditation Standards. The accreditation progress assessment was conducted in the following hospitals: five hospitals that are under accreditation (Bushenge, Kibungo, Rwamagana, Ruhengeri and Ruhango) and 10 hospitals that are not under full accreditation: Nyamata, Kinihira, Nemba, Ruli, Kibuye, Butaro, Byumba, Nyagatare, Gihundwe and Kabgayi. The survey came out with assessment findings report that provided the status of each hospital in meeting Rwanda Essential Hospital Accreditation Standards. After the assessments, the team of surveyors presented assessment findings to the hospitals. The hospitals finding reports will facilitate them to develop standards implementation plans, which will help them to improve on quality of services delivered to the patients.

- Accreditation facilitation was conducted in 11 hospitals for implementation of accreditation standards. Rwamagana, Kibungo, Ruhango, Bushenge, Ruhengeri, Kibuye, Kinihira, Nyamata, Rutongo, Nembaand Ruli. Most hospitals made significant improvement on the process of achievement standards.

2.9. Health Information Management

Rwanda has made many gains during the past years in the area of Information management. These include achievements in the automation of systems that are operational at all levels of the health system (HMIS, SISCom, RapidSMS, LMIS, etc. During 2013-2014 fiscal years, there are three key realizations under the Health Information Management:

- TRACnet, the HIV electronic-based system and the TB paper-based systems were migrated into HMIS, and were integrated in one national reporting system with purpose of harmonization and sustainability.
- The sector improved reporting compliance for the HMIS to nearly 100%.
- Planning, Monitoring and Evaluation and Coordination Division reinforced the data quality control through a standardized and regular data quality assessment (DQA) and Integrated supportive supervision (ISS) methodology at all health facility levels. Thus, from 23 February to 5 April 2014, RBC conducted DQA/ISS to 43 DH and one sampled Health Center (HC) in each DH catchment area. The period assessed was October-December 2013 and covered Malaria,

HIV, TB, NCD indicators. Findings from ISS/DQA were thereafter disseminated to District Hospitals (DH) and customized recommendation letters were issued to DHs for implementation.

2.10. Knowledge Management and Research

To respond to the growing demand for health research in Rwanda, the Ministry of health in collaboration with the University Of Rwanda School Of Public Health through the Center of Excellence for Health Systems Strengthening initiated the development of the National Health Research Agenda that will be implemented for the period 2014 through 2018. As a first step, the gap analysis was conducted with the aim of identifying research priority areas based on the national health policies, strategies, and mission, as well as non-health sectors whose actions have impact on health.

The NHRA development process was based on the health priorities and research areas identified from the national set of agreed health priorities in which research efforts will be concentrated over the next five years (2014-2018). This research agenda is largely aligned to the HSSP III 2012-2018 in which most themes and research priorities have been identified under specific strategic areas; the agenda also considers non-health research areas that have an impact on the health status of the population. Specifically, 9 themes have been identified based on the national health priorities, under each theme, health priorities and main research areas were identified. The Ministry of Health expects that the success of this document will be based on broad participation of all stakeholders: research community, implementers, and development partners to support the implementation of this NHRA.

This document has been arranged into 10 chapters. These are: the introduction, background; Goal Objectives, and Guiding Principles; Methodology; priority areas for the research agenda (themes, research priority areas, framework: policy, implementation, monitoring and evaluation (M&E), and beneficiaries); Implementation of the Research Agenda; Monitoring Evaluation of the Research Agenda; dissemination of research findings; and financing.

A number of operational researches were also conducted in 2013-2014:

- Second Drug Resistance Survey for TB, for 6 months, to have real picture of the resistance in country
- Prevalence of enteric bacteria and their antimicrobial susceptibility patterns 2013-2014
- National Remapping of schistosomiasis and soil-transmitted helminthes in Rwanda, covering 400 primary schools in which 50 boys per school are tested using stool and urine. In total 20,000 boys so far have been tested
- Refugee Health Assessment (RHA): in collaboration with CDC, 423 Congolese refugees stool sample were screened for Giardia lambria, Entamoeba Hystolytica and Cryptospordium using monoclonal ELISA
- Evaluation of Dried tube specimens as an alternative approach for proficiency testing program in Rwanda.

3. HEALTH SERVICE DELIVERY

The overall Objective of Health Service delivery is to strengthen policies, resources and management mechanisms of health services delivery systems to ensure optimal performance of the health programs (output, input, and process levels).

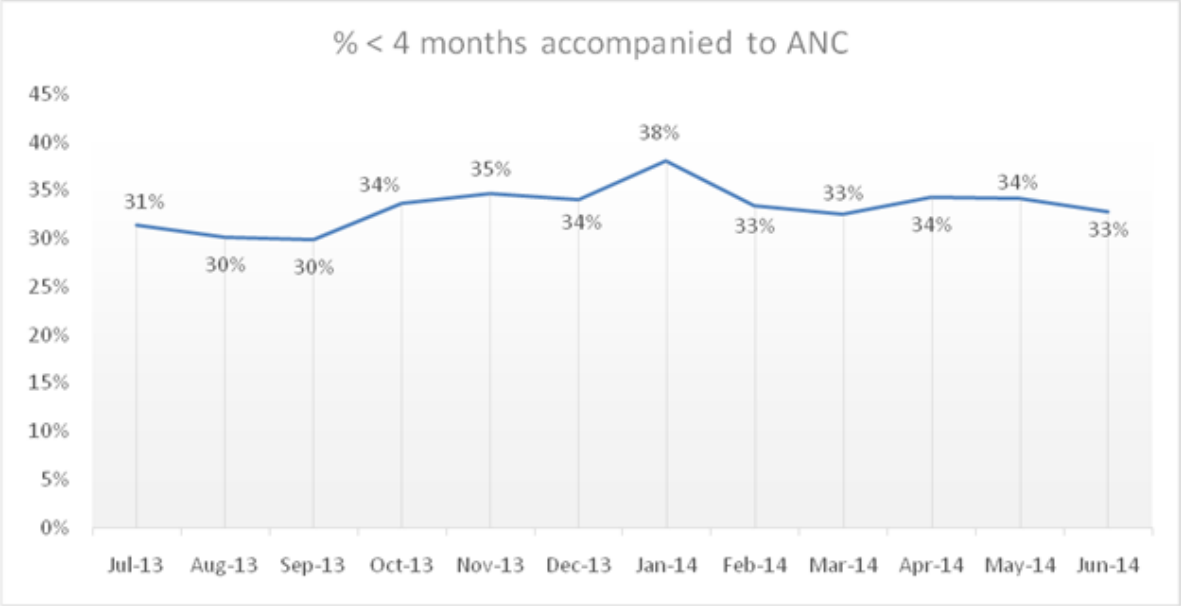
In Rwanda, Health service delivery is structured as a pyramid referral hospitals and provincial Hospitals at the apex followed by district hospitals, and health centers. The health centers, in turn, supervise health posts and community health workers, and other community-based associations for community outreach activities.

