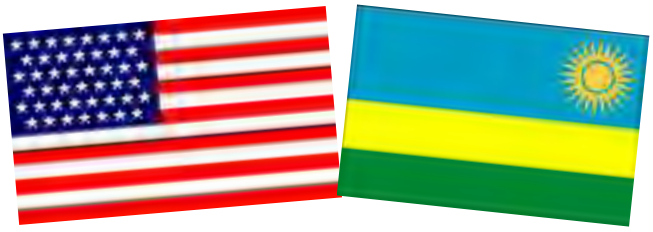
# Global Health Initiative Strategy

## Rwanda

June 1, 2011



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# ACRONYM LIST

| | |
|---|---|
| AI | Avian Influenza |
| AIDS | Acquired Immune Deficiency Syndrome |
| AIS | AIDS Indicator Survey |
| ANC | Antenatal Care |
| ARI | Acute Respiratory Infection |
| ART | Antiretroviral Therapy |
| BCC | Behavior Change Communication |
| BSS | Behavioral Surveillance Survey |
| BTC | Belgium Technical Cooperation |
| CBD | Community Based Distribution |
| CDC | Centers for Disease Control and Prevention |
| CHAI | Clinton Health Access Initiative |
| CHW | Community Health Worker |
| CNLS | National AIDS Control Committee |
| COE | Center of Excellence |
| COP | Country Operational Plan |
| CPDS | Coordinated Procurement and Distribution System |
| CSO | Civil Society Organization |
| CTX | Cotrimoxazole prophylaxis |
| DFID | United Kingdom Department for International Development |
| DHS | Demographic and Health Survey |
| DOD | U.S. Department of Defense |
| DOS | U.S. Department of State |
| DPG | Development Partners Group |
| EDPRS | Economic Development and Poverty Reduction Strategy |
| EID | Epidemic Infectious Diseases |
| FAO | United Nations Food and Agriculture Organization |
| FP | family planning |
| GCF | Gender Challenge Fund |
| GDP | Gross Domestic Product |
| GHI | Global Health Initiative |
| GLIA | Great Lakes Initiative on HIV/AIDS |
| GOR | Government of Rwanda |
| GTZ | German Society for Technical Cooperation |
| HAS | HIV/AIDS and Sexual Transmitted Diseases Unit |
| HHS | U.S. Department of Health and Human Services |
| HIV | human immunodeficiency virus |
| HMIS | health management information system |
| HRIS | human resources information system |
| HPV | Human Papillomavirus |
| HRH | Human Resources for Health |
| HSWG | Health Sector Working Group |
| HSSP | Health Sector Strategic Plan |
| IDHS | Interim Demographic and Health Survey |
| IDSR | Integrated Disease Surveillance and Response system |
| IEC | information, education and communication |
| IMCI | Integrated Management of Childhood Illness |
| IPPF | International Planned Parenthood Federation |
| IRS | Indoor Residual Spraying |
| ITN | Insecticide Treated Nets |
| IUD | Intrauterine Device |
| JHSR | Joint Health Sector Review |
| LLIN | Long Lasting Insecticidal Nets |
| M&E | Monitoring and Evaluation |
| MARP | Most-At-Risk-Population |
| MC | Male Circumcision |
| MCH | Maternal and Child Health |
| MDGs | Millennium Development Goals |
| MDR | Multidrug resistant |

| | |
|---|---|
| MINAGRI | Ministry of Agriculture and Animal Resources |
| MOH | Ministry of Health |
| MSM | Men who have Sex with Men |
| NGP | National Gender Policy |
| NISR | National Institute for Statistics of Rwanda |
| NMCP | National Malaria Control Program |
| NRL | National Reference Laboratory |
| NSA | National Strategy Application |
| NSP | National Strategic Plan |
| NTD | Neglected Tropical Disease |
| OI | Opportunistic Infection |
| OVC | Orphans and Vulnerable Children |
| PBF | Performance-Based Financing |
| PDA | Personal Digital Assistant |
| PEP | Post Exposure Prophylaxis |
| PEPFAR | The United States President's Emergency Plan for AIDS Relief |
| PIO | Public International Organization |
| PIT | Partner Initiated Testing |
| PLWHA | People living with HIV/AIDS |
| PMI | U.S. President's Malaria Initiative |
| PMTCT | Prevention of Mother-To-Child Transmission |
| RBC | Rwanda Biomedical Center |
| RH | Reproductive Health |
| SDC | Swiss Development Cooperation |
| SGBV | Sexual and Gender-Based Violence |
| SIDA | Swedish International Development Agency |
| SPA | Service Provision Assessment |
| SPH | School of Public Health |
| STEPS | STEPwise approach to Surveillance |
| STH | Soil-Transmitted Helminth |
| STI | Sexually Transmitted Infections |
| SWAp | Sector-Wide Approach |
| TB | Tuberculosis |
| TRAC Plus | Center for Treatment and Research on AIDS, Malaria, TB and Other Infectious Diseases |
| TWG | Technical Working Group |
| UN | United Nations |
| UNAIDS | The Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNHCR | United Nations High Commissioner for Refugees |
| UNICEF | United Nations Children's Fund |
| UNIFEM | United Nations Development Fund for Women |
| USAID | United States Agency for International Development |
| USG | United States Government |
| VCT | Voluntary Counseling and Testing |
| WFP | World Food Program |
| WHO | World Health Organization |

# I. GLOBAL HEALTH INITIATIVE VISION

## A. GOR VISION FOR HEALTH IN RWANDA

Building upon the priorities of the Government of Rwanda (GOR) and the successes of the United States Government (USG) health program to date, the Global Health Initiative (GHI) comes at a particularly opportune time to capitalize on the GOR's strategic "Vision 2020." This document, which is used to guide overall development in Rwanda, sets three ambitious goals: 1) to promote macroeconomic stability and wealth creation to reduce aid dependency in the short-term; 2) to transform from an agrarian to a knowledge-based economy in the medium-term; and 3) to create a productive middle class and foster entrepreneurship in the long-term. Nested under Vision 2020 is the country's Economic Development and Poverty Reduction Strategy (EDPRS) for 2008 – 2012, which in turn serves as the framework for the national Health Sector Strategic Plan II (HSSP II) for 2009 – 2012. In the HSSP II the GOR states that its vision for the health system is to "continually [improve] the health of the people of Rwanda through coordinated interventions by all stakeholders at all levels, thereby enhancing the general well-being of the population and contributing to the reduction of poverty" [HSSP II]. Rwanda's efforts towards the Millennium Development Goals (particularly numbers 1, 4, 5, and 6) contribute to the attainment of this vision.

## B. USG VISION FOR ITS CONTRIBUTION

In support of these national strategies and the health sector vision, the USG role in Rwanda is to assist the country to develop, implement, and sustain evidence-based, cost-effective, and high-quality health services. In this work, the USG collaborates directly with GOR and with other development partners through a coordinated process managed by the GOR, described further in Section III.D and in Appendix F. The USG provides expert technical assistance in order to build local capacity to plan, manage, monitor, evaluate, and disseminate results from Rwanda's health programs. The USG also provides coordinated financial assistance to the health sector to advance responsible country ownership. With a focus under the GHI of promoting gender equality and supporting capacity building efforts at all levels, the USG will work to strengthen the overall health system, which will in turn produce sustained, improved health outcomes for the population of Rwanda.

In Rwanda, the USG strives to support Rwanda's health system with a shared vision for the future, a common understanding about the strategies needed to achieve that vision and the tools and skills necessary to implement them. The underlying principles of engagement between USG and GOR include trust, integrity, and respect. Each partner is critical in that neither can achieve its goals without the help and support of the other. The USG team believes that this model is the most effective way to ensure that all stakeholders are achieving their individual objectives, as well as their shared goals.

# II. COUNTRY CONTEXT

Rwanda has made remarkable progress since the tragedy of the 1994 genocide, with growth in real per capita income averaging nearly five percent and accelerating to an average of nearly six percent in the last five years.[1] It nevertheless remains one of the world's poorest countries. The United Nations Development Program (UNDP) ranked Rwanda 152 out of 169 worldwide on its most recent Human Development Index.[2] According to the most recent household survey, undertaken in 2005/6, 57 percent of the population lives below a poverty line of approximately $1.30 per day, of which nearly two-thirds, or 37 percent of the total population, fall below an extreme poverty threshold of about $0.90 per day.[3] Agriculture is extremely important to the Rwandan economy. Over 90 percent of households practice some form of crop cultivation while the sector serves as the principal source of employment for nearly 80 percent of the labor force and accounts for about one-third of gross domestic product (GDP).[4] The majority of this agricultural labor is provided by women. With an estimated population density of 436 persons/square km,[5] Rwanda is the most densely populated country in Africa. If unchanged, the current growth rate of 2.8% per annum will produce a population of 14 million and density of 581 persons/square km by 2020, threatening economic growth and efforts to reduce poverty. In response, the GOR leads and supports a voluntary family planning

**Table 1. Rwanda Health and Economic Indicators**

**Population & Medical Personnel**

- Total population: 10.4 million (U.S. Census Bureau, International Data Base, 2008)
- Per capita utilization of health facilities: 70% (HMIS, 2007)
- Doctors: 1/15,780 inhabitants (Rwanda Health Statistical Booklet 2008, MOH)
- Nurses: 1/1,444 inhabitants (Rwanda Health Statistical Booklet 2008, MOH)

| **Key health indicators** | 2005 DHS | 2007/2008 IDHS |
|---|---|---|
| o Infant mortality (per 1000 live births) | 86 | 62 |
| o Under 5 mortality (per 1000 live births) | 152 | 103 |
| o Maternal mortality (per 100,000 live births) | 750 | - |
| o Modern contraceptive prevalence | 10% | 27% |
| o Total fertility rate | 6.1 | 5.5 |

**HIV/AIDS and other epidemics**

- HIV prevalence: 3% (DHS, 2005)
- TB case detection rate: 27% (TRAC Plus/WHO, 2009)
- Malaria prevalence in children under five: 2.6% (IDHS, 2007/2008)
- Children under five sleeping under LLIN: 60% (IDHS, 2007/2008)

**Rate of Enrollment in Social Health Insurance (Mutuelles de Santé)**

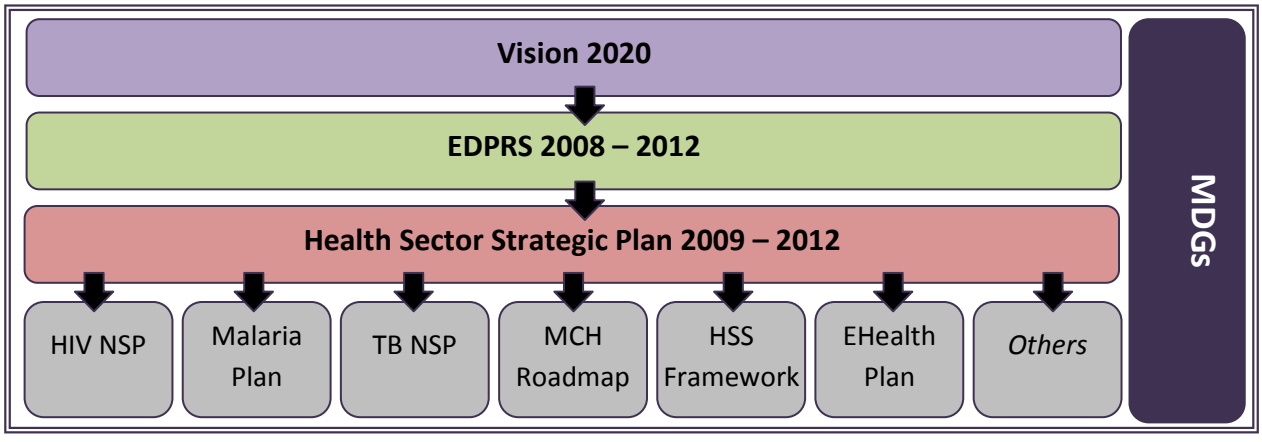
- 2006=44% (MOH)
- 2007=75% (MOH)
- 2008=85% (MOH)

[1] Based on data from the IMF's WEO database, October 2010.
[2] UNDP, *The Real Wealth of Nations: Pathways to Human Development*, Human Development Report 2010.
[3] NISR, "EICV Poverty Analysis for Rwanda's Economic Development and Poverty Reduction Strategy," EICV 2005/06 Final Report, May 2007. Poverty lines are converted to purchasing power parity (PPP) using PPP values from the IMF's October 2010 WEO database.
[4] Labor force data comes from EICV 2005/06 Final Report. NISR estimated agriculture's share of GDP as 34 percent in 2009. In the last ten years, it has varied between 32 and 39 percent.
[5] This assumes an estimated population of 10,746,311 (U.S. Census Bureau, International Data Base, 2009) and a land mass of 24,668 sq/km (CIA World Fact Book).

program that has already achieved considerable success as outlined in Table 1. It is estimated that 53% of the population is below 20 years of age.[6] Rwanda's foremost development challenges are: to transform from the largely agrarian population into a knowledge-based workforce, while keeping pace with public expectations of adequate economic opportunities for all; to meet its urgent health and education needs while reducing reliance on donor support; and to ensure that all its citizens have equal access to a strengthened judicial sector and independent media, and increasing opportunities at both local and national levels for civic participation.

