World Health Organization

Country Cooperation Strategy *at a glance*

Rwanda

http:// www.who.int/countries/en/

WHO region	Africa
World Bank income group	Low-income
CURRENT HEALTH INDICATORS	
Total population in thousands (2012)	11458
% Population under 15 (2012)	43.56
% Population over 60 (2012)	3.94
Life expectancy at birth (2012) Total, Male, Female	66 (Female) 65 (Both sexes) 63 (Male)
Neonatal mortality rate per 1000 live births (2012)	21 [13-35] (Both sexes)
Under-5 mortality rate per 1000 live births (2012)	55 [42-72] (Both sexes)
Maternal mortality ratio per 100 000 live births (2010)	340 [200-590]
% DPT3 Immunization coverage among 1-year olds (2012)	98
% Births attended by skilled health workers (2010)	69
Density of physicians per 1000 population (2010)	0.056
Density of nurses and midwives per 1000 population (2010)	0.689
Total expenditure on health as % of GDP (2011)	10.8
General government expenditure on health as % of total government expenditure (2011)	23.7
Private expenditure on health as % of total expenditure on health (2011)	43.3
Adult (15+) literacy rate total (2010)	71.1
Population using improved drinking-water sources (%) (2011)	80 (Urban) 66 (Rural) 69 (Total)
Population using improved sanitation facilities (%) (2011)	61 (Urban) 61 (Rural) 61 (Total)
Poverty headcount ratio at $1.25 a day (PPP) (% of population) (2011)	63.2
Gender-related Development Index rank out of 148 countries (2012)	76
Human Development Index rank out of 186 countries (2012)	167

Sources of data:
Global Health Observatory April 2014
http://apps.who.int/gho/data/node.cco

HEALTH SITUATION

The epidemiological profile of Rwanda is still dominated by communicable diseases, which constitute 90% of main complaints in health facilities. The most common communicable diseases are diarrheal diseases, acute respiratory infections, HIV and AIDS, tuberculosis and malaria. Other diseases occur in the form of epidemics: typhus, cholera, measles and meningitis. These diseases are the subject of specific control strategies and permanent surveillance in Rwanda. The surveillance strategy proposed by WHO, called Integrated Disease Surveillance and Response (IDSR) concerning 19 pathologies, is applied in Rwanda since 2003.

There has progress made in the fight against communicable diseases, notably the elimination of maternal and neonatal tetanus, a reduction of neonatal, child and maternal mortality, documentation of the eradication of poliomyelitis, measles control and reduction of malaria related mortality.

Since 2005, HIV prevalence in Rwanda has remained constant at 3.0% for women and men aged 15-49 HIV prevalence is three times higher in urban areas (7.1%) than in rural areas (2.3%), and prevalence vary by age, with HIV prevalence highest among women age 35-39 and men age 40-44. The impact of TB control activities have shown good progress towards MDG 6 /Stop TB targets, including a decrease of TB incidence, HIV+ rate among TB cases. There has been a decreasing trend of MDR rate among new patients because of case finding efforts and increased coverage of MDR TB diagnosis and services. Initial results of the National TB prevalence survey showed lower prevalence than previously estimated by WHO.

Rwanda has achieved significant reductions in the burden of malaria over the past decade, including significant reductions in incidence, morbidity, mortality and test positivity. The epidemiology of malaria in Rwanda has changed due to the successful scale up of mandatory laboratory confirmation of malaria before artemisinin-combination treatment (ACT) in 2009, the achievement of universal coverage with long lasting insecticide treated bed-net coverage in 2011, ten rounds of indoor residual spraying (IRS) in high malaria burden districts, and nationwide coverage of integrated community case management (iCCM).

Despite the remarkable decrease in prevalence of acute malnutrition in children under five, the prevalence of stunting in children under five remains high (44.2%, DHS 2010). The country has set as a priority the elimination of stunting in children under five through a revised food and nutrition policy and strategy focusing on the reduction of stunting, a national campaign focusing on the first thousand days and plans by each district to eliminate malnutrition.