3.1. Community-Based Health Program

The Community-Based Health Program is a crosscutting intervention that interfaces with most of service delivery (EPI, FP, nutrition, TB, malaria, mental health, CCM, C-BNP, EH), but also with many of the system strengthening interventions (finance, M&E, transport).At the community level, community health workers contribute to the improvement of antenatal care by accompanying pregnant women Health Facilities.

They also screen children for malnutrition and treat Under 5 Children for Malaria, diarrhea and pneumonia. Here trends of selected indicators:

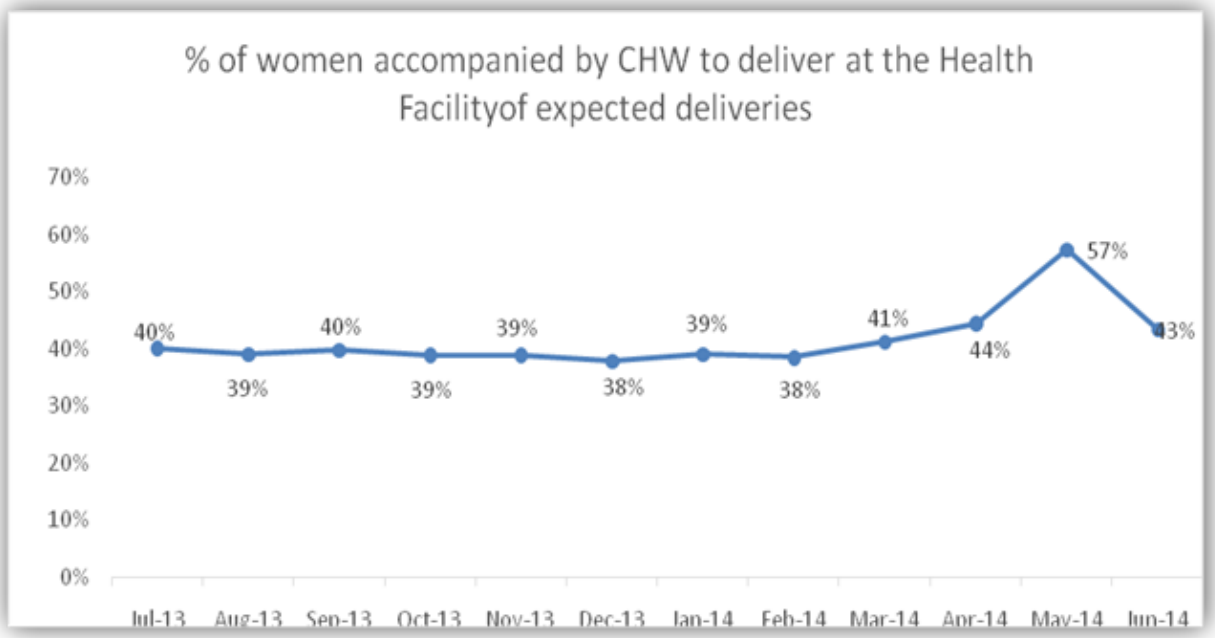
Figure 17: Perecentage of < 4 months pregnant women accompanied to ANC



Source: MCH Annual Report 2013-2014

The number of women accompanied by ASMs under 4 months has remained same over the year, meaning some women are not seen in the villages or prefer to go HC without being accompanied as seen the figure above.

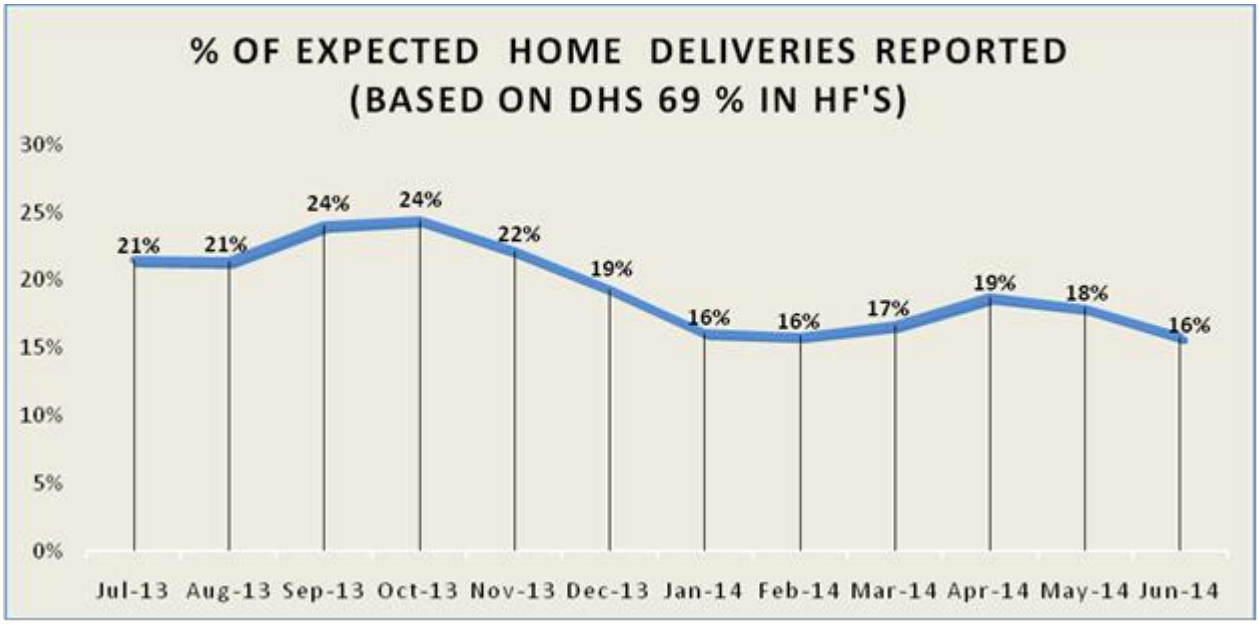
Figure 18: % of women accompanied by CHW to deliver at the health facility