Although Rwanda has made significant progress in improving the health status of its population, much work remains. Females have a life expectancy of 53.8 years and account for 51.7% of the population; males have a life expectancy of 49.4 years (NISR, 2009). Rwanda has one of the highest fertility rates in Africa, with 5.5 children per woman (IDHS 2007/2008). The burden of disease in Rwanda is similar to that of other developing countries. Acute respiratory infections (ARI) accounted for 34% of all outpatient illnesses in 2008, followed by presumed and confirmed malaria (12%).[7] The relationship of the two diseases was reversed for hospital mortality, with malaria the leading cause of hospital mortality (16%), followed by ARIs (12%); HIV was the third leading cause of hospital mortality with 8% of deaths.[8] In Rwanda, every three hours a women dies due to complications related to pregnancy or delivery.[9] As shown in Table 1,[10] core health indicators have improved dramatically in recent years, but continued progress is essential.

Rwanda's strategic planning architecture in the health sector includes Vision 2020, EDPRS, HSSP II, sub-sector strategies and Millennium Development Goals (MDGs). Vision 2020 includes 47 indicators and targets for 2010 and 2020, and indicators and targets to measure progress towards MDGs have been set for 2015. The EDPRS is the medium-term development strategy




[6]National Institute of Statistics of Rwanda, National Population Projection 2007-2022, July 2009. The last census of Rwanda was conducted in 2002. The next census is scheduled for 2012.
[7]Rwanda Ministry of Health, Annual Statistical Bulletin, 2008
[8]Ibid
[9] Ministry of Health, Rwanda, Strategic Plan for the Accelerated Reduction of Maternal and Infant Morbidity and Mortality 2009 – 2012, January 2009
[10]There is currently a Demographic and Health Survey underway in Rwanda. Initial data should be available by late spring. This information will be used to provide updates to key health statistics referenced here.

to implement Vision 2020 and achieve MDGs. Key EDPRS priorities include maximizing preventive health measures and building capacity for high quality healthcare services for the entire population. Finally, the HSSP II focuses on three major programmatic interventions and seven cross-cutting approaches to systems strengthening to reach the goals outlined in the EDPRS, MDGs, and Vision 2020. These are summarized pictorially in the GHI Results Framework (Appendix A). In view of the expected completion of the HSSP II in 2012, the Ministry of Health (MOH) has begun to plan for an external review of progress and the formulation of HSSP III. Given achievements to date under HSSP II and the alignment of its goals and targets with Rwanda's MDGs for 2015, the HSSP III is expected to build on successes to date.

To achieve the goals of the EDPRS and the HSSP II, the GOR reports contributing 13% of its domestic budget to the health sector (Joint Health Sector Review, 4/2011), and donor support contributes 67% of the health budget, including 32% of health workers' salaries. Several bilateral donors provide both general and sector-level budget support. In 2008, 92% of the GOR budget was executed according to what was planned (Budget Execution Analysis 2008). The national government strives to implement a zero tolerance approach to corruption.

The GOR has long been implementing many of the principles articulated under the GHI. Section III.B., Application of the GHI Principles in Rwanda, includes a full discussion of this topic.

# III. USG/RWANDA GHI PRIORITY AREAS

After conducting a review of existing programs and future priorities for the GOR and the USG, the USG health team identified human and institutional capacity building, and gender equality as its GHI priority areas. The first priority area is specifically "to strengthen the human and institutional capacity of the public health system to plan, manage, implement and monitor sustainable health programs at all levels" as updated in the USG/Rwanda Partnership Framework for HIV/AIDS of 2009-2012. The second priority area is "to set the Rwandan society free from all forms of gender based discrimination and see both men and women participate fully and enjoy equitably from the development process" as prioritized in Rwanda's National Gender Policy. These two GHI principles are at the core of the USG's efforts in Rwanda, and they are cross-cutting priorities for the GOR. As high-priority, high-profile strategies for the GOR, there is significant political commitment to promoting their implementation. Furthermore, as they are integral parts of both short- and long-term national policies and plans, they will likely continue to be high priorities for the GOR in the foreseeable future.

## A. PRIORITY AREA 1: CAPACITY BUILDING

*Strengthen the human and institutional capacity of the public health system to plan, manage, implement and monitor sustainable health programs at all levels*

Rwanda is a dynamic country, characterized by the rapid adoption of new approaches, strategies and programs. However, Rwanda also has critical deficits in human resource capacity, which is the result of its limited pool of highly educated teachers, mentors and other highly qualified national professionals to transfer capacity and knowledge to individuals and of the regular movement of staff within and outside of the health sector. For this reason, Rwanda has recently expressed a clear way forward to address these gaps in its Strategic Plan for Human Resources 2011 – 2016, and is calling all partners to support and work in alignment with this plan to achieve a high quality and self-sustaining health system.

This situation has compounded systemic deficits, contributing to persistently low levels of institutional capacity at all strata of the health system. Yet the full transition of USG-supported activities to national ownership is dependent on the capacity of Rwandan institutions and individuals. This has been recognized by the GOR and is prioritized in multiple GOR health-related strategy documents as a key area of focus, including the Rwanda Vision 2020, the EDPRS and the HSSP II. Increased investment in Rwandan staff, processes and systems, as well as introduction of new technologies, is thus required to ensure the high quality and sustainability of health services provided in Rwanda.

*How will GHI contribute to capacity building in Rwanda?*

Through the GHI, the USG will leverage established relationships to promote greater emphasis on capacity building by all stakeholders, develop new partnerships with national organizations to support country ownership, and integrate capacity building as a core component of all USG health assistance. In particular, the USG will provide high-quality, coordinated technical and financial assistance to Rwanda to increase human and institutional capacity at all strata of the health system, in line with national plans and objectives and with an emphasis on building and transferring capacity in a sustainable manner. With increased capacity, Rwanda will be able to achieve its ambitious targets for the improved health of its population, including those for maternal and child mortality, as well as to ensure a strong and sustainable health system.

Illustrative activities within the capacity building priority area include:

- Support to institutions of higher learning in Rwanda to improve their capacity to train health sector professionals;
- Support to strengthen application of the national resource tracking database, performance based financing at the district, facility and community levels, and community-based health insurance;
- Support Rwandan institutions to conduct evaluations to inform public health programs; and
- Support to civil society organizations to improve their capacity to receive and manage direct donor funding.

The need for institutional and organizational capacity building is especially timely with the signing of the Rwanda Biomedical Center (RBC) Law passed in January 2011. Under the Law, 14

key health sector entities will be merged under one umbrella, including the disease prevention and control programs, national public health reference laboratory, national reference hospital, the national health procurement authority (CAMERWA), the National AIDS Control Commission (CNLS), and the schools of medicine and public health. Under the law these wide-ranging agencies are being reorganized into new units or departments within the RBC umbrella, and will be managed by a general directorate that is headed by a chief executive officer (CEO). The RBC umbrella will be under the supervision of the MOH.

The implications of this merger are fundamental to the health outcomes the USG is supporting. It alters roles, responsibilities, and accountabilities of the key players in the health sector. Concretely, key support will be needed to help the merged RBC with the following:

- planning and budgeting of the consolidated entities, especially as it relates to the implementation of key sector strategies;
- staffing, recruitment, and HR management policies and systems across all departments of the RBC;
- clarification on authorities and decision-making power granted to individual units; and
- financial management the RBC, at the individual unit level

At present, the USG supports institutional and human capacity building in the GOR from the central to the community level, in civil society organizations (CSOs) and in the private sector. Benchmarks have been established to measure institutional capacity in these areas; as capacity is demonstrated consistently over time responsibilities will continue to shift progressively towards Rwandan ownership. At the policy level, the USG is closely involved in the review and revision of decision-making processes and coordination of donor and sector activities through an improved Sector-Wide Approach (SWAp). In addition, the USG has provided technical assistance in drafting key national strategy and policy documents related to capacity building. The USG supports technical assistance to key staff at national and district levels to provide effective supervision and oversight, establish and promote evidence-based policies, programs and practices and identify and guide the strategic direction of the health sector. The USG utilizes institutional twinning and technical assistance to assist Rwandan institutions to assume primary responsibility for strategic planning and management, implementation, and monitoring and reporting. For example, the USG supports institutions of higher learning in health education to become effective managers and leaders in research, training and community outreach programs.

At the community level, the USG has contributed to the training and deployment of 60,000 CHWs, who will in turn collaborate with local leaders to promote health-seeking behavior and provide basic home-based care. The USG provides technical assistance to CSOs, who are active in the health sector, but need improved capacity to directly manage donor funds and to implement high-quality sustainable programs. The USG has also supported the GOR in private sector engagement, for example through an assessment of private sector readiness to provide family planning (FP) commodities.

Under the GHI, the USG team will continue to support the GOR, civil society and private sector to strengthen human and institutional capacity and to utilize this increased capacity by investing in host country systems and processes. The expectation of the USG is that all partners have a focus on human and institutional capacity building as aligned with national plans. The expected results are medium-term achievements, such as high quality health professional including nurses and specialists, quality improvement and increased uptake of health services, and long-term achievements such as reduced maternal and child mortality and lower prevalence of HIV, TB and malaria.

Of course, greater human resources for health (HRH) capacity will be critical to achieving these health outcomes and as such addressing the shortage of healthcare workers in the country as described in the HRH Strategic Plan will be a priority for the USG. One of the WHO's "HRH Crisis Countries," Rwanda has approximately 600 doctors in the country, for a physician to population ratio of 1 to 15,780 (MOH Statistical Booklet, 2008). Overall, the country has barely three healthcare workers (i.e., doctors, nurses and midwives) per 10,000 people, far fewer than the WHO's "critical threshold" of 23 per 10,000 population. While retention of healthcare workers within the country and the public sector is not a major issue for the country, the quality and skill mix of the current workforce, as well as the capacity of pre-service institutions, are major points of concern. The USG co-chairs the national technical working groups (TWG) on HRH, through which it supports the GOR to develop its national strategic plans and policies on HRH, including those for continuous professional development, performance-based financing (PBF) and non-financial incentives, and human resources information system (HRIS). In addition, the USG provides funding to the Faculty of Medicine, School of Public Health, Kigali Health Institute and other pre-service institutions to improve their quality of teaching, enhance their IT infrastructure, and develop evidence-based curricula.

The USG plans to employ three strategies to achieve its objective of increasing human and institutional capacity in Rwanda. First, the USG will leverage established arrangements, for example as shadow co-chair of the Health Sector Working Group (HSWG) and as co-chair and members of national Technical Working Groups, to promote a greater policy-level emphasis on, and investment in, capacity building by all stakeholders in Rwanda (see Appendixes F and G for further information on the organization of the Rwandan health sector). During the upcoming year, the USG expects to participate in the mid-term review of the HSSP II, which involves an emphasis in evaluating capacity, and which can serve as a baseline for on-going efforts. The USG has been the lead donor supporting the GOR health sector resource tracking tool to better inform decisions regarding how resources are allocated among interventions, as well as directly link the funding to the outcomes. Through this tool, and together with other GOR tools, the USG will also monitor gaps in human resource and institutional capacity and tailor strategies to remedy these deficiencies.

Second, the USG will explore opportunities for new and strengthened relationships with national partners. A main component of this will be the continued focus on country ownership through increased direct funding to local entities. Under the GHI, the USG will be working to increase the number of local government and non-governmental institutions that receive direct

support. For example, the USG will monitor and evaluate the transition of HHS-funded activities such as national blood transfusion safety, biomedical prevention, and HIV clinical services from USG implementing partners to the GOR. As the multi-year transition moves forward, the USG will continue to provide support to the MOH and health facilities to ensure that the quality of care at transitioned sites remains high. Similarly, as the USG looks towards direct funding of the national medical store and the performance-based financing program, capacity building of the personnel, systems and infrastructure will be critical and a high priority. The USG will also support capacity building of gender desks in key ministries to operationalize the national gender policy.

Finally, as a cross-cutting component, capacity-building will continue to be integrated as a core component across all health assistance, including continued support for training institutions such as the schools of nursing and midwifery and the new Rwandan University of Health and Medical Sciences. For example, with indoor residual spraying (IRS), the USG will be working to transfer planning, management and implementation to district authorities, including working with community leaders to ensure that IRS remains a health priority. The USG will also continue to support the GOR to increase local capacity to manage the malaria insectary. The USG will support leadership and capacity-building in health finance, particularly in the transfer of the management and capacity to develop or maintain the national resource tracking database to the MOH. The USG will continue to support capacity for operational research and data collection with key local institutions, such as the Rwandan Biomedical Center and the National Institute for Statistics of Rwanda (NISR). The development of a national laboratory network that meets international accreditation standards remains a high priority. The USG will continue to support health workforce training programs, such as for health economics and finance, Field Epidemiology and Laboratory Training Program (FELTP), clinical and laboratory services and community health workers, using faculty and professional mentors and other high qualify professional to build and transfer capacity and reinforce its pre-services and in-services educational system. Using a systems approach, efforts will not focus solely on training and deployment, but on increasing efficient utilization and integration of the workforce at the district, sector and community level, and on strengthening national management of service delivery, management of resources and leadership of human resources.

There are several areas that need to be reviewed and addressed as the country continues decentralization. Chief among them is the need to strengthen the role and the capacity of teaching institutions, health care facilities and civil society in health governance as a means of increasing the national level of service delivery and uptake as well as accountability to the citizen-consumers of health services. This in turn is likely to increase both the quality of health services as well as the efficiency of the health system. Strengthening civil society, while at the same time increasing their responsibilities, will allow them to share in monitoring the performance of health centers, mutuelles, and CHWs with district administrators. The best practice of co-governance is based on a sharing of planning, management, and oversight responsibilities between district governments and the relevant CSOs.