HEALTH POLICIES AND SYSTEMS

The Rwandan Constitution, Articles 41 and 45 states that all citizens have rights and duties relating to health. The State has the duty of mobilizing the population for activities aimed at promoting good health and to assist in the implementation of these activities. The Ministry of Health has revised its National Health Policy, based on Vision 2020 and EDPRS II. The overall policy objective is to strengthen policies, resources and management mechanisms of health support systems to ensure optimal performance of the health programs.

HSSP III is fully aligned with EDPRS II and All districts will develop comprehensive district plans which shall also be aligned to the overall EDPRS II.

The Rwanda health system consists of three levels of service provision: central, intermediary and peripheral. The central level includes the central directorates and programmes of the Ministry of Health and the national referral hospitals. All district health units are to develop five-year health plans in collaboration with the management of the district hospitals and the responsible staff in the health centers.

Rwanda's health system is financed both by state funds and by individuals' contributions through health insurance and direct fees for services. The largest health insurance program is the Community-Based Health Insurance Scheme called "Mutuelles de Sante", estimated to cover 91% of the population while the formal health insurance is estimated at 6% of the population.

To cope with the threat of emerging and reemerging health threats, the Ministry of Health has developed and implemented an outbreak preparedness and response plan and strengthened capacities at central, borders and district levels for early detection and response to outbreaks and crisis; established an IDSR electronic system that is operational and performing well since 2013A "One Health" Strategic Plan has been developed and endorsed. An assessment of core capacities for IHR implementation and the development of IHR plan are in process.

To reverse the trends of HIV infection by 2015, WHO, in collaboration with the other UNAIDS co-sponsors and partners, consolidated and strengthened the process of going on scale towards universal access, in the framework of the "ONE UN" pilot experience in Rwanda such as Strategic information (HIV Drug Resistance), Care and Treatment (guidelines, protocols and tools), Prevention (Voluntary Male Circumcision, E-MTCT), Operational Research (HIV /Syphilis and Hepatitis surveillance among pregnant women), which activities are targeting most at risk population such as female sex workers and Truck drivers.

COOPERATION FOR HEALTH

In the health sector, more than 15 actors are operating in Rwanda, among them bilateral cooperation agencies, international institutions and UN agencies. The main health partners are the United States of America, the World Bank, the European Union and the United Nations system. Some development partners have advanced in harmonization, such as the One UN, streamlining UN agencies procedures, together reducing their specific requirements on procurement and thus becoming more aligned. Other like the European Union (EU), African Development Bank (AfDB), and the World Bank provide general budget support (GBS) through treasury. Others like Belgian cooperation earmark their funds to the sector, providing sector budget support (SBS). Other funding modalities are Global Fund, GAVI, PEPFAR. The coordination mechanism of cooperation for health is under the Health Sector Working Group and different technical working groups chaired by the Ministry of Health.

WHO COUNTRY COOPERATION STRATEGIC AGENDA (2009-2013)