Source: MCH Annual Report 2013-2014

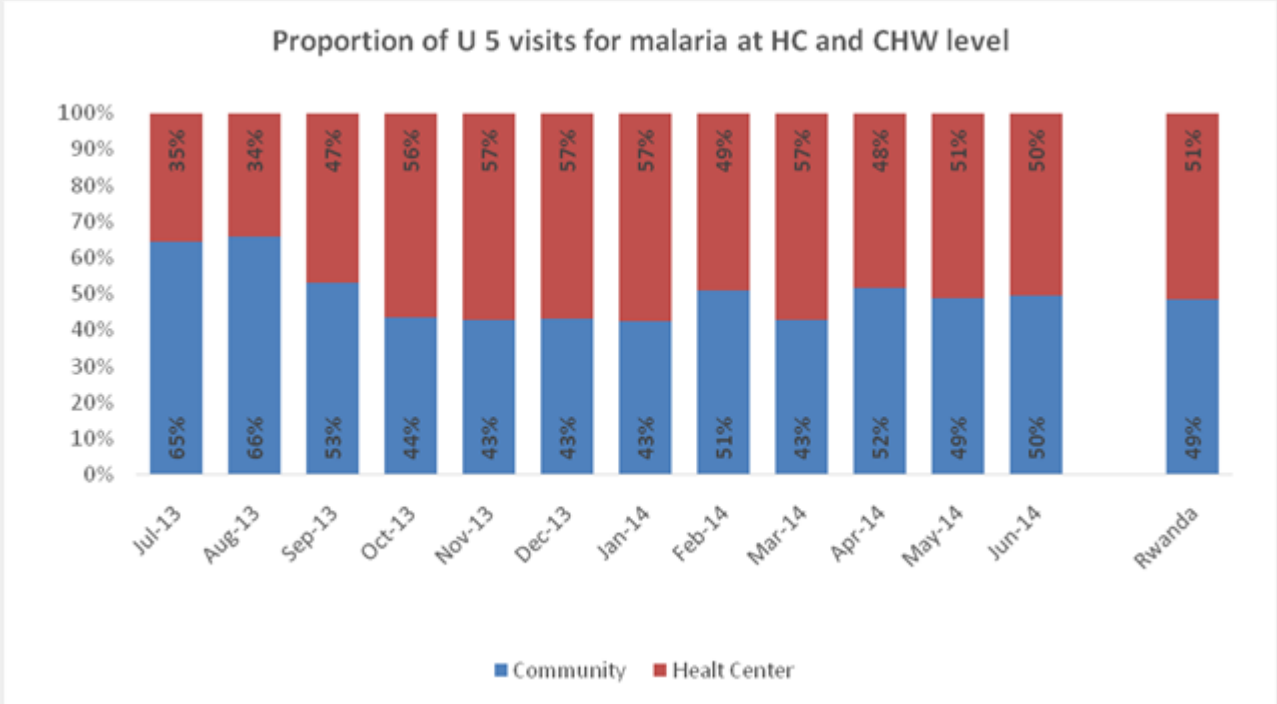
The number of women delivering at HC Accompanied by ASM has remained same over the year, meaning some women are not seen in the villages or prefer to go HC without being accompanied as seen the figures are higher in HMIS compared to SIScom reports.

Figure 19 % of expected home deliveries reported



Source: MCH Annual Report 2013-2014

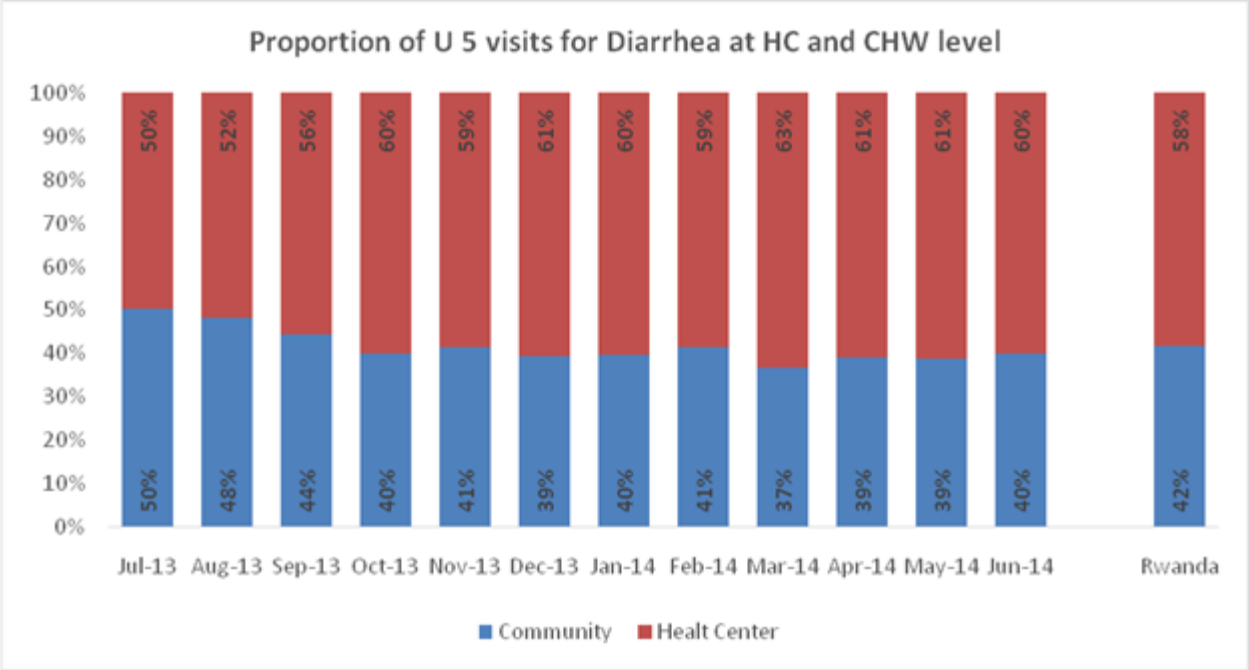
Figure 20: proportion of U5 visits for malaria at HC and CHW level



Source: MCH Annual Report 2013-2014

The figure above shows that the cases of Malaria treated by CHW's have increased by 15 % between 2013 and 2014.