## B. PRIORITY AREA 2: GENDER EQUALITY

*Set the Rwandan society free from all forms of gender based discrimination and see both men and women participate fully and enjoy equitably from the development process*

In the Rwandan National Gender Policy (NGP), it is written that: "Rwandan society is characterized by a patriarchal social structure that underlies the unequal social power relations between men and women, boys and girls. This has translated into men's dominance and women's subordination. Gender inequalities [are] not seen as unjust, but as respected social norm[s]." There are adequate policies in place to address gender inequalities. The next critical piece is to ensure that those policies are implemented within all health programs nationwide.

*How will GHI contribute to improving gender equality in Rwanda?*

USG will support Rwanda in operationalizing its national gender policy and other strategies that identify scaling-up, sexual and gender-based violence (SGBV) prevention and treatment; advancing professional development of women in the health sector and services that benefit primarily women; strengthening SGBV referral systems among health services; promoting couples voluntary counseling & testing; providing information on the dangers of cross-generational sex and concurrent relationships; encouraging increased male involvement in maternal and child health, family planning/reproductive health, prevention of mother to child transmission of HIV/AIDS and antenatal care ; and actively linking low-income women and child- or female-headed households to income-generating and social welfare programs. As compared to gender-related programming previously, the current activities focus on the mainstreaming of gender into all program areas and the incorporation of a gender approach to the delivery of all health interventions and services.

Illustrative activities in the gender priority area include:

- Promoting couples voluntary counseling and testing;
- Encouraging male involvement in MCH, PMTCT and ANC visits; and
- Strengthening referral systems for SGBV throughout the health system.

Identified in the NGP are several factors which contribute to this situation. Chief among these are: limited access to and utilization of secondary education; poor understanding among women of their legal rights and how to use the legal system; high fertility rates and low contraception use; religious beliefs; cultural norms; the disproportionate effect of HIV/AIDS on women as both patients and caregivers; and demographic disparities. Recognizing the complexity of this situation, as well as the devastating effects gender inequality can have on national prosperity and stability, the GOR has made a concerted, multi-sectoral effort to address these issues. As the GOR has made clear in the Constitution, Vision 20/20, the EDPRS, the HSSP II and other documents, improving the status of women and girls and promoting gender equality are top priorities for the country in the coming years. The USG health team believes that supporting these efforts is essential to not only the success of national health programs, but all development activities. As such, gender equality is a central pillar of the country's GHI strategy and a common goal of all USG-supported health projects.

At present, the USG support for gender activities covers a wide range of interventions and issues. The USG health team defines gender as addressing the needs of men and women, boys and girls. Currently, the most important activities include: scaling-up sexual and gender-based violence (SGBV) prevention and treatment; strengthening SGBV referral systems among health services; promoting couples voluntary counseling and testing (VCT); providing information on the risks of cross-generational sex and concurrent relationships; encouraging increased male involvement in maternal and child health (MCH), FP/RH, prevention of mother-to-child transmission programs (PMTCT) and antenatal care (ANC); and actively linking low-income women and child- or female-headed households to income-generating and social welfare programs. As compared to gender-related programming previously, the current activities have a greater focus on the mainstreaming of gender into all program areas and the incorporation of a gender approach to the delivery of all health interventions and services.

Under the GHI, the USG will convene a gender mainstreaming workshop with relevant partners and support to identify gender-based needs and issues, summarize existing data and research findings, and to analyze the extent to which these needs are being met, and to formulate strategies and implementation plans to strengthen the promotion of gender-sensitive interventions and gender equality through USG-supported initiatives. Together with USG implementing partners and national counterparts, the USG team will support the implementation of new programs and interventions. With support from the Gender Challenge Fund (GCF), partners will engage in a broad set of activities designed to address some of the most critical gaps in current programming. As part of this package, there will be a greater effort to address SGBV with evidence-based programs and provide a broad package (clinical, legal, psychosocial) of services to survivors; special attention will be paid to the roles of the military, police and health and social service providers, as well as the needs of handicapped populations in these efforts. The GCF will also support the training of Peace Corps Volunteers serving as teachers on how to recognize and address the signs of SGBV, neglect, and abuse among students; needs assessments of vulnerable populations, such as trafficked persons and child prostitutes; and behavior change communication (BCC) activities on counter-productive male norms and behaviors. Another new activity will be cross-border collaboration on, and harmonization of, legal policies and procedures by police and military organs. In addition, these institutions will expand their work on male norms and behaviors. New approaches will also be adopted in order reach more children, and boys in particular, with SGBV prevention, care, and treatment activities. Special emphasis will be given towards supporting professional development of women, especially to fill provider roles in services that are most relevant to women, such as midwifery.

# IV. GHI IMPLEMENTATION

The HSSP II and the USG support for health in Rwanda encompass all eight GHI target areas (see Appendix G). All services are integrated to the greatest extent possible, although the USG and the GOR continuously strive to improve the efficiency and efficacy of all health interventions.

## A. USG Response by Target Area

**HIV/AIDS:** Rwanda is one of the original 15 focus countries for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The United States is Rwanda's largest partner in its fight against HIV/AIDS. PEPFAR/Rwanda is a collaborative, interagency USG effort. In support of the Rwandan HIV National Strategic Plan (NSP), PEPFAR provides direct financial and technical support to seven GOR institutions In Rwanda PEPFAR supports PMTCT, VCT activities, youth intervention programs, and male circumcision (MC); provides antiretroviral drugs and treatment for HIV/AIDS and opportunistic infections (OI) in comprehensive, integrated health programs; supports education and life skills training for orphans and vulnerable children; supports the collection and use of strategic information to monitor health outcomes; and promotes health system strengthening through relevant national plans, coordinated procurement quality improvement/assurance and accreditation, community-based health insurance, and human resources capacity building – through support of the national HRH Strategic Plan. Within the USG/Rwanda Partnership Framework For HIV/AIDS 2009 - 2012, PEPFAR is continuing to support the GOR's commitment to national ownership, data-driven approaches, quality service delivery, implementation of evidence-based policies, institutional capacity building, and a coordinated financial response. The Partnership Framework places an emphasis on sustainability of HIV/AIDS activities to enable a strong Rwandan health system, with a focus on technical, management, financial and political sustainability.

**TUBERCULOSIS:** The USG currently supports national TB control and TB-HIV integrated activities through PEPFAR and regional TB funding, in collaboration with the Global Fund and the World Bank. As defined in the Rwandan TB and HIV NSPs, the main priorities of the national TB program are to improve national TB case detection rates, to expand the implementation of the World Health Organizations (WHO) "Three I's" (intensified TB case finding, isoniazid preventive therapy and infection control) in health facilities providing HIV services, and to provide high quality TB diagnosis and treatment of people living with HIV/AIDS (PLWHA) with active TB disease, including early initiation of antiretroviral therapy (ART). Consistent with these aims, PEPFAR is supporting the scale up of "one-stop" TB/HIV services. The USG also supports other national TB control objectives including support of a regional Center of Excellence (COE) for the programmatic management of drug resistant TB.

**MALARIA:** Rwanda is one of four second-round focus countries for the U.S. President's Malaria Initiative (PMI). The USG supports the GOR's malaria prevention and treatment objectives. PMI's goal is to reduce deaths due to malaria by half through reaching 85 percent of the most vulnerable groups – principally pregnant women, children under five years of age, and PLWHA by supporting three key areas: indoor spraying of homes with insecticides (IRS), insecticide-treated mosquito nets, and treatment to prevent malaria in pregnant women. In Rwanda, PMI, in collaboration with the Global Fund and other partners, supports the National Malaria Control Program (NMCP) with a primary focus on vector control activities (IRS, long-lasting insecticide-treated nets, entomologic surveillance), case management of malaria at the community level,

and health system strengthening by supporting human resource needs at the NMCP, strengthening of the health management information system (HMIS), the National Reference Laboratory (NRL), and pharmaceutical management system.

**MATERNAL AND CHILD HEALTH**: Rwanda participates in the Safe Birth Africa Initiative, which aims to reduce maternal and neonatal deaths in children aged three to five years through proven lifesaving interventions. The USG assistance supports the training of health providers in emergency obstetric care and management of obstetric complications, including prevention and management of fistula in order to improve maternal health in Rwanda. Going forward, there will be continued focus on the training of midwives and other relevant cadres to better tackle these issues and to better equip facilities to respond to these needs. Postnatal care, newborn and child health are being addressed through technical assistance, for example facility- and community-based integrated management of childhood illnesses (IMCI); immunization; essential nutrition; safe drinking water; improved hygiene and sanitation, and emergency and basic care for newborns. The USG provided financial and technical support for the introduction of the pneumococcal vaccine and is currently providing support for the introduction of a vaccine for rotavirus and human papillomavirus (HPV). In addition, the USG provides technical support in review of policies and strategies addressing MCH in Rwanda to include better management of post-partum hemorrhage, eclampsia and pre-eclampsia, as well as on newborn resuscitation. The USG also promotes advocacy efforts towards safe motherhood and supports the participation of civil society as well as high-level advocacy initiative like the White Ribbon Alliance for safe motherhood.

*Water and Sanitation:* In collaboration with the Global Fund and in support of the GOR's plan to have universal access to safe drinking water and proper sanitation in place by 2020, the USG provides water-related hygiene promotion and point-of-use drinking water treatment. These efforts primarily target pregnant women and breastfeeding mothers, children under five years old, and PLWHAs, but are also intended to benefit the general population. In addition, local leaders, businesses, community, and faith-based partnerships have been strengthened to implement improved sanitation, hygiene and safe water utilization and storage. Furthermore, the USG is working with Agriculture, Climate Change and Economic Growth programs to provide comprehensive support for water programming.

**NUTRITION**: Nearly half (45%) of all Rwandan children under five years old are stunted and will suffer the negative effects of chronic childhood undernutrition for their entire lives[11]. In response, in 2009 President Paul Kagame launched a national campaign on the issue, called the President's Emergency Plan to Fight Malnutrition. Subsequently, in 2010 the USG developed an Integrated Nutrition Investment Framework under the new U.S. Presidential Feed the Future Initiative (FtF) to support the GOR's national multi-sector three-year strategy to eliminate malnutrition in Rwanda. The USG supports the national strategy targets of strengthening and scaling up community-based nutrition interventions and programs for children under five years of age and pregnant and lactating women as well as eliminating micronutrient deficiencies,

[11] Rwanda Demographic and Health Survey, 2005

supporting multi-sector district planning, behavior change communications and M&E of nutrition activities at all levels. Through agricultural and economic growth investments, USG support will focus on a selected number of value chains for maximum impact, including beans, maize, dairy and a small number of high-value crops such as coffee, pyrethrum, and avocado. As local markets develop for these value chains and food consumption expands beyond that which is produced at home, the USG may also support local food fortification of maize flour and dairy products.

**FAMILY PLANNING AND REPRODUCTIVE HEALTH**: In 2007, recognizing its negative impact on economic growth, the GOR made family planning a national priority. The USG supports the GOR national family planning program, which seeks to increase the demand, access, availability, quality and use of contraception. As a key element of its support, the USG works to increase the availability of FP/RH services. To this end, the USG's local partners provide technical assistance to the MOH to train and supervise health providers; sensitize Rwandans to the importance of family planning with specific strategies for men and women; and ensure that health facilities can adequately meet their clients' needs. There will be continued efforts to increase the number and quality of trained health professionals, including nurses and midwives using the national curriculum. The USG supports the purchase of more than 45% of modern contraceptive commodities for the public sector, and supports their distribution at the facility and community levels by health workers. In addition, virtually all condoms, including public sector and socially marketed condoms, are financed by development partners. The GOR supports coordinated quantification to project needs and identify resources. The main sources of condoms are USAID, who supplied about 95 percent of the condoms used between 2007 and 2008. UNFPA is also a key supporter.[12] Increasing male involvement and meeting unmet demand are also integral aspects of the program.

**NEGLECTED TROPICAL DISEASES:** The USG, through PEPFAR, supports the Environmental and Community Health Desks in the MOH and the Epidemic Infectious Diseases (EID) Unit within TRAC Plus. Specifically, these MOH desks work to promote control of water- and soil-transmitted parasitic diseases though environmental mitigation efforts and community-based activities such as mass drug treatment campaigns in schools. Additionally, the USG supports integrated disease surveillance and response (IDSR) and HMIS, which will include several neglected tropical diseases (NTD). The EID Unit is also responsible for NTD control activities including clinical guidelines, population-based surveys, and surveillance.

**AVIAN INFLUENZA**: The USG, under the U.S. National Strategy for Pandemic Influenza and the Pandemic Influenza Plan, aims at strengthening local capacity to increase preparedness and response capabilities in Rwanda with the intent of stopping, slowing or otherwise limiting the spread of an influenza pandemic. Through an agreement with the GOR, the AI program supports the following objectives: preparedness and communication; surveillance and detection; and response and containment. Additionally, Rwanda will be benefiting from the

[12]Rwandan Ministry of Health, National Strategic Plan for Comprehensive Condom Programming in Rwanda, 2009-2012 (http://www.rwandangoforum.org/index.php?option=com_docman&task=doc_download&gid=22&Itemid=7)

global Emerging Pandemic Threats program that seeks to aggressively pre-empt or combat diseases like AI through its four projects: predict, respond, identify and prevent.