Strategic Priorities	Main Focus Areas for WHO Cooperation
STRATEGIC PRIORITY 1: Sustain the achievements in the fight for Maternal and Child Health against infectious diseases and invest in prevention and control of—MDGs number 1 (nutrition), 4 (child), 5 (MCH) and 6 (disease control).	• Maternal, Child and Adolescent Health: To strengthen capacity of health providers in MNCH (EmNOC, Essential Newborn care, community management of mother and newborn, post-partum and post abortion care) and in ASRH&R with emphasis on those at high risk; review of child survival strategy and the strategic plan to reduce maternal and neonatal morbidity and mortality and their implementations and monitoring and evaluation of neonatal and child health interventions; • Nutrition: To develop an intersectoral and decentralized policy and strategy aiming at reducing all forms of malnutrition; to improve nutrition surveillance data analysis and dissemination of results; capacity building of health care providers for prevention of stunting in children under five and on operational research determining the specific causes of malnutrition in children. • Vaccination Preventable Diseases: To contribute in reducing the under-five mortality rate through the use of Community Health Workers to enhance immunization services, strengthen IMCI services and Community IMCI (C-IMCI) in order to reduce the five major child killers: ARI, malaria, diarrheal diseases, HIV, malnutrition.
STRATEGIC PRIORITY 2: Reduce the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and vaccine-preventable diseases, using disease control strategies including prevention, treatment, elimination and eradication.	• HIV: Strengthen HIV prevention strategies to reduce HIV new infections; to reduce morbidity and mortality of people living with HIV; impact mitigation of HIV to enable people infected and/or affected by HIV to have the same opportunities as the general population • Tuberculosis: Stronger focus on diagnosis and treatment for key populations, innovative diagnosis tools and diagnosis algorithm for TB, prevention, TB control measures and the adjustment of costing estimates to the projected decrease in external funding, with prioritization on the most cost-effective interventions. • Malaria: Shift from nationwide scale up to enhanced surveillance, focalized responses, and targeting interventions based on real-time data, coordinated responses such as bed nets distribution, focus IRS, and test and treat (DOT) based on the data, then target and stop the transmission. The Laboratory confirmation is mandatory of malaria before artemisinin-combination treatment (ACT) and nationwide coverage of integrated community case management (iCCM). • NTD: Support implementation of NTD strategic plan to reduce the morbidity caused by NTDs particularly lymphatic filariasis, soil- transmitted helminthiasis, shistosomiasis, trachoma, in providing technical support for NTD mapping and in facilitating deworming campaigns (mass drug administration) to meet WHO targets for NTD control and elimination by 2020.
STRATEGIC PRIORITY 3: Halt/stabilize and reverse non communicable diseases including mental health, injuries, violence and disability and embrace healthy lifestyles in a supportive and enabling risk mitigating environment through the course of life for improved quality of health and increased health adjusted life expectancy.	• Noncommunicable Diseases: To develop an intersectoral and decentralized policy and strategy including prevention and management of NCDs and capacity building of health care providers for prevention and management of NCDs. • Health Promotion and Social Determinants of Health: To enhance/improve intersectoral and decentralized mechanisms for assessing and implementing remedial measures on social determinants of health and on health promotion and capacity building of health promotion practitioners at decentralized level.
STRATEGIC PRIORITY 4: Put in place a responsive, client-centered, technologically driven and sustainable health system that is facilitating movement towards universal access to demand driven quality health and related services, with protection from catastrophic health expenditure	• To improve accessibility to health services (financial, geographical, community health) and; to increase support especially in terms of management and premiums contributions to low income and informal sector population through the community health insurance schemes (CBHI). To improve quality of health provision (quality assurance, training, medical products and technologies , equipment, monitoring); • To reinforce institutional strengthening (regulation and legislation especially toward district health services, District Health Us); • To improve quantity and quality of human resources for health (planning, quantity, quality, management).
STRATEGIC PRIORITY 5: Have adequate capacity for disaster preparedness, surveillance, and effective response to disease outbreaks, acute public health emergencies and the effective management of health-related aspects of humanitarian disasters to contribute to health security.	• Preparedness surveillance and response to outbreaks and crisis: • Develop country capacities for disaster risk management (DRM) in health sector through improvement of the health sector's management of disaster risks, including providing a comprehensive health response to emergencies and disasters. • Specifically ensure the availability of relevant policies, strategies and capacities to guide health sector interventions for DRM; reduce the number of emergencies progressing to disasters, by managing risks and improving preparedness and response; strengthen the use of evidence for early warning, preparedness and response to emergencies and disasters. • Epidemic Infectious Diseases: strengthen capacity to prevent and control epidemic diseases and other public health emergencies in Rwanda through the implementation of an effective and efficient national epidemiological surveillance system.