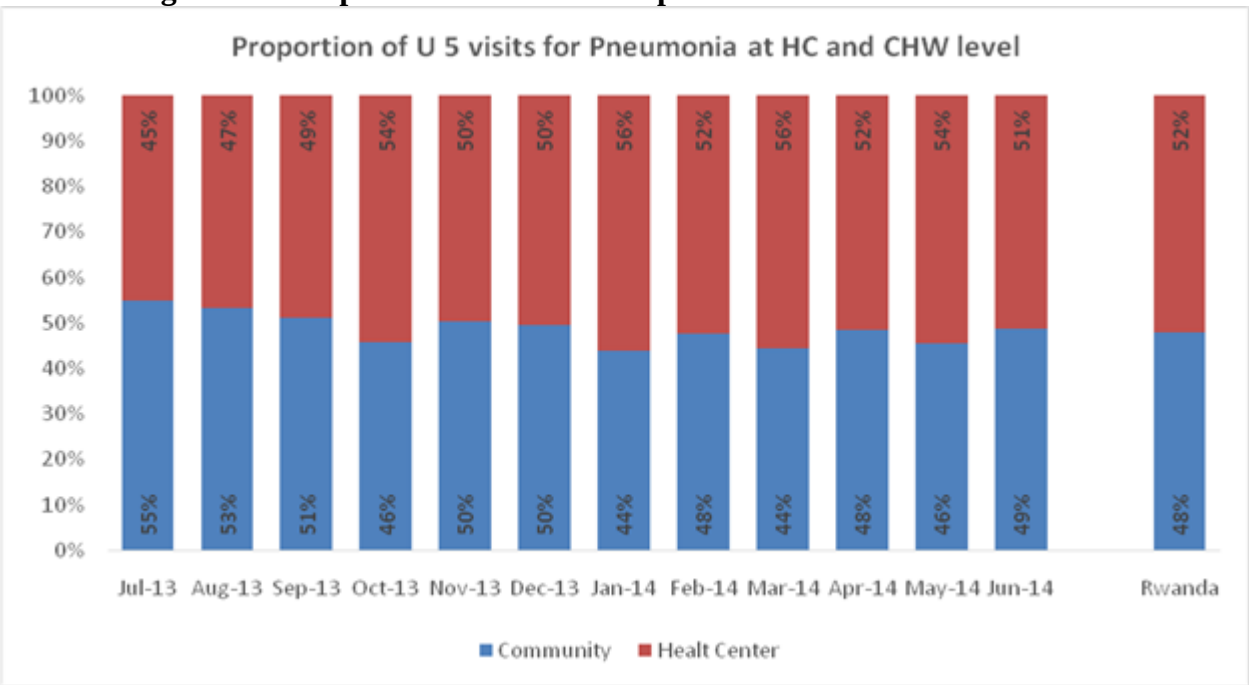
Figure 21: proportion of U5 visits for diarrhea at HC and CHW level



Source: MCH Annual Report 2013-2014

The figure above shows that cases of Diarrhea treated by CHWs have slightly increased between 2013 and 2014.

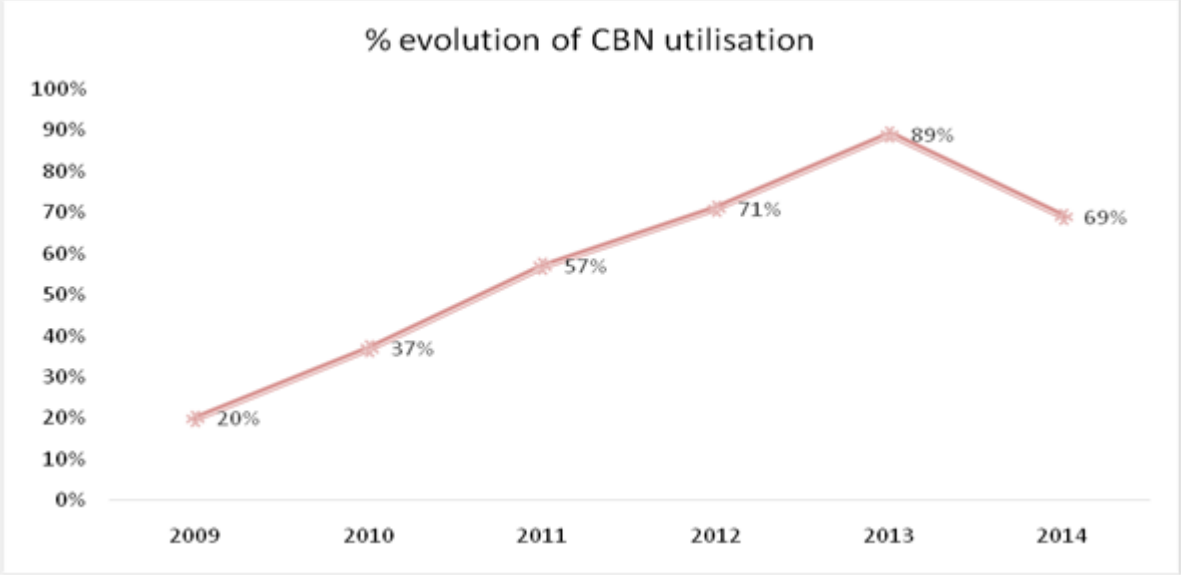
Figure 22: Proportion of U5 visits for pneumonia at HC and CHW level



Source: MCH Annual Report 2013-2014

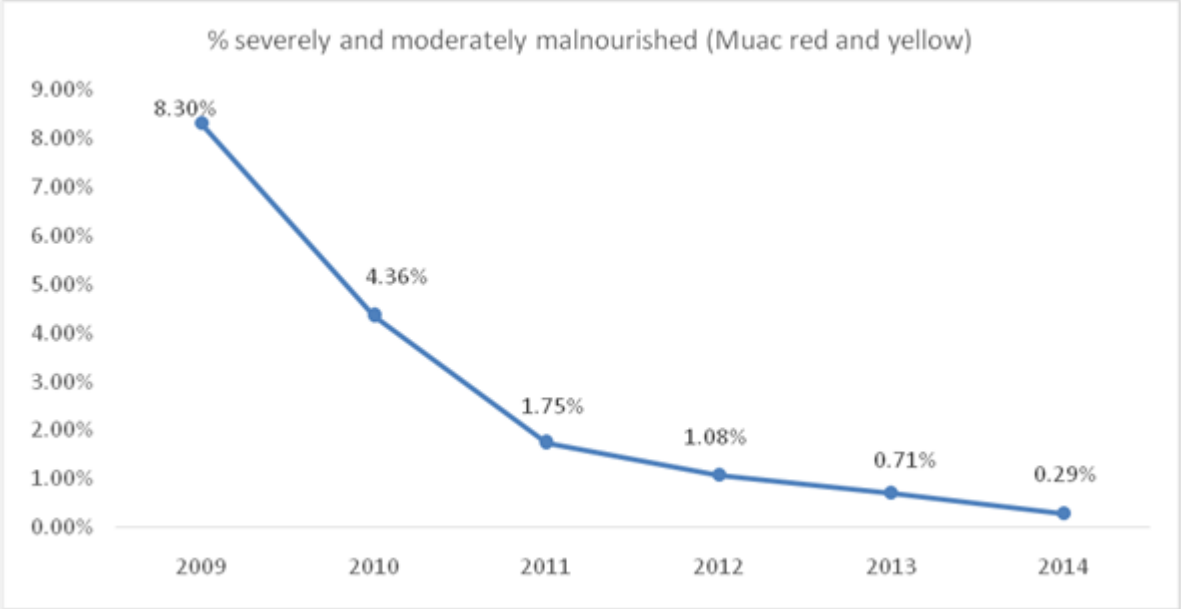
The figure above shows that the cases of pneumonia treated by CHWs have slightly increased between in 2013-2014.