## B. APPLICATION OF THE GHI PRINCIPLES IN RWANDA

The GHI Principles are in complete harmony with many of guiding strategies that the GOR has implemented in recent years to improve health status. Rwanda's health sector is characterized by vision, leadership, strategic planning, commitment, and a dedicated work ethic. The USG Health Team in Rwanda likewise engages in collaborative teamwork to reach clearly defined goals. As a result, the joint GOR-USG health programs already mirror many of the principles of the GHI.

**Women- and girl-centered approach to reducing morbidity and mortality**
Globally, maternal mortality, HIV, and malaria are key contributors to health disparities between the sexes. Rwanda has achieved impressive reductions in maternal mortality over the past decade, in part due to USG-supported strategies such as community health worker (CHW) promotion of assisted delivery in health facilities through PBF incentives; emergency obstetric medical care; integrated maternal, neonatal, and child health services including ANC; and effective promotion of family planning. Rwanda has adopted gender-mainstreaming approaches to mitigate the impact of HIV/AIDS, malaria, and other infectious and chronic diseases, including: changing policies and programs to ensure that at-risk female commercial sex workers and transit camp detainees receive comprehensive HIV prevention, care and treatment services; targeting women and their partners for HIV counseling and testing and family planning services through ANC visits; providing 1 million long-lasting insecticide treated nets to children and pregnant women through ANC clinics; distributing new integrated M&E tools to antenatal clinics combining PMTCT, FP, immunization and malaria prevention; and establishing a national strategy for prevention, care, and treatment of cervical cancer. In addition, with USG support Rwanda has mainstreamed gender into most health areas, which has resulted in increased male involvement in health, as evidence through increased rates of modern contraceptive use, couples HIV VCT, and delivery in health facilities.

Under the GHI, the USG will continue to support the mainstreaming of gender into health services and programs. For example, the USG team will provide technical assistance to the MOH to implement a new national cervical cancer prevention, care, and treatment program – one of the first programs in Rwanda to address cancer. In support of a wide range of family planning options for couples and families, the USG will continue to support the introduction of vasectomy for men and the promotion of longer-term methods for women, such as hormonal implants, while continuing health education activities that dispel family planning myths and misconceptions, as well as teaching couples interpersonal communication skills and promoting HIV prevention. Furthermore, the USG will maintain its support for integrated approaches to health, particularly as linking the two increases access to and uptake of key health services, like VCT. The USG will continue its support for the training of relevant health professionals, in order to increase the services available to the population at decentralized levels. In addition to proven HIV prevention methods of behavior change, condom use promotion and PMTCT, the

USG will continue to focus on effective biomedical approaches such as MC. USG will continue to support the GOR in furthering: equitable access to health services; operationalization of the gender policy and increased participation of women and girls in planning, design, implementation and monitoring of health programs; prevention and responses to (S)GBV; and programs that foster and strengthen positive role models for boys and girls.

**Improving USG health program impact through strategic coordination and integration**

Rwandan policies and practices promote the delivery of integrated MCH, RH, family health, HIV, TB, malaria and other health services in the community and health facilities. The USG advances the GOR goal of integrated health services in policy formulation and strategic planning by providing direct technical and financial support to MOH units responsible for integration and decentralization, and community health, as well as for specific health concerns such as MCH and the control of communicable diseases. At the district level, the USG provides financial and technical support to district authorities to plan, manage and monitor integrated service delivery and progress towards improved health outcomes. At the facility and community level, the USG supports health providers to deliver essential health interventions in a timely manner and in compliance with quality standards of care. Going forward, the GOR has identified a critical need for the training of qualified health and facility managers. Rwanda's health programs are implemented in a highly integrated fashion: screening for both HIV and TB is conducted at the point of primary care, with the one-stop TB/HIV service model being the norm; PMTCT is integrated into antenatal and postnatal care where both services are available; and routine tools such as immunization cards and antenatal clinic registers are increasingly being integrated to ensure complete delivery of HIV, TB, IMCI, malaria and FP services. This national package of family health services is accomplished by leveraging the USG, Global Fund, GOR and other donor resources for HIV, TB, malaria, RH, and MCH. Under the GHI, the USG will continue to support Rwanda's smart integration, including the development of tools for integrated supervision, the promotion of integrated training for health care workers in both pre-service and in-service settings, and investments in infrastructure improvements (e.g., solar energy equipment, supply chain management) that benefit the Rwandan health system as a whole. This will represent an essential building block to ensure the overall readiness of the health system to tackle the challenge of chronic diseases. Continuity of care and integration between health care providers as well as between health centers, district, provincial and referral hospitals will be critical. Finally, the availability of highly trained health providers at all levels is important to ensure a well-functioning health system.

Rwanda's integrated health service delivery platform is a reflection of the GOR's emphasis on coordination across the health sector. The GOR utilizes donors' relative strengths through its active promotion of 'division of labor' amongst partners. As a lead donor in the health sector, the USG will play a more prominent role in the Development Partners Group (DPG) as well as in supporting the GOR in the coordination of the health sector as a shadow co-chair of the HSWG beginning January 2011. Under the HSWG, the USG co-chairs a number of Technical Working Groups, including Human Resources for Health, Quality of Services, Laboratory Services, Nutrition, and Prevention of Communicable Diseases. In addition to these structures, Rwanda employs a SWAp. As part of the SWAp, the GOR asks that all partners – Rwandan civil society,

the private sector, and international partner organizations – jointly participate in the development, implementation and evaluation of national strategic planning and policy documents, such as the HSSP II and associated sub-sector strategies, as well as National Strategy Applications (NSA) to the Global Fund. Through this framework of coordination across the health sector, partners – including the USG – align their contributions in support of the GOR goals and strategic plans.

**Strengthen and leverage key multilateral organizations, global health partnerships, and private sector engagement**

The USG has established strong collaborative working relationships in Rwanda with a number of multilateral organizations. Together with the One UN, White Ribbon Alliance, and the Global Alliance for Vaccines and Immunizations for example, the USG supports Rwanda's impressive immunization program, which has successfully introduced the pneumococcal vaccine and plans to introduce the rotavirus and H1N1 vaccines. Similarly, the USG coordinates closely with the World Bank on Rwanda's renowned PBF program and the East African regional laboratory capacity strengthening initiative. Similarly, the USG works closely with the GOR as principal recipients of Global Fund grants to ensure efficient and non-duplicative investments in HIV, malaria and TB programs and health systems strengthening. With the recent approval of the NSAs in HIV/AIDS and TB, the USG will continue to work to ensure harmonized implementation to support national health objectives. For example, the USG will continue to work closely with Global Fund on its new awards to CSOs focused on the shared goals of capacity building and community-level outreach. The USG also plans to participate in the development of the application of an NSA in malaria.

The Rwandan MOH has engaged the private sector in pursuit of its health aims. For example, with USG support the MOH with private telecommunication companies to implement a mobile phone information support program for CHWs. With regard to health systems, in addition to the existing national medical supplies store and pharmacies in the public health facilities, the MOH works with private pharmacies and logistics companies to ensure the availability of essential pharmaceuticals and health commodities. Most recently, the GOR secured a donation of HPV vaccine, which it plans to deploy as part of the new national program on cervical cancer. In addition, the GOR has leveraged private sector resources supporting Rwanda's Health Enterprise Architecture and is benefitting from the USG global Health Informatics Public Private Partnership, which is co-sponsored by Rockefeller Foundation, Gates Foundation and International Development Research Centre. With improved country ownership, clear roles and responsibilities, and enhanced engagement of the USG health team, this project has the potential to transform the Rwandan health information system. The USG support for public-private partnerships will continue to be important under the GHI, and the USG will continue to provide financial and technical advice to ensure that these partnerships realize health improvements. To this end, the USG will offer technical assistance for the M&E of the first national immunization campaign for HPV among school-aged girls (slated to begin in April 2011), the expansion of the CHW mobile phone program, and the engagement of private pharmacies in providing essential drugs and supplies.

**Build sustainability through health systems strengthening**

The current Rwandan health system is, in practical terms, little more than five years old. While various elements of the national health policy have been discussed and debated since the early post-genocide years, it was not until the Rwanda Health Sector Strategic Plan (HSSP I 2005–2009) and the complementary National Community Health Policy were developed in 2004 that the country had a blueprint for its health system. More importantly, it was not until the passage of the decentralization laws and the beginning of their implementation in 2005 – 2006, including the creation of district governments and corresponding elections, that a true health governance system became fully articulated. Key principles and practices that underlie and define the new system include: it is to be demand driven with communities identifying their needs and priorities; the health system is to respond to community needs; local governments are to be the focal point of accountability for health service facilities and the responsible body for their operations with authority for personnel and financial resources.

Rwanda's progress with decentralization reforms in the health sector is demonstrated through a number of traditional and new health-oriented, community-based organizations (CBOs), such as mutuelles, health center community committees (COSA), and CHW cooperatives, participating in a number of planning, management, and oversight functions at the sector- and district-levels. In the case of the mutuelles, they are also key elements of the district and sector health financing system, while CHWs are directly involved in service delivery at the community level. Both the mutuelles and the CHWs are the core elements of the community-based primary health care system. Significant authorities have been transferred to health facilities at the district (hospital and pharmacy) and sector (health center) levels. District administrations are now to be directly accountable for the overall management of these facilities while the MOH provides technical oversight. Each of the facilities has internal management committees (comité de gestion or COGES in health centers and administrative and finance committees in district hospitals) that together, with the community structures noted above, are to manage day-to-day operations.

Rwanda has devoted significant resources to strengthening its health system, leveraging resources from its national budget, the Global Fund, the USG, and other donors. With these resources, Rwanda has achieved worldwide recognition for its innovative health financing programs, such as PBF and community-based health insurance. These programs, as well as current efforts to determine the costs of essential health services and to pilot a web-based system to track all resources in the health sector, are supported by USG and other development partner funding and technical assistance.

The USG support extends to other health system strengthening pillars. For example, in support of the MOH's increased emphasis on HRH, the USG is investing significantly in HRH by supporting: the implementation of the HRH Strategic Plan; district- and facility-level burden of disease analyses to inform the deployment and retention of critical health cadres; the development and implementation of a HRIS to effectively manage HRH nationwide; and the strengthening of pre-service health science institutions. Further, the USG underwrites salaries and equipment (e.g., mobile phones, PDAs) for health care workers at the national, facility, and

community levels. The GOR vision is to emphasize long-term training for missing specialties in Rwanda.

With regard to health commodities, the USG invests significantly in ensuring the availability of pharmaceuticals, equipment and supplies for health service delivery. This includes capacity building of the national medical store to forecast, procure, store, and distribute health commodities; as well as assistance to the coordinated procurement and distribution system for all health commodities; technical assistance for the Pharmacy Department in MOH, and plans to support the establishment of the planned National Medicines Authority and the national pharmacovigilance system; support for an expanded cold chain in support of the introduction of new vaccines; and technical assistance to develop and implement PBF incentives within the supply chain system.

Improving the quality of services provided is another key area of both the GOR and the USG systems support. The USG is providing technical and financial assistance to the MOH to develop a national accreditation system for tertiary and secondary health facilities, as well as the laboratory network. Quality improvement modules are also being incorporated into pre-service curricula at institutions receiving USG assistance and a central level cadre of quality improvement supervisors is being developed with technical support from USG partners.

**Improve metrics, monitoring and evaluation**

The GOR has established nested, aligned sets of indicators and targets outlined in its various national plans, policies, and strategies. These deliberately selected indicators focus primarily on maternal and child mortality, FP/RH, HIV, malaria, and immunization. The USG supports the development of policies and systems to collect health information to monitor progress towards these indicators. For instance, the USG supports Rwanda's national HMIS, the formulation of E-Health and M&E policies, and the development of an IDSR. In addition, the USG provides technical and financial assistance for the implementation of Demographic and Health Surveys (DHS), behavioral surveillance surveys (BSS), national maternal death audits, and other surveillance activities. To complement these data collection activities, the USG supports routine data quality audits and promotes the use of data for decision-making. With USG support, Rwanda's innovative application of data triangulation has not only helped define the axes of the national HIV strategic plan as originally conceived, but it is now being extended to improve existing MCH programs and inform the upcoming third Health Sector Strategic Plan for 2012-2017.

Under the GHI, the USG will continue its broad support for E-Health systems (TRACnet, logistics management information systems, electronic medical records, HRIS), the implementation of national surveillance systems (IDSR, antenatal clinic HIV serosurveillance, TB and malaria surveillance), and building capacity of GOR agencies to conduct surveys and research (e.g., DHS, AIDS Indictor Survey (AIS), TB Prevalence Survey, BSS, national HIV care and treatment program evaluations, immunization coverage surveys). The USG-GOR partnership will prioritize capacity building and support for dissemination of surveys and evaluation results, both to improve programs in Rwanda as well as to inform the global public health and scientific communities.