Figure 23: % of evaluation of CBN utilisation



Source: MCH Annual Report 2013-2014

Figure 24: % severely and moderately malnourished (Muac red and yellow)



Source: MCH Annual Report 2013-2014

3.2. District Health Services (HP, HC, and DH) and Management (DHU)

According to the Rwanda Annual Health Statistics Booklet-2013, health facilities received a total of 10,119,063 new patients; including 8,862,174 (88%) patients who were seen in health centers, 498,999 (5%) in district hospitals, 98,334 (1%) in referral hospitals, while 252,268 (2%) were treated by CHWs practicing community-based integrated management of child hood illness (C-IMCI).

The Community-owned health facility, Dispensary, Medical Clinic, Prison Clinic, Health Post and Police Hospital) reported in HMIS from 2013 with the new cases of 407,288 (4%).

During the same year, primary health care utilization rate was approximately 0.94 visits per habitant (10,121,076 visits/10.817.006 population).This is a significant jump from 0.84 in 2012 (using the new 2012 census population denominator).

3.3. Provincial and National Hospitals (including specialized hospitals)

The Cabinet Meeting held on 14.05.2014 approved the plan of upgrading Karongi, Ngoma and Musanze District Hospitals to Referral Hospitals and Kinihira, Rwamagana, Bushenge and Ruhango Hospitals to Provincial Hospitals. The move is intended to improve the quality tertiary healthcare in Rwanda.

3.4. Specilised healthcare services: National referral hospitals

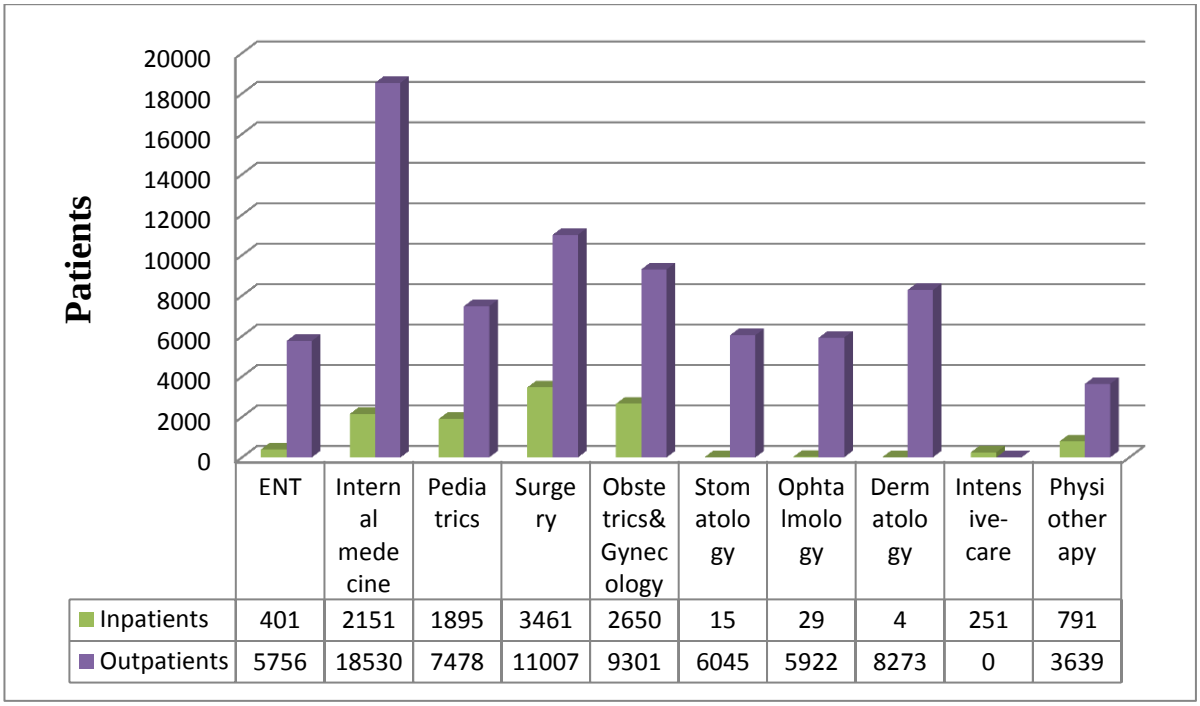
3.4.1. University Teaching Hospital of Butare (CHUB)

The University Teaching Hospital of Butare (CHUB) is located in HUYE District, Southern Province. It is one of the National Referral Hospitals serving around 3,363,944 people. Its hospitalization capacity is 500 beds, but only 366 beds are currently functional. In 2013-2014, CHUB had 468 staff. Synthetic data on consultation and hospitalization services from July 2013 to June 2014 show that Internal Medicine and Surgery are departments mostly frequented by both outpatients and inpatients.

- **Outpatients Department:** Internal medicine department received the biggest proportions of patients (18530). It is followed by Surgery with 11007 patients; including 4750 emergency cases from operating theatre.

- **Inpatients:** the biggest number of hospitalized patients comes from the big three departments and mostly Surgery where the total number of inpatients was 3461 in comparison with other clinical departments. It is followed by Obstetrics (2650) Internal medicine (2151), and pediatrics (1895).

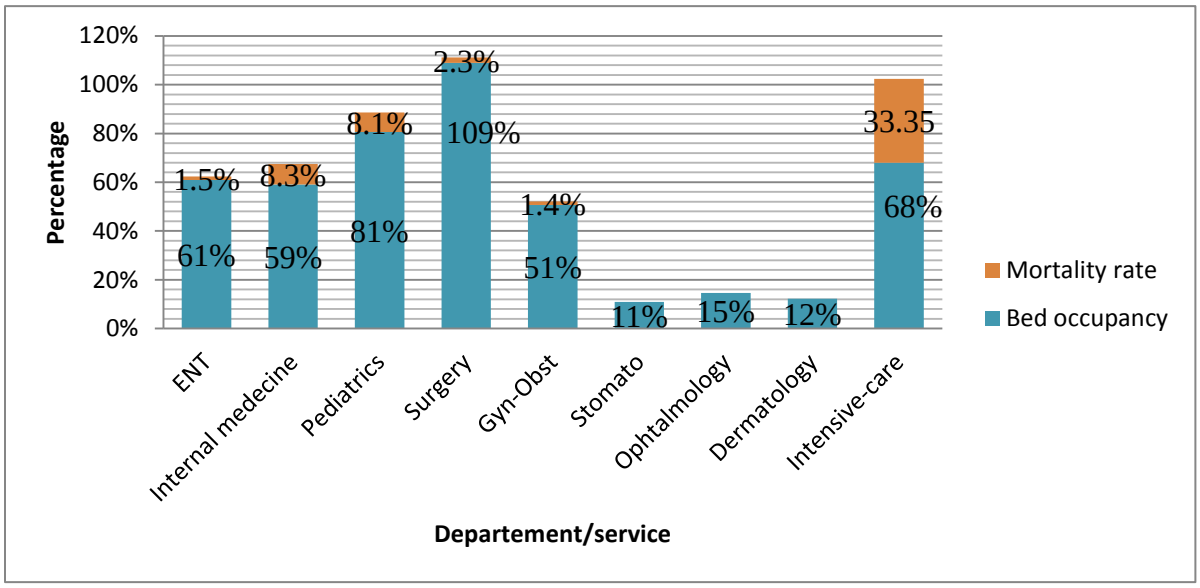
Figure 25: Distribution of Inpatients and Outpatients by departments/services