**Encourage country ownership and invest in country-led plans**

In Rwanda, the reality and practice of country ownership is advanced and partners are already aligned with national strategies and vision. Rwanda's commitment to improved health was most recently acknowledged in January 2011 by the Africa Public Health Alliance, 15%+ Campaign, and WHO, when they ranked Rwanda as the country in Africa to allocate the highest percentage of its domestic budget to health in support of the MDGs and African health. Rwanda's remarkable progress in health is in large part due to the GOR's clear vision for and commitment to attaining the MDGs articulated within health sector and sub-sector strategic plans. With sound national goals, policies and strategic plans for improved health available, the USG has chosen to directly adopted Rwanda's national goals and objectives, thus furthering country ownership and investments in country-led plans. Under PEPFAR II and the GHI, the USG has increased the amounts of funding directed to government agencies and local CSOs. Funding going directly to GOR institutions has increased since 2008, and the USG is continuing to explore opportunities to expand direct agreements with local institutions, including those in the public sector and within civil society. Presently, the USG directly finances seven national health institutions, including the MOH, TRAC Plus, the School of Public Health, the Kigali Health Institute, CNLS, the National Blood Transfusion Center and the NRL. One of the principal activities supported directly is the transition of the Department of Health and Human Services supported Track 1.0 HIV clinical services program, which will be completed by the end of 2012. Rwanda is the only country in which the host government will assume sole responsibility for management of these services, and the hand-over is managed by a Transition Task Force comprised of the USG, GOR, and US implementing partners. More generally, beginning in FY2011 and in support of the GHI, direct investments are expected to increase through both existing and new mechanisms with both the GOR and civil society to promote sustained implementation in the longer-term. The USG will continue to support implementation of the Strategic Plan for HRH, which emphasizes the creation of a critical mass of trained health professionals at most levels of the health system. These direct investments in GOR institutions will continue to be rigorously monitored through partnership with the USG.

Under strong GOR leadership, Rwanda has directed its own health programs in theory and in practice for many years, and country ownership is fundamental to the GOR-USG relationship. Both the GOR and the USG have recognized, however, that strong government ownership does not alone constitute country ownership. Within the HSWG, the MOH has allocated seats to key civil society and private sector constituencies, and using their Global Fund grants, they have launched a program to fund over 100 non-governmental institutions to actively provide health interventions and services in support of Rwanda's ambitious health targets. In support of the GHI, the USG will continue to actively support the participation of civil society and the private sector in the health sector, through direct grants, advocacy and technical advice, and looks forward to collaborating with all stakeholders in Rwanda in order to achieve its collective goals for a coordinated and participatory health system.

**Promote research and innovation**

Rwanda is well-known in health sector circles for its innovation and proven track record in achieving impressive health gains. For example, PBF in a resource poor setting was first successfully piloted and subsequently launched nation-wide in Rwanda. Many other countries, such as Mozambique and Zambia, are looking to Rwanda for guidance on the application of PBF in their own countries. Similarly, Rwanda was one of the first countries to successfully introduce a community-based health insurance system that now provides financing at the community and facility level for many key services, such as ANC, post-partum and infant consultations, referral and accompaniment of pregnant mothers to deliver at health facilities, nutrition monitoring for under-fives and referrals for family planning services. Another example of innovation includes the introduction of home-based management of diarrheal diseases and febrile illnesses through the universal use of rapid diagnostic tests for malaria. The GOR and the USG support this activity with a view toward achieving timely detection and treatment of malaria, which remains among the leading causes of morbidity and mortality in under-fives, although remarkable progress has been achieved in combating this disease. The USG also supports community distribution of family planning methods including injectable contraception to address the unmet need, and adoption of the Kangaroo mother care system.

In support of Rwanda's engagement in substantive programmatic innovation, the USG has consistently supported the expansion of Rwanda's capacity for program evaluation and operations research. Examples abound of innovative research undertaken in Rwanda with USG support. Consistent with the principle of country ownership, a priority goal of the USG is to support national institutions to implement research projects with high quality, to strengthen capacity for data analysis and manuscript development, and to disseminate the findings in national and international fora (conferences, peer-reviewed journals). Rwanda is one of the only countries to implement "option B" of the 2010 WHO PMTCT guidelines, in which HIV-infected mothers will receive highly active antiretroviral therapy (HAART) as their PMTCT regimen from 14 weeks gestation through the duration of breastfeeding. Consequently, Rwanda is conducting an evaluation of HIV-free survival amongst infants born to HIV-infected mothers who receive this regimen. Numerous other nationally representative evaluations have been or will be undertaken in support of key HIV interventions, including: adult and pediatric ART evaluations, serodiscordant couples program evaluation, and evaluation of the HIV/AIDS electronic reporting system. With malaria, Rwanda is conducting a household survey to assess the duration of insecticide impregnation of bednets, and an evaluation of home-based malaria case management. A national TB prevalence survey is planned for 2011 with support from WHO, the USG and other partners. Complementary to surveys and evaluations, the USG supports sentinel surveillance, for example the system for influenza has demonstrated the burden of influenza-like illness and severe ARI in children aged less than five years. As Rwanda achieves gains in controlling the major infectious diseases (HIV, TB, malaria), the MOH is paying greater attention to the emergence of non-communicable diseases including cancer, diabetes, and hypertension in the population. The USG is also supporting the MOH technically and financially with the implementation of a WHO STEPS survey to establish the baseline epidemiology of non-communicable diseases in Rwanda. Finally, the GOR and the USG have and will continue to collaborate on activities aimed at generating a robust epidemiologic base for on-going HIV programming in the context of already high service coverage and ambitious

national coverage targets. For example, in 2012-2013, the GOR and the USG (via Global Fund and PEPFAR funding) will support the first AIS in Rwanda, including CD4 cell count measures. This will make Rwanda only the second country in the region (after Kenya) to develop an immunologic profile of the HIV-infected population which will allow for more effective targeting of services in order to reach the goal of universal access to ART, among other goals.

The USG is committed to generating evidence and promoting best practices to meet national and global knowledge needs. The USG continues to support the GOR health interventions, particularly those that are backed by strong government commitment like family planning and the availability of relevant qualified providers, and to this end the USG supports operational research that includes: identifying barriers (e.g., physical and economic access, psychosocial factors and provider skills and biases) to expanded contraceptive use; the feasibility of postpartum family planning using the intrauterine device (IUD), currently a method that is not widely practiced but which is gaining acceptance; and the acceptability and provision of non-scalpel vasectomy. The USG also supports efforts to determine the quality of care for obstetric services, and to assess the facilities preparedness for emergency obstetric care, including post-abortion care at the facility and community levels. The USG supports integration of health services, and studies are underway to enhance family planning access and uptake in immunization services, and to improve care for HIV-exposed infants through immunization programs with an expanded child health card.

## C. GHI Engagement with Government, Civil Society and Other Stakeholders

The implementation of the GHI in Rwanda will be coordinated with the GOR and in consultation with other donors and stakeholders, including civil society, professional associations and the private sector. The USG health team leverage established relationships and collaborate with all key stakeholders primarily through the HSWG and associated technical working groups (TWG), co-chaired by the GOR and development partners. In addition, through active participation in the twice-yearly Joint Health Sector Reviews, the Country Coordinating Mechanism for Global Fund and other planning and review meetings at the national, regional and district level, the USG will leverage implementation of the GHI with all stakeholders in the health sector. Collaboration with other donors will be assured through the health sector DPG, the overarching Development Partners Coordination Group, and other relevant forums. As noted previously, increased efforts will be made to harmonize the USG health sector activities with the Global Fund in order to maximize investments and increase efficiencies.

A priority focus of USG work in Rwanda is to transition activities from being primarily supported through the U.S.-based international non-governmental organizations (NGOs), with local organizations and health facilities as sub-recipients with GOR oversight and direction over to direct agreements with local institutions. Currently, there are direct agreements to seven GOR entities and they have all demonstrated improved program and financial management. The USG is continuing to broaden the possible options for support to the host government using their own structures. In addition, USG intends to develop direct agreements with local civil society organizations. This will enhance Rwanda's capacity to manage both USG and other

funding, including the Global Fund. In addition, it will increase the use of direct national mechanisms to disburse and manage funds.

Within a decentralized system, the districts and communities are key players. The USG will continue to support District Health Administrations in planning, managing and supervising health services delivery, and managing and allocating resources, complementary to continued support for health facilities and CHWs to deliver evidence-based, high quality interventions. The USG will continue to support training for better, decentralized decision-making.

## D. GHI Implementation Arrangements

The GHI in Rwanda will be guided by the overall direction of the US Ambassador or his or her designee. The Ambassador will have responsibility for ensuring that the GHI strategy is being carried out according to the GHI principles and that the USG team is working through a whole of government approach to diplomacy, development and defense. The Ambassador will sign all relevant documents including the GHI Strategy that will officially be submitted to headquarters, after being endorsed by the GOR.

The GHI Planning Lead (currently the PEPFAR coordinator) will serve a convening function, bringing together the USG agencies working in health, including but not limited to HHS/CDC, DOD, DOS/Embassy, Peace Corps, and USAID, and serve a secretariat function to ensure that the GHI documentation is complete, annual progress results and reports are captured and reported as per requirements. The governance structure will include expanding the scope of the interagency PEPFAR Management Team to be renamed the GHI Management Team. The current PEPFAR Management Team includes representation from all of the USG agencies working in the health area. Expanding the scope of this group is the most efficient and logical way forward as the same individuals will be involved in managing both initiatives. The new GHI Management Team meets on a weekly or bimonthly basis and is chaired by the Ambassador or his designee. In order to maximize the USG investments in cross-cutting development programs, the GHI Planning Lead will also convene, from time to time, broader USG meetings in order to explore greater efficiencies and effectiveness. This interagency collaborative structure has already been used in order to facilitate the GHI process in-country without overburdening the USG health team with additional meetings.

The components of this strategy have been developed by the USG interagency team. The GHI/Rwanda Team will develop guiding principles on how the agencies will share input into design and planning of activities and programs, and will develop a harmonized approach to USG-supported technical assistance. Each agency will take responsibility for ensuring that an inclusive process is followed for planning and implementing programmatic priorities. Such a process is expected to maximize integration and coordination and will strive to align with the GOR fiscal year and timeframes. The GHI team will review the overall program focus and budget but individual agencies will be responsible for overseeing their own budgets. The agencies together will be responsible for collecting and reporting of all results.

# V. MONITORING AND EVALUATION

## A. RESULTS FRAMEWORK

The Results Framework that the USG will be supporting under the GHI is that of the GOR, as outlined in the HSSP II document (see Appendix A for the diagram). The specific program areas supported under HSSP II are categorized along two axes: three strategic objectives which are supported by seven strategic programs. The strategic objectives contain all objectives and outputs directly related to improving the health outcomes. The seven strategic programs are cross-cutting issues that provide an enabling environment for service delivery to be optimally effective and efficient. These strategic programs all relate to health system strengthening and improvements in these areas are essential to ensure that the three strategic objectives are met. All interventions in the HSSP II are divided into three service delivery modes: family oriented community-based services (including household behavior change activities, and CHW services); population-oriented services (including outreach and campaigns); and individual-oriented clinical services (including diagnosis and treatment). These levels of interventions are offered in a continuous manner so that they can respond to unpredictable health emergencies.

The USG focus areas under the GHI are both reflected in the Results Framework. Human and institutional capacity building are included as the top two strategic programs that provide an enabling environment for high quality, sustainable health services. Improving gender equality is also a critical cross-cutting requirement in order to ensure that each of the three strategic objectives are met. Viewing activities with a gender lens will ensure that men and women have equal access to information, are equally able to accessing services, and have equal opportunities for healthy, productive lives.

## B. METRICS

Given its support for the GHI principles and target areas, in addition to aligning with the Paris and Accra Declarations, the USG has purposefully adopted the HSSP II framework as its GHI results framework. In doing so, the USG also ensures direct alignment with national priorities and objectives. Similarly, the USG will monitor progress and evaluate effectiveness of the GHI implementation in Rwanda using nationally adopted health indicators, tools and timelines. This will avoid any additional reporting burden and facilitate data use at all levels.

To specifically measure the two GHI Priority Areas, the team has selected specific national indicators and targets which will be compared with baseline information in order to measure progress. The USG health team believes that capacity building is an approach to be adopted throughout the program, rather than a set of specific activities. Thus, a key indicator of progress towards strengthening the human and institutional capacity of the public health system to plan, manage and implement sustainable health programs at all levels is the health impact of national programs. In addition to evaluating improvements in human resource

capacity, availability and performance, the USG will continue to monitor Rwanda's progress towards reaching its HSSP II, EPDRS, and MDG targets (see Appendix E).

Given that the objective of achieving gender equality is common to all Rwandan national plans and programs, there are a plethora of national indicators and targets related to gender. The USG health team has chosen to adopt sixteen of these key indicators and targets for its GHI Strategy. These indicators and targets are listed in Appendix D, along with their baseline levels, strategic sources and the corresponding GHI target area(s). This combination of output and outcome indicators covers six GHI target areas and were chosen to reflect the GHI's global aims, as well as important national objectives that the team believes will support the attainment of these health targets in the long run, such as girls' access to education, or girls getting advanced degrees in health, such as in nursing and midwifery. The USG health portfolio already supports activities which contribute to each of these targets, but commits to continuing this collaboration and encouraging the GOR to make these interventions more effective, efficient, and sustainable.

## C. LEARNING AGENDA: SHARING LESSONS LEARNED

As discussed in the section on promoting research and innovation, there is already much work being undertaken in this area. The GHI Strategy priority areas allow for opportunities to review and focus investments in research, innovation, M&E to address important questions that are immediately relevant to both the GHI and Rwandan principles and objectives. As described above, the USG learning agenda priorities closely mirror those of the GOR that have been defined in the HSSP II, HIV NSP, and TB NSP, among other key strategic planning documents. The USG team recognizes that program evaluation and operations research opportunities and priorities are dynamic and is open to help support other regional and/or headquarters based learning agenda's in a manner consistent with country ownership. Furthermore, the USG team believes that Rwanda has much to contribute to south-to-south and south-to-north learning exchanges and capacity building, and as such strives to support those efforts. Lastly, as part of its overall fiduciary responsibility, the USG recommits itself to the transparent and comprehensive evaluation, reporting and dissemination of results from health programs and projects supported by US taxpayer monies.