	ENT	Internal medecine	Pediatrics	Surgery	Obstetrics& Gynecology	Stomatology	Ophtalmology	Dermatology	Intensive-care	Physiotherapy
Inpatients	401	2151	1895	3461	2650	15	29	4	251	791
Outpatients	5756	18530	7478	11007	9301	6045	5922	8273	0	3639

Source: CHUB Annual Report 2013-2014

Figure 26: Mortality rate and bed occupancy distribution by department/service



Source: CHUB Annual Report 2013-2014

- **Rate of beds occupancy**: Surgery comes first with 109% of bed occupancy, and an average length of stay estimated at 14 days. It is followed by Pediatrics (81%) that deals with medical care of infants, children, and adolescents suffering from serious illness. The average length of stay in Pediatrics is 10 days.
- **Mortality rate:** the highest mortality rates in 2013-2014 were registered in ICU (33.5%), internal medicine (8.3%), and pediatrics (8.1%).

Table 5: Top five diagnosis of mortality & Morbidity at CHUB

Department	**Diagnosis**	
	Top 5 Causes of Morbidity	**Top 5 Causes of Mortality**
1. Pediatrics	1. Prematurity	1. Prematurity
	2. Asphyxia	2. Asphyxia
	3. Pneumonia	3. Congenital malformation
	4. Malaria	4. Neonatal infection
	5. Acute gastro enteritis	5. Heart failure
2. Internal Medicine	1. Gastroduodenal diseases	1. Cancers
	2. Malaria	2. Kidney disease (Acute and chronic)
	3. Cardiac diseases	3. Pulmonary tuberculosis
	4. Cancers	4. Stroke (Ischemic & hemorrhagic)
	5. Diabetes	5. Liver diseases (all)
3. **Gynaecology and Obstetrics**	1. Preeclampsia/eclampsia	6. Post partum hemorrage
	2. Hypertension on pregnancy	7. Obstetrical complications other
	3. Post operation infection	8. Eclampsia or severe preeclampsia
	4. Malaria on Pregnancy	9. Sepsis post partum infection
	5. Post partum hemorrhage	10. Abortion (symptoms suggesting induced abortion)

Source: CHUB Annual Report 2013-2014

3.4.2. University Teaching Hospital of Kigali (CHUK)

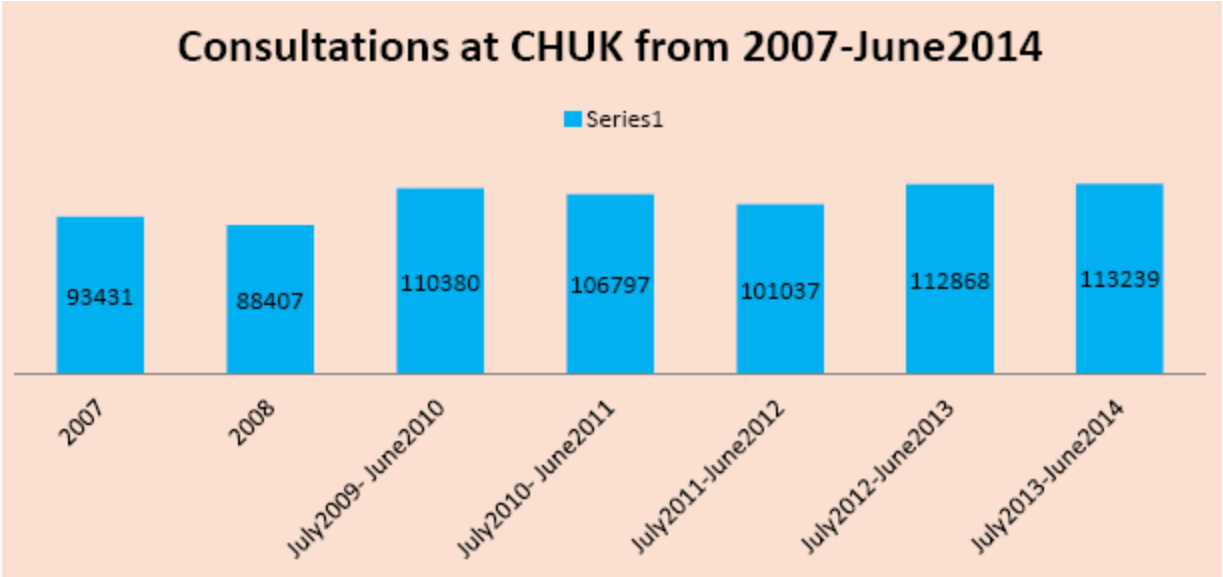
The University teaching hospital of Kigali (UTHK) is also one of big national referral hospitals. It has the capacity of 385 beds. As of June 2014, UTHK employed 807 people including 89 medical doctors and 498 nurses and midwives.