In an effort to support improved south-to-south and south-to-north learning, the team proposes to support information sharing related to Rwanda's experience with country ownership. Rwanda is a model of how country ownership is a critical tool to improving health outcomes in developing countries. Providing information on the experience here, through such items as policy papers, study tours, presentations at international conferences, etc., will help to strengthen the global understanding of country ownership. These particular learning agenda items will be undertaken as a collaborative effort between the USG team and the GOR.

### PRIORITY AREA 1: CAPACITY BUILDING

There are a number of areas in which Rwanda's lessons learned would contribute to the national and international knowledge base for human and institutional capacity building. As part of Rwanda's continuing progress toward local ownership, the USG team proposes a learning agenda that covers the use of host country systems to build capacity from the national to the community level for government and non-governmental organizations.

The USG team will develop lessons learned that may provide useful regional and global best practices. Specific examples of progress that Rwanda has to share include the creation of academic partnerships to scale up the quality and quantity of human resources for health, the development and deployment of the national resource tracking database; transition of clinical and non-clinical health services; innovations in PBF, including the impact on medium- and long-term health outcomes; the generation of an evolving cadre of field epidemiologists skilled at disease surveillance, outbreak identification, investigation and response; institutionalization of IRS activities to local districts; and the development of a national commodity procurement and distribution system. As another key part of the global learning agenda, the USG recognizes that there are gaps in measurement indicators for capacity-building. The team has developed proposed indicators for the GHI Strategy, but seeks to continue refinement of these indicators in conjunction with the global dialogue on this issue. The USG Rwanda would like to engage with its partners in Rwanda, the TWGs in USG headquarters and with global institutions to develop a better understanding of how to measure progress in human and institutional capacity-building.

### PRIORITY AREA 2: GENDER EQUALITY

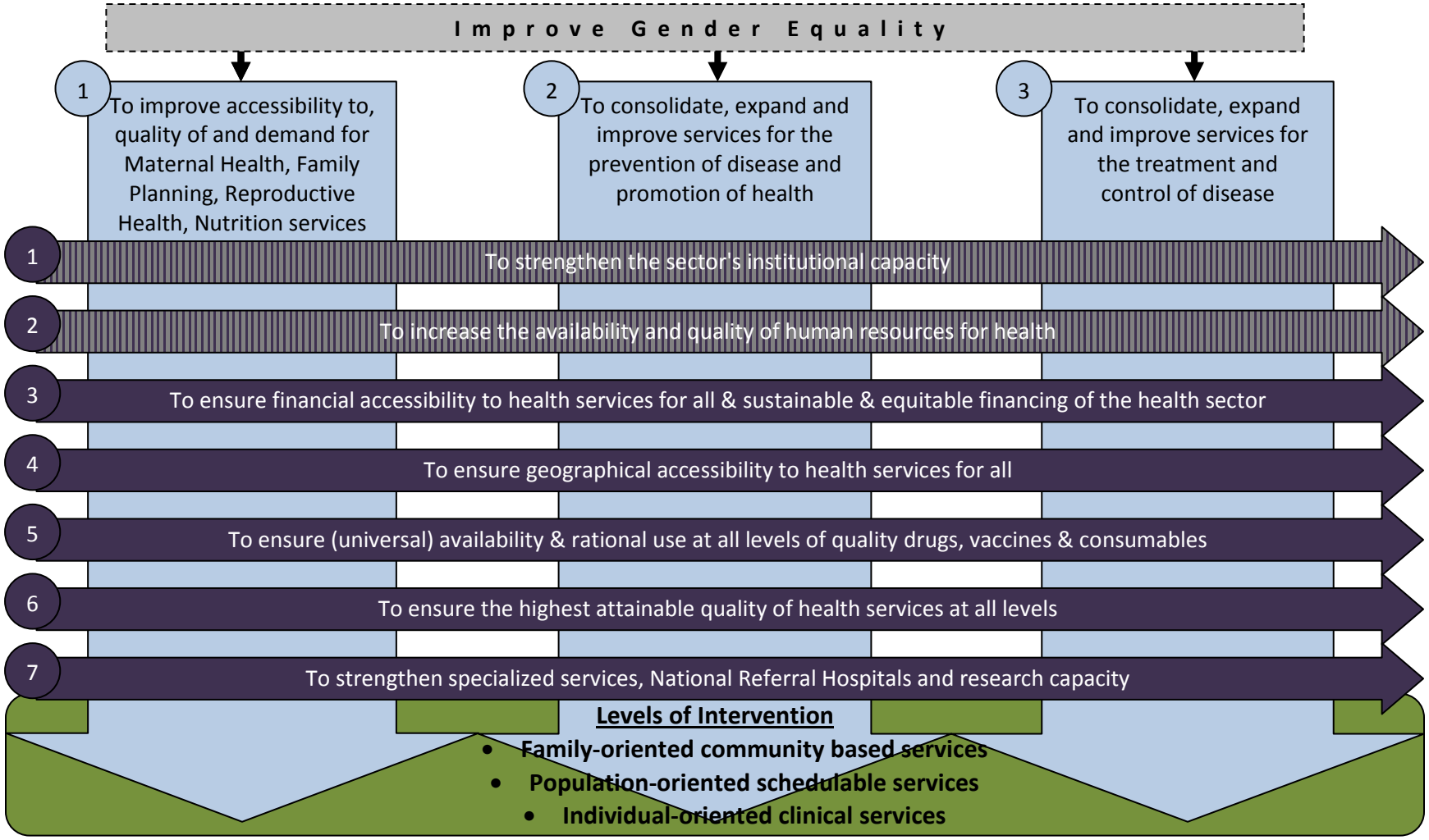
The proposed learning agenda regarding gender encompasses a broad spectrum of challenges and opportunities. The majority of ongoing program evaluations, surveys, and surveillance studies will be or have been analyzed according to gender. Currently planned or implemented research activities, presented in order of priority, include: an assessment of barriers to uptake of family planning; study on cross-generational sex; analyses of sexual risk behavior in CSWs, youth, and other vulnerable populations; a pilot project on the health-seeking behavior of men who have sex with men (MSM) and provider perceptions of MSM; an assessment of the readiness of providers to provide post-abortion care; and secondary analysis of data from the DOS Office of the Global AIDS Coordinator Special Initiative on SGBV in Rwanda.

With additional resources, possible additional areas for the team to explore as part of the learning agenda, in rank order, are: an examination of the root causes of persistently low levels of full ANC visits; a needs assessment and size estimation related to vulnerable populations; an evaluation of gender equality activities in rural areas; enhanced M&E (coverage, safety, and impact) of the introduction of the new HPV vaccine in adolescent girls; evaluations of clinical algorithms for screening and treatment of cervical cancer in adult women; and a review of strategies to better design health services for men. In addition, a main area of interest for the team is SGBV, and particular questions to be explored on this front include: rates of SGBV among children; the strength of service linkages; male perceptions and norms regarding SGBV; the relationship between mental health and SGBV; and the role of alcohol in SGBV.

The USG health team also believes that there are success stories and lessons learned in Rwanda that may be of help to other countries. Specific examples of Rwanda's great progress, in order of global relevance, include: increasing male involvement in VCT, ANC and immunizations; rapid uptake of family planning and the political commitment around this issue; changing cultural norms on MC; the implementation of a new girl-friendly model for youth centers; and the development and implementation of policies and laws to enforce gender equality. A feature common to all of these success stories is the high level of political commitment from the GOR and civil society, a feature which would also be explored as part of the learning agenda.

# VI. APPENDICES

## A. RESULTS FRAMEWORK




The Results Framework is taken directly from the Rwanda HSSP II. The USG/Rwanda health team added "improve gender equality" and changed the shading on the two capacity building priorities in order to reflect the priority areas for the GHI Strategy.

## B. RESULTS MATRIX

The below Results Matrix includes national level information on baselines and targets, priorities and initiatives and key priorities. The USG health program contributes to some of the activities to achieve these results, but does not have activities in all areas described below.

| GHI Global Area | Baseline info/Country-specific GHI Target | Relevant Key National Priorities/Initiatives | Key Priority Actions Likely to Have Largest Impact | Key Partners |
|---|---|---|---|---|
| **HIV/AIDS:**<br>Support the prevention of more than 12 million new infections;<br><br>Provide direct support for more than 4 million people on treatment;<br><br>Support care for more than 12 million people, including 5 million orphans and vulnerable children. | New HIV infections/year<br>-Current Estimate: 9,040<br>-Target: 4,680<br><br>Number in facility-based care:<br>-Current: 174,090 (June 2010)<br>-Target: 188,200 (in 2012)<br>USG Target: 122,025 (in 2012)<br><br>Number in treatment:<br>-Current: 83,041 (June 2010<br>-Target: 115,100 (in 2012)<br>USG Target: 72,321 (in 2012) | From the NSP for HIV/AIDS 2009-2012:<br><br>Prevention<br>• Reduction of sexual transmission of HIV<br>• Reduction of vertical (mother-to child) transmission of HIV<br>• Maintenance of low levels of blood-borne transmission of HIV<br>Care<br>• PLWHAs receive care and support according to needs<br>• PLWHAs systematically received OI prophylaxis, treatment, and other co-infection treatment<br>• People infected/affected by HIV (including child headed households) have improved economic opportunities and social protection<br>• Social and economic protection are ensured for orphans and vulnerable children<br>• Reduction of stigma and discrimination of PLWHA and OVC in the community<br>Treatment | Prevention<br>• General population reached by comprehensive HIV prevention programs<br>• Women aged 15-24 are at reduced risk of HIV infection<br>• MARPs and other vulnerable are reached with comprehensive prevention programs<br>• HIV infections resulting from SGBV are prevented<br>• Male and female condoms are available and accessible for all populations<br>• Newborn boys, adolescents and adults have increased access to circumcision<br>• Increased availability and accessibility of high quality STI treatment<br>• Extension of PMTCT program to all Health facilities in the country<br>• Ensuring that HIV positive women have access to FP services<br>• Reinforcement of universal precautions in all Health facilities | Global Fund, One UN (UNDP, UNFPA, UNHCR,UNICEF, UNAIDS, UNIFEM, WHO), GLIA, the private sector, BTC, GTZ, Netherlands Embassy, Lux-Development, SIDA, DFID, Partners in Health, CHAI |

| GHI Global Area | Baseline info/Country-specific GHI Target | Relevant Key National Priorities/Initiatives | Key Priority Actions Likely to Have Largest Impact | Key Partners |
|---|---|---|---|---|
| | | • PLWHAs eligible for ART receive it<br>Health system (overall)<br>• Strengthening the health system to ensure that it is responsive to the needs of the Rwandan population | • Ensure access to PEP for all health care workers and other cases in need<br>Care<br>• PLWHAs and STIs receive systematic screening and treatment for STIs<br>• PLWHAs and TB receive appropriate treatment for TB<br>• HIV-positive Rwandans are identified in order to initiate treatment by:<br>o Increasing communication campaigns to encourage HIV testing<br>o Increasing service coverage to health centers including VCT and PIT<br>o Public private partnerships for expanding HIV testing<br>Treatment<br>• Increase the availability and coverage of ART at health facilities by:<br>o Strengthen the supply and distribution of drugs and commodities<br>o Implementation of task shifting | |
| **TB:**<br>Save approximately 1.3 | **Prevalence rate**<br>1990: 242 TB cases (all | From the GOR's TB NSP, 2009-2012:<br>• Decrease **TB prevalence** by | • Develop one USG TB plan, based on TB NSP | TRAC Plus TB and HAS Units, MOH, |

| GHI Global Area | Baseline info/Country-specific GHI Target | Relevant Key National Priorities/Initiatives | Key Priority Actions Likely to Have Largest Impact | Key Partners |
|---|---|---|---|---|
| million lives by treating a minimum of 2.6 million new TB cases and 57,200 MDR cases of TB, contributing to a 50% reduction in TB deaths and disease burden. | forms) /100,000 inhabitants (124 NPTM+/ 100,000; Global TB control WHO TB report 2008)<br><br>Number (%) of **TB suspects tested for HIV:** 7% in 2008<br><br>Number (%) of **notified MDR TB cases (bacteriologically confirmed)** among expected cases: 74 (37%) in 2008<br><br>**Treatment success rate among MDR TB cases**: 87% in 2008<br><br>USG Targets:<br>Percent and number of HIV-positive patients who were screened for TB in HIV care or treatment settings: 93%/113,483 (in 2012) | 50% by the year 2015 compared to 1990, approximately 121 TB cases (all forms) /100,000 (62 smear-positive TB / 100,000)<br>• Increase **TB case detection rate** to 70% at national level. (This indicator will be informed by TB prevalence survey in 2011).<br>• Maintain new SS+ TB **treatment success rate** at 87% in 2011 and 2012<br>• Maintain % **TB patients tested for HIV** at 97%<br>• 80% of **TB suspects tested for HIV** by 2012<br>• 95% of **TB/HIV patients receiving CTX** during TB treatment by 2012<br>• 70% **TB/HIV patients receiving ART by the end of TB treatment** in 2012<br>• 95% of **TB Diagnostic and Treatment Centers with functional "one stop TB/HIV service"** by 2012<br>• 100% **notified MDR TB cases (bacteriologically confirmed)** among expected cases by 2012 (206 MDR-TB cases)<br>• Maintain **treatment success rate among MDR TB cases** at 88% | • Improve TB screening among HIV positives and HIV testing in TB suspects<br>• Improve ART linkages for TB/HIV patients<br>• Improve and expand TB diagnostic services at NRL, intermediate lab network, and District Hospital level, including new technologies such as GENEXPERT.<br>• Strengthen TB, TB/HIV, and MDR TB surveillance, including 2011 TB prevalence survey<br>• Support the MDR TB COE implementation plan<br>• Expand infection control activities<br>• Continue to base PEPFAR COP programming decisions on gaps analysis of TB NSA | NRL, SPH, WHO, Global Fund, Partners in Health, World Bank, PIOs |
| **Malaria:**<br>(1) Halve the burden of | Current est. of **prevalence**: 3% | • 90% <5 correctly treated within 24 hours | • Procurement, distribution and promotion of LLINs | MOH, PIOs |

| GHI Global Area | Baseline info/Country-specific GHI Target | Relevant Key National Priorities/Initiatives | Key Priority Actions Likely to Have Largest Impact | Key Partners |
|---|---|---|---|---|
| malaria for 450 million people, representing 70 percent of the at-risk population in Africa. | Target prevalence: 2%<br><br>Current est. **incidence**: 1.25 million cases in 2009<br>Target incidence: 500,000<br><br>Current estimate of **deaths**: 856<br>Target reduction in deaths: 20%<br><br>USG Targets:<br>Number of houses sprayed with IRS with USG support: 360,000 (in 2012)<br><br>Number of artemisinin-based combination treatments distributed with USG funds: 180,000 (in 2012) | • 100% diagnostic confirmation<br>• 85% LLIN use (pregnant women, children <5)<br>• Prompt detection of epidemics<br>• 90% IRS coverage in target areas | • Annual IRS round for up to 360,000 structures<br>• Strengthen malaria diagnostics at health facility and community level<br>• Support for community case management<br>• Expand NMCP capacity to conduct routine entomologic monitoring | |
| **Maternal Health:**<br>Reduce maternal mortality by 30% across assisted countries | Current **estimate**:<br>-**Maternal mortality rate**: 750 per 100,000 live births (DHS 2005)<br><br>Target:<br>- 600 per 100,000 live births by 2012 (HSSPII) and 200 per 100,000 live birth by 2020 (Vision 2020)<br><br>USG Targets: | From the MOH's HSSPII as it feeds into the GOR's Vision 2020:<br><br>• Decrease the fertility rate from 5.5 (IDHS) to 4.5 (HSSPII)<br>• Increase the number of women in unions (15-49) using modern contraceptives from 27% to 50%<br>• Increase % of pregnant women with 4 antenatal visits from 23.9 % to 50%<br>• Increase the % of deliveries in | • Improve accessibility and quality of FP/RH services especially long term contraceptives<br>• Promote four ANC visits during pregnancy, starting in the first trimester, with integrated PMTCT services<br>• Ensure that all deliveries are attended by qualified staff at health facilities<br>• Ensure provision of emergency obstetric and neo- | MOH, WHO, Global Fund, UNICEF, UNFPA, UNDP, UNAIDS, DFID, GTZ, BTC, World Bank, SDC, Lux Development |

| GHI Global Area | Baseline info/Country-specific GHI Target | Relevant Key National Priorities/Initiatives | Key Priority Actions Likely to Have Largest Impact | Key Partners |
|---|---|---|---|---|
| | Number of ANC visits by skilled providers from USG-assisted facilities: 260,143 (in 2012)<br><br>Percent of women with at least one ANC visit: 95% (in 2012)<br><br>Number of deliveries with a skilled birth attendant in USG-assisted programs: 207,823 (in 2012) | Health Facilitates from 45.2% to 50%<br>• Increase the % of women using ITNs from 12.8% to 85%<br>• Increase normal delivery by skilled attendant from 52% to 55%<br>• Increase active management of the third stage of labor from 22% to 55% | natal services including referrals<br>• Build capacity for managing obstetric emergencies including post-abortion care<br>• Initiate use of misoprostol and monitor its implementation to improve management of postpartum hemorrhave<br>• Develop clear guidelines/policy for roles and responsibilities in care of SGBV victims at all levels of the health sector<br>• Expand integrated community health care package to all 30 districts<br>• Strengthen postpartum care within the first 48 hours, 72 hours and first week, particularly for those delivering at home<br>• Promote good nutrition practices, including under fives, school children, pregnant and breastfeeding women<br>• Define a minimum package of services for adolescent reproductive health. | |
| **Child Health:**<br>Reduce under five mortality rates by 35% across assisted countries | Current estimate:<br>-**Infant mortality rate**: 62 deaths per 1,000 live births<br>**-Child mortality:** 103 | From the MOH's HSSPII as it feeds into the GOR's Vision 2020:<br><br>• Decrease infant mortality rate from 62 to 50 death per 1,000 | • Strengthen postnatal care within the first three days<br>• Support essential newborn care, including resuscitation, as a standard component of | MOH, WHO, Global Fund, UNICEF, UNDP, UNAIDS, DFID, GTZ, BTC, World Bank, Saudi |

| GHI Global Area | Baseline info/Country-specific GHI Target | Relevant Key National Priorities/Initiatives | Key Priority Actions Likely to Have Largest Impact | Key Partners |
|---|---|---|---|---|
| | deaths per 1,000 live births<br>Target:<br>**-Infant mortality rate:** 50 deaths per 1,000 live births<br>**-Child mortality rate (U5):** 70 deaths per 1,000 live births by 2012<br><br>USG Targets:<br>Number of children less than 12 months of age who received DPT3 from USG-supported programs: 132,332 (in 2012)<br><br>Number of children under 5 years of age who received vitamin A from USG-supported programs: 385,197 (in 2012) | live births by 2012<br>• Decrease under 5 mortality rate from 103 to 70 deaths per 1,000 live births | emergency care<br>• Increase essential interventions: the full integrated management of neonatal and childhood illnesses package became available in 71% of health centers<br>• Expand integrated community health care package to all 30 districts<br>• Strengthen integrated management of neonatal and childhood illnesses in all health facilities<br>• Continued expansion of immunization services including Pneumococcal conjugate and rotavirus<br>• Promotion of exclusive breast-feeding for 0-6 months<br>• Promote good nutrition practices, including under fives, school children, pregnant women and breastfeeding mothers<br>• Reduced prevalence of soil transmitted helminthes in school aged children (NTDs) | Fund, SDC, Lux Development, PIOs |
| **Nutrition:**<br>Reduce child under-nutrition by 30% across assisted food insecure countries in conjunction with the President's Feed the Future | Current estimate (2005 DHS):<br>Chronic malnutrition (**stunting**): 45%;<br>**Underweight**: 22%,<br>Acute malnutrition | • From **National Multi-sectoral Strategy** to **Eliminate Malnutrition**:<br>• Strengthen identification and management of under-nutrition | • Annual screening and identification of malnutrition and sharing of results at district level<br>• Incorporate nutrition in the curriculum of medical, public | FAO, WFP, Global Fund, CHAI, MINAGRI, UNICEF, WHO, MOH, PIOs |

| GHI Global Area | Baseline info/Country-specific GHI Target | Relevant Key National Priorities/Initiatives | Key Priority Actions Likely to Have Largest Impact | Key Partners |
|---|---|---|---|---|
| Initiative | (**wasting**): 4%<br><br>Targets (2013):<br>Chronic malnutrition (**stunting**): 36.4%;<br>**Underweight**: 10.3%<br>Acute malnutrition (**wasting**): 3%<br><br>USG Targets:<br>Prevalence of exclusive breast feeding of children under six months: 90% (in 2012) | • Strengthen and scale up community-based nutrition intervention programs to prevent and manage malnutrition in children under age 5, and in pregnant and lactating mothers<br>• Eliminate micronutrient deficiencies<br>• Complete multi-sectoral district plans to eliminate malnutrition<br>• Prevent and manage nutritional deficiency and excess-related diseases<br>• BCC<br>• Coordinate nutrition partners<br>• Monitor and evaluate nutrition activities at all levels | health and nursing schools<br>• Iron/folate supplementation during ANC visits<br>• Develop community based mobilization tools and cascade training sessions for CHW<br>• Provision of 1500 cows to households with severely malnourished children in districts with highest prevalence of malnutrition<br>• Organize cooking demonstrations at village level<br>• Promote home-based food fortification or use of fortified complementary food products<br>• Promote establishment of akarima k'igikoni (kitchen gardens) and household consumption of produce | |
| **Family Planning and Reproductive Health:**<br>Prevent 54 million unintended pregnancies;<br><br>Reach a modern contraceptive prevalence rate of 35 percent across assisted countries, reflecting an average 2 percentage annual increase by 2014;<br><br>Reduce from 24 to 20 | Current estimate of contraceptive prevalence: 27% (IDHS 2007/8)<br>Target contraceptive prevalence: 70% (2012, EDPRS)<br><br>Adolescent pregnancy: 4.5%<br>Target: 2%<br><br>USG Targets:<br>Number of USG-assisted | National FP Action Plan:<br>1. Improve geographic accessibility to FP services<br>2. Increase accessibility to FP for adolescents<br>3. Increase community mobilization to address myths and misconceptions<br>4. Strengthen and focus advocacy<br>5. Reinforce integration of FP into other services and increase access to full range of services<br>6. Strengthen private sector | • Training of CHW<br>• Integrate youth FP service delivery at all levels<br>• Training and supportive supervision of CSOs in BCC approaches<br>• Community-based distribution of contraceptives<br>• FP advocacy at all levels<br>• Reinforce vasectomy service delivery<br>• Strengthen capacity in FP/MCH/HIV integration; | MOH, UNFPA, GTZ, IPPF, KfW, Hewlett Foundation |

| GHI Global Area | Baseline info/Country-specific GHI Target | Relevant Key National Priorities/Initiatives | Key Priority Actions Likely to Have Largest Impact | Key Partners |
|---|---|---|---|---|
| percent the proportion of women aged 18 -24 who have their first birth before age 18 | service delivery points providing FP counseling or services: 716 (in 2012)<br><br>Number of new family planning users: 25,639 (in 2012) | partnerships for increased coverage<br>7. Assure quality and formative supervision in public and private sectors<br>8. Develop sustainable financing<br>9. Reinforce increased use of evidenced-based decision making<br>10. Increase access to FP commodities | Ensure all providers have necessary skills to integrate FP, safe motherhood, PMTCT, and malaria prevention and treatment<br>• Complete key evaluations of feasibility of post-partum IUD, barriers to contraceptive use, men's attitudes towards modern contraception, and expanding post-partum FP uptake in immunization services | |
| **NTDs:**<br>Reduce the prevalence of 7 NTDs by 50% among 70% of the affected population, contributing to:<br>(1) The elimination of oncho-cerciasis in Latin America by 2016;<br>(2) The elimination of lymphatic filariasis globally by 2020; and<br>(3) The elimination of leprosy. | Prevalence of **STH** among school-aged children was 66% in 2008 (TRAC Plus, 2009)<br><br>Prevalence of **schistosomiasis mansoni** among school-aged children was 2.7% in 2008 (TRAC Plus, 2009)<br><br>Overall prevalence (in 2 Districts) of active **trachoma infections** <2% (lower than WHO threshold of 10% to designate a disease of public health importance)<br><br>According to 2008 survey (MOH), only 1 case of **lymphatic filariasis** detected; not considered | No available NTD NSP; some information in NTD National Action Plan, EID Unit, TRAC Plus (2010):<br><br>• Perform baseline surveys of remaining NTDs of potential public health importance, including human trypanosomiasis and onchocerciasis (or request WHO confirmation that these entities are non-endemic).<br>• Reduce prevalence of STH among school-aged children to <50% by 2012.<br>• Reduce prevalence of S. mansoni among school-aged children to <2% by 2012.<br>• Achieve treatment success of leprosy cases of 85% by 2012. | • Support development of national strategic plan for NTDs<br>• Coordination of NTD supported activities with GOR and in-country stakeholders<br>• Coordination of NTD supported activities with other USG entities and activities, particularly those that yield GHI synergy<br>• Planning, implementation and monitoring of overall NTD activities, and in particular activities focusing on mass drug administration<br>• Coordinate with GOR/TRAC Plus M&E activities, including activities on mapping of NTDs<br>• Planning, implementation and monitoring of NTD-related operational research | TRAC Plus, MOH, SPH, WHO, World Bank |