Table 6 UTHK main indicators for the year from July 2013 - June 2014

1	Number of beds for the year from July 2013 to June 2014	385
2	Total hospitalized patients for the year from July 2013 to June 2014	12873
3	Total deaths for the year from July 2013 to June 2014	1235
4	Average occupancy rate for the year from July 2013 to June 2014	89%
5	Total hospital days	125345
6	Mortality rate in the Hospital for the year from July 2013 to June 2014	6.00%
7	Average length of stay for the year from July 2013 to June 2014	10days
8	Annual average turnover	33/bed
9	Total Deliveries for the period from July 2013 to June 2014	1925
10	Normal deliveries for the period from July 2013 to June 2014	1125
11	Abnormal deliveries for the period from July 2013 to June 2014	800
12	Live born for the period from July 2013 to June 2014	1889
13	Total Interventions for the period from July 2013 to June 2014	13634
14	Planned Interventions for the period from July 2013 to June 2014	8721
15	Urgent Interventions for the period from July 2013 to June 2014	4913

Source: UTHK Annual Report 2013-2014

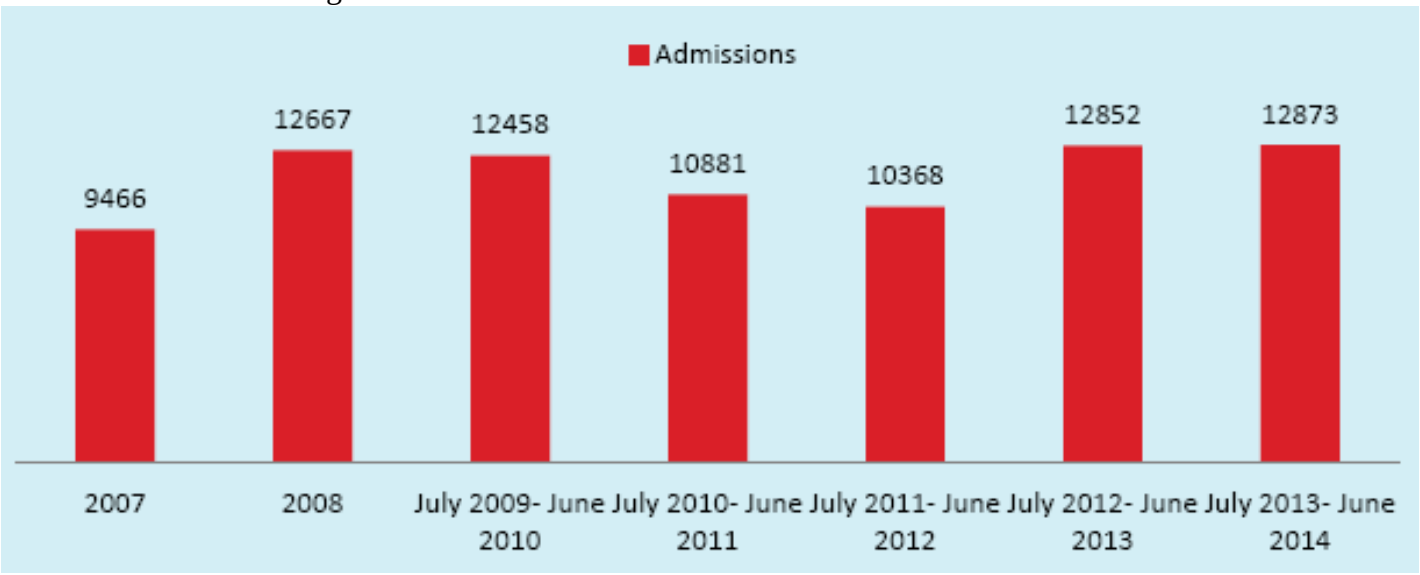
Figure 27: Evolution of consultation at UTHK from January 2007-June2014



Source: UTHK Annual Report 2013-2014

As it appears in the chart above, consultations were very low in 2008 and very high in the last year 2012-2013. However proportions of consultations for the last three years are almost the same.

Figure 28: Admission Chart at CHUK from 2007 To 2014



Source: UTHK Annual Report 2013-2014

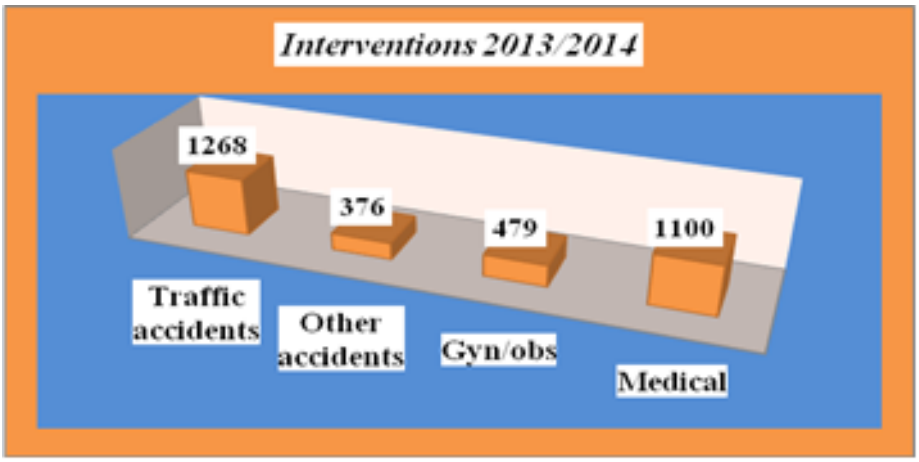
From 2007 to June 2014, the number of admissions increased until 2008. From that year until June 2012, the number has decreased considerably. Since July 2012 to June 2014, there was no great change in Hospital admissions but the number is still high.

3.5. Pre-Hospital Care Services and Referrals

Pre-hospital care services are managed by the unit called Service d'Assistance Médicale d'Urgence (SAMU). As of December 2013, all Districts had at least 5 ambulances each. Ambulances are usually based at district hospitals and remote health centers. The deployment of ambulances in healt facilities is intended to contribute to the vision of the Ministry of health to build up a sustainable and integrated pre-hospital emergency care system that provides the necessary quality services to individual in needs at a reasonable cost from the scene to definitive treatment as well as a coordinated response to emergency situations. The key highlights in 2013-2014 are:

- All SAMU staff were vaccinated against hepatitis B receiving all the 3 doses
- Emergency nurses and drivers from health facilities from all 4 Provinces received a training on Basic Life Support and the use of ambulances
- 912-call centre was upgraded to electronic registration of all calls received
- SAMU performed 3223 interventions in the City of Kigali and in Provinces using its 5Emergency and Resuscitation Medical Service (ERMS) teams. The 912-call centre received 39987 calls. The graph below shows the number of interventions according to the problems.

Figure 29: SAMU Interventions in 2013-2014



Source : SAMU Annual Report 2013-2014

4. GOVERNANCE

4.1. Regulatory Framework and Decentralization

The Draft law establishing the University Teaching Hospital (CHU) and Determining its Mission, Organization and Functioning was prepared by the legal advisor in collaboration with CHUK senior management and it was submitted to the competent organs for approval.

- The law of CHU is in place and it was published in official gazette NO 06/10/02/2014.
- The draft ministers' order are prepared and submitted to the ministry of health before approval by the cabinet meeting. Those are the following prime minister's orders:
- The PM determining the supervising authority and category of university teaching hospital (CHU),
- he PM's order determining modalities of collaboration between the university teaching hospital and the Rwanda University
- The PM order determining organization, functioning and responsibilities of CHU's organs
- The prime minister order establishing the organizational structure and summary of job positions for university teaching hospital (CHU)

4.2. Sector Organization and Management, Coordination and SWAp

During the fiscal year of 2013- 2014, the analysis of the health system highlighted the need for the development of a National Guide for the Health sector Policy and Strategic Plan Development; and recommended the review of Health Sector Policy and sub sector policies.