| GHI Global Area | Baseline info/Country-specific GHI Target | Relevant Key National Priorities/Initiatives | Key Priority Actions Likely to Have Largest Impact | Key Partners |
|---|---|---|---|---|
| | public health problem in Rwanda<br><br>Targets: To be determined | | • Support leprosy surveillance and active case finding activities | |
| **Health systems strengthening:**<br>Address critical barriers that impede GHI health impact. | **Human Resources for Health**<br>• Ratio of medical doctor to inhabitants<br>Baseline: 0.7/10,000, HRH Database, 2008<br>Target: 1/10,000<br>• Ratio of qualified nurses to inhabitants<br>Baseline: 0.36/5000, HRH Database, 2008<br>Target: 1/5000<br>• % CHW trained to deliver basic package of services<br>Baseline: 67%, MOH/CHW Desk, 2010<br>Target: 100%<br><br>**Medicines, Vaccines, Technology including consumables**<br>• % health facilities submitting pharmacovigilance reports:<br>Baseline: 0<br>Target: 100%<br>• % health facilities | • Strengthening of productive capacity of education institutions for health professionals<br>• Improvement of management capacity, including retention and equity distribution strategies of human resources for health<br>• Continuous accreditation and professional development, of HRH<br><br>• Develop and implement a procurement and Maintenance framework for medical equipment and energy for health sector<br>• Strengthening pharmaceutical sector coordination<br>• Improvement of quality control of drugs<br>• Strengthening procurement | 1. Improve recruitment and retention mechanisms.<br>2. Carry out regular analysis of staffing data and revise the staffing projections in the light of changing service needs.<br>3. Develop and maintain accurate and up-to-date staffing database through the improvement of the HRIS and evidence based research.<br>4. Develop and implement a training plan for the creation of a new cadre of well-trained facility professionals (HRH specialists, administrators, pharmacists, data managers, lab technicians, specialized nurses).<br>5. Review the motivation strategies and schemes to improve performance and retention of personnel.<br>6. Develop a mentoring scheme for young health professionals.<br>7. Develop retention mechanisms for instructors in health science institutions of training.<br>8. Establish an appropriate and | GOR, Global Fund, CHAI, GTZ, BTC, one UN |

| GHI Global Area | Baseline info/Country-specific GHI Target | Relevant Key National Priorities/Initiatives | Key Priority Actions Likely to Have Largest Impact | Key Partners |
|---|---|---|---|---|
| | with stock outs of essential drugs as defined by MOH treatment guidelines Baseline: Target: 0%<br>• % of HF with electricity and water Baseline: 17% without electricity, District Health System Strengthening Survey; without water: TBD Target: 100%<br><br>**Health Financing**<br>• % population covered by health insurance Baseline: 91% including RAMA, MMI, and private (RAMA, 2008) Target: 100%<br><br>**Health Information**<br>• % health facilities | distribution and storage, including developing a drug price regulatory system<br>• Promotion of rational drug use<br><br>• Allocation Health Sector Budget according to priority areas (need)<br>• Render the Mutuelle system financially and administratively viable<br>• Extend PBF for HF and CHW cooperatives<br>• Improvement of technical capacity of community health workers<br>• Construct, extend and rehabilitate and equip HF according to norms and standards<br><br>• Developing capacity for | independent RFMA with a mandate for control and regulation of medicines through registration, inspection, quality control, related clinical trials and other products regulated by the law.<br>9. Strengthen pharmaceutical quality assurance system (inspection, registration and pharmaceutical quality control laboratory; pharmacovigilance).<br>10. Support establishment of R&D facilities within the schools of pharmacy and medicine.<br>11. Establish price monitoring policy and price information exchange systems.<br>12. Support and extend the active distribution system: district pharmacies to health centers.<br>13. Use information technology to improve the supply chain management system.<br>14. Establish and strengthen different mechanisms to promote rational and safe use of medicines and discourage self-medication: Drugs &Therapeutics Committees (DTC); National Pharmacovigilance System for both the public and private health care; Medicine Committees. | |

| GHI Global Area | Baseline info/Country-specific GHI Target | Relevant Key National Priorities/Initiatives | Key Priority Actions Likely to Have Largest Impact | Key Partners |
|---|---|---|---|---|
| | reporting according to existing HMIS norms<br>Baseline: 93% for public and Agree, 0% for private, HMIS, 2008<br>Target: 100% | planning and M&E at central and decentralized level<br>• Developing a harmonized planning and M&E framework<br>• Strengthening and harmonize all HMIS systems at all levels from the community to the central level<br>• Development of the decentralized levels to strengthen the bottom-up approach in planning and policy formulation and review<br>• Ensure community involvement in biomedical research<br>• The Rwandan Medical Journal is approved and functional | | |
| | **Health Service Delivery**<br>• % of fully accredited health facilities<br>Baseline: 2.4%, 2010<br>Target: 100% for district hospitals<br>• % of health facilities with the full package of activities (CPA,MPA)<br>Baseline: 42 DH (CPA) and 428 HC (MPA), 2010<br>Target: TBD | • Strengthening the health system to effectively and efficiently improve quality of services with input from civil society and community representatives<br>• Institutionalizing standard setting, monitoring and regulation<br>• Developing and ensuring the implementation of an operational plan for accreditation and certification process at all levels of the health system<br>• Develop and implement a | | |

| GHI Global Area | Baseline info/Country-specific GHI Target | Relevant Key National Priorities/Initiatives | Key Priority Actions Likely to Have Largest Impact | Key Partners |
|---|---|---|---|---|
| | | sector research agenda focused on priority areas<br>• Ensure an effective, secure and safe blood transfusion service<br>• Improve the accessibility and quality of mental health services<br>• Reinforce the coordination of the PBF strategy<br>• Performance's evaluation of health facilities<br>• Improve the monitoring and evaluation through steering committees | | |

## C. CAPACITY BUILDING INDICATORS AND TARGETS

| Indicator | Source(s) of Target/Indicator | Baseline (Year) | Target (Year) |
|---|---|---|---|
| **Number of testing facilities (laboratories) that are accredited according to national or international standards** | NRL Annual Report | **0** (2009) | **3** (2012) |
| **Number of new health care workers who graduated from a pre-service training institution** | HRIS/National Training Institutions | **430** (2010) | **450** (2012) |
| **Percentage of facilities where staff report receiving pre- or in-service training in the previous 12 months** | SPA | **89** (2007) | **100%** (2012) |
| **Percentage of facilities with external supervisory visit during the past 6 months** | SPA | **88** (2007) | **100%** (2012) |
| **Ratio of health professionals to 1,000 population**<br>**Doctors***<br>**Nurses***<br>**Midwives*** | HRIS | <br>**1/15,780** (2008)<br>**1/1,444** (2008)<br>**TBD** | <br>**TBD**<br>**TBD**<br>**TBD** |
| **Percentage of health facilities that experienced stock-outs of health commodities in the last 6 months**<br>**Family planning commodities**<br>**HIV/AIDS commodities**<br>**Malaria commodities** | SPA | <br>**50%** (2007)<br>**54%** (2007)<br>**58%** (2007) | <br>**0%** (2012)<br>**0%** (2012)<br>**0%** (2012) |
| **Percentage of all women 15-49 years using a modern contraceptive method** | HSSP II | **27%** (2007) | **50%** (2012) |
| **Percentage of deliveries in health facilities** | EDPRS, HSSP II | **45.2%** (2007) | **75%** (2012) |
| **Percentage of women with four antenatal visits** | EDPRS, HSSP II | **23.9%** (2007) | **50%** (2012) |
| **Percentage of pregnant women using ITNs** | HSSP II, MDG | **64.7%** (2007) | **85%** (2012, 2015) |
| **Percentage of children under 5 yrs using ITNs** | HSSP II, MDG | **60.2%** (2007) | **85%** (2012, 2015) |
| **Percentage of CHW trained to deliver the maternal and new born care package** | Strategic Plan CHW Unit | **30%** (2010) | **100%** (2012, 2015) |

- ***Numbers of doctors, nurses, and midwives will be disaggregated by gender in reporting.***

## D. GENDER INDICATORS AND TARGETS

| Indicator | Source(s) of Target | Baseline[13] (Year) | Target (Year) |
|---|---|---|---|
| **Condom utilization rate by gender** | EDPRS | **26% women**<br>**39% men**<br>(2005) | **35% women**<br>**50% men**<br>(2012) |
| **Percentage of HIV pregnant women who received ART to reduce MTCT** | 2009 Annual Report TRAC Plus/HAS | **74%**<br>(2009) | **90%**<br>(2012) |
| **HIV prevalence in the population aged 15-24 years** | EDPRS, HSSP II | **1.4% women**<br>**0.5% men**<br>(2005) | **0.5% women**<br>**0.5% men**<br>(2012) |
| **Percentage of partners of pregnant women in ANC who were tested for HIV in the last 12 months and who know their results** | NSP | **78%**<br>(2008)[14] | **90%**<br>(2012) |
| **Percentage of pregnant women using ITNs** | HSSP II, MDG | **64.7%**<br>(2007) | **85%**<br>(2012, 2015) |
| Percentage **of children under 5 years using ITNs** | HSSP II, MDG | **60.2%**<br>(2007) | **85%**<br>(2012, 2015) |
| **Maternal mortality rate per 100,000 live births** | EDPRS, HSSP II | **750**<br>(2005) | **600**<br>(2012) |
| Percentage **of women with four antenatal visits** | EDPRS, HSSP II | **23.9%**<br>(2007) | **50%**<br>(2012) |
| **Ratio of girls to boys in secondary education** | MDG | **0.81**<br>(2005) | **1.0**<br>(2015) |
| Percentage **of pregnant women who received iron supplementation during ANC** | National Strategy to Eliminate Malnutrition | **41%**<br>(2007) | **100%**<br>(2013) |
| Percentage **of children 6-59 months who are malnourished (wasting, stunting, or underweight)** | National Strategy to Eliminate Malnutrition | **4.6% wasting**<br>**15.8% underweight**<br>**52% stunting**<br>(2009)[15] | **3% wasting**<br>**10.3% underweight**<br>**36.4% stunting**<br>(2013) |
| Percentage **of all women 15-49 yrs using a modern contraceptive method** | HSSP II | **27%**<br>(2007) | **50%**<br>(2012) |
| Percentage **of deliveries in health facilities** | EDPRS, HSSP II | **45.2%**<br>(2007) | **75%**<br>(2012) |
| **Total fertility rate** | EDPRS, HSSP II | **5.5**<br>(2007) | **4.5**<br>(2012) |

[13] All baseline data comes from the 2005 DHS or the 2007 Interim DHS unless otherwise noted.
[14] Data comes from TRAC Plus service records.
[15] Data comes from 2009 Rwanda Comprehensive Food Security and Vulnerability Assessment and Nutrition Survey.

## E. USG SUPPORT FOR HSSP II OBJECTIVES

**Strategic Objective 1: To Improve Accessibility to, quality of and demand for MCH/FP/RH/Nutrition services**

Rwanda has made substantial progress in reducing maternal and infant mortality and improving nutrition, yet serious problems remain. The strategy – more easily stated than achieved – is to strengthen ANC, increase facility deliveries, extend breastfeeding and promote family planning and improved nutrition. The government is developing one of the most ambitious community health programs in Africa, training locally-based volunteers to diagnose and treat common illnesses (e.g., malaria and ARI) and refer more complex cases to nearby health facilities.

The USG invests substantial technical and financial resources in all four areas, as well as in the community health program. The USG supports provider training, behavioral change communication, commodity procurement, and technical assistance in forecasting, quantification and contraceptive logistics. In 2010, in partnership with the GOR and other development partners, the USG procured contraceptives to meet 45% of public sector needs, trained over 10,000 health care providers, and directly supported 554 service delivery points. The USG supports the GOR's scale up Community Based Distribution (CBD) of Contraceptives initiative that is currently being implemented in three districts and a national training plan to train 60,000 CHWs to participate in the CBD activities.

**Strategic Objective 2: To Consolidate, Expand and Improve Services for the Prevention of Disease and Promotion of Health**

The most common causes of morbidity in Rwanda are infectious diseases, which can be prevented by improvement of hygiene and sanitation conditions as well as behavioral change. Health prevention focuses on promoting personal and community practices that enhance good health and prevent disease. IEC/BCC activities are used to promote behavioral change and common practices known to improve the health of the population. Environmental health focuses on ensuring safety of food and water, improving hygienic latrines/toilets, safe waste disposal and injection safety and family hygiene.

The USG focuses preventive interventions on HIV and malaria, while also promoting family planning. Substantial PEPFAR funds are targeted to orphans and vulnerable children, as well as to PMTCT. Two-thirds of the PMI budget is allocated for procurement, distribution and use of long-lasting insecticide treated nets (LLINs).

**Strategic Objective 3: To Consolidate, Expand and Improve Services for the Treatment and Control of Disease**

Government programs, supported by Global Fund and the USG, focus on HIV, malaria, and TB. In 2008 ART coverage was an estimated 77% of adults and 49% of children in need. As more HIV-infected persons are identified and enrolled in care, there is a need to improve the follow-up and provision of basic care services (prophylaxis of OIs, TB screening, STI screening, FP/RH services, provision of bednets and safe water) to both pre-ART patients and patients on ART. One-stop services for HIV and TB are under development. There is a continuing though

decreasing need for malaria case management now aided by expansion of the community health program and increased availability of rapid diagnostic tests.

As noted above, the USG supports approximately 60% of the GOR's program for ART, reaching 53,121 individuals in need (CPDS, 2010). While the bulk of USG resources for malaria are allocated for preventive activities, the program also invests heavily in community case management, private sector sales of treatment drugs, and improved quality of care at health facilities.

**Strategic Program Areas: Health System Strengthening**
The Rwandan government places great stress on all seven of the cross-cutting systems interventions shown on the chart in the Appendix A. Especially notable are advances in community health insurance (mutuelles) and PBF, as well as both routine and cell phone-based information systems. Much work has gone into defining standards and procedures and ensuring good work conditions for staff. The quality assurance program is one of the stronger in the region.

In addition to supporting the immediate goal of improving Rwandans' health and saving lives, the USG health activities contribute to long-term capacity building and system strengthening. Significant support is provided through technical assistance to the GOR for decentralization in the health sector, health policy development, pre-service training and competency-based nursing curricula design, support for master's and doctoral programs in public health, strengthening post-graduate medical training and health care financing.

## F. ORGANIZATION OF THE HEALTH SECTOR IN RWANDA