The National Guide for health sector policy was developed to ensure that all the Health Sector and subsector policies and strategic plans follow the same structure as proposed in the Cabinet Manual. The guide explains the key aspects to be addressed while developing the health sector policies and strategic plans in terms of content and process. It provides the details under each component to ensure a systematic approach to policy and strategic plan development, and proposes the formats for both the policy and strategic plans.

As reagrds to the Health Sector Policy, it was reviewed and updated in order to be aligned to EDPRS II and decentralization policy. The previous policy which was adopted in 2005, was addressing the

predominant health problems of that time and the challenges set by the HIV/AIDS pandemic, Malaria, TB and other infectious diseases. The reviewed health policy has taken into account lessons learned from the implementation of the previous health sector policy and other important changes in epidemiology, maternal and child health, human resource for health, infrastructure, health financing, service delivery etc.

In the updated policy, the guiding principles for the Sector have been reformulated to ensure that health interventions are people-centered, integrated and sustainable while enhancing self-reliance of the sector, and were adapted to the transition of epidemiology. The new health sector policy is built on the following four policies objectives:(i) Improve demand, access and quality of essential health services : Maternal, Neonatal and Child Health; Family Planning and Reproductive Health; Nutrition Services; Communicable Diseases (STI/HIV/AIDS, TB, Malaria), IDSR and Disaster Preparedness and Response (DP&R); Non communicable Diseases; Health Promotion.(ii)Strengthen policies, resources and management mechanisms of health support systems to ensure optimal performance of the health programs: Governance, Medical products, HRH, Health Financing, Health services delivery, Health information system (iii) Strengthen policies, resources and management mechanisms of health services delivery systems to ensure optimal performance of the health programs : Community , Health centers, District health system, Referral hospitals, Pre-hospitalization medical services,(iv) Strengthen the Health Sector Governance mechanisms (decentralization, partnership, aid effectiveness, and financial management) to ensure optimal performance of the health sub-programs.

5. Health Sector Domestic Budget Execution 2013/2014

Programs	Sub programs	Budget	Execution	%
Administrative and support services		**4,919,980,186**	**4,950,594,862**	**101%**
	Administrative and support services: minisante	1,330,144,458	1,397,657,218	105%
	Administrative and support services: ndera and kacyiru	406,454,296	406,454,296	100%
	Administrative and support services: rbc	3,183,381,432	3,146,483,348	99%
Health sector planning and information		**164,628,380**	**165,158,225**	**100%**
	Health sector planning, monitoring and evaluation	63,810,000	65,560,000	103%
	Health information and technologies	80,228,380	79,008,225	98%
	Partnerships coordination and mobilisation	20,590,000	20,590,000	100%
Health human resources		**30,918,431,533**	**30,492,500,469**	**99%**
	Health professional development	3,311,325,748	3,216,828,370	97%
	Health staff management(Earmarked salaries DHs and HCs)	27,607,105,785	27,275,672,099	99%
Financial and geographical health accessibility		**28, 598, 815,906**	**27, 904, 098,414**	**98%**
	Insurance system organisation	2, 335, 782,587	2, 330, 782,587	100%
	Health service subsidisation	4, 650, 365,711	4, 643, 615,711	100%
	Performance-based financing	6, 670, 617,017	6, 666, 824,913	100%
	Health infrastructure equipment and transport	11, 560, 757,161	10, 891, 833,493	94%
	Health infrastructure, equipment and goods(earmarked)	3, 381, 293,430	3, 371, 041,710	100%
Policy development and health service regulation		**1, 097, 553,259**	**913, 635,542**	**83%**
	Health service policy development and regulation	1,033,853,259	855,234,591	83%
	Health profession regulation	50,400,000	45,400,000	90%
	Health research regulation	13,300,000	13,000,951	98%
Maternal and child health		**4,230,562,471**	**4,180,452,631**	**99%**
	Family planning and reproductive health	648,532,257	575,216,970	89%
	Maternal and child health improvement	1,066,223,540	1,109,565,258	104%
	Hygiene and environmental health	422,247,144	403,474,254	96%
	nutrition	235,802,658	235,074,740	100%
	community health	659,808,460	659,158,460	100%
	Disease Control(Earmarked)	1,197,948,412	1,197,962,949	100%

Programs	Sub programs	Budget	Execution	%
Specialised health services		**10, 548, 176,272**	**10, 011, 848,173**	**95%**
	Specialised service delivery	10, 506, 016,272	9,969,688,173	95%
	Clinical and operational research	19,650,000	19,650,000	100%
	District hospital mentoring and supervision	22,510,000	22,510,000	100%
Health quality improvement		**979,017,983**	**1,015,640,997**	**104%**
	health communication	162,708,648	152,852,648	94%
	medical research	106,026,445	106,026,445	100%
	medical infrastructure and equipment maintenance	72,699,660	72,699,660	100%
	medical procurement and distribution	278,764,960	274,600,959	99%
	blood transfusion	116,109,302	143,515,044	124%
	medical production	83,383,208	114,627,523	137%
	lab diagnostic quality assurance	159,325,760	151,318,718	95%
Disease prevention and control		**1, 949, 031,648**	**1, 896, 185,193**	**97%**
	HIV/AIDS, STIs and other blood borne diseases	46,477,005	46,477,005	100%
	Malaria and other parasitic diseases	364,907,804	403,907,804	111%
	Vaccine preventable diseases	849,535,122	798,868,273	94%
	Epidemic infections, diseases	152,056,057	140,705,870	93%
	Non-communicable diseases	201,183,132	170,410,806	85%
	TB and other respiratory communicable diseases	179,463,138	197,776,895	110%
	MENTAL HEALTH	155,409,390	138,038,540	89%
	TOTAL	**83,406,197,638**	**81,530,114,506**	**98%**

CONCLUSION

The fiscal year 2013-2014 was successful for the health sector. Building on lessons from the previous fiscal year (2012-2013) more efforts were put in the consolidation of the four components of the HSSP III: Programs, Health Support Systems, Health Services Delivery and Governance. In the same way, the Ministry of Health continued to support the process of services decentralization in the health sector.

For the Fiscal Year 2014-2015, Health Sector actions will continue to focus on programs and interventions meant for the improvement of availability, accessibility and utilization of Maternal Health and Child health services; the quality of services offered by public and private health facilities; geographical and financial accessibility to Health services; and the reduction of the burden of communicable and non-communicable diseases among Rwandan population, as well as ensuring the universal availability and accessibility of drugs and consumables.

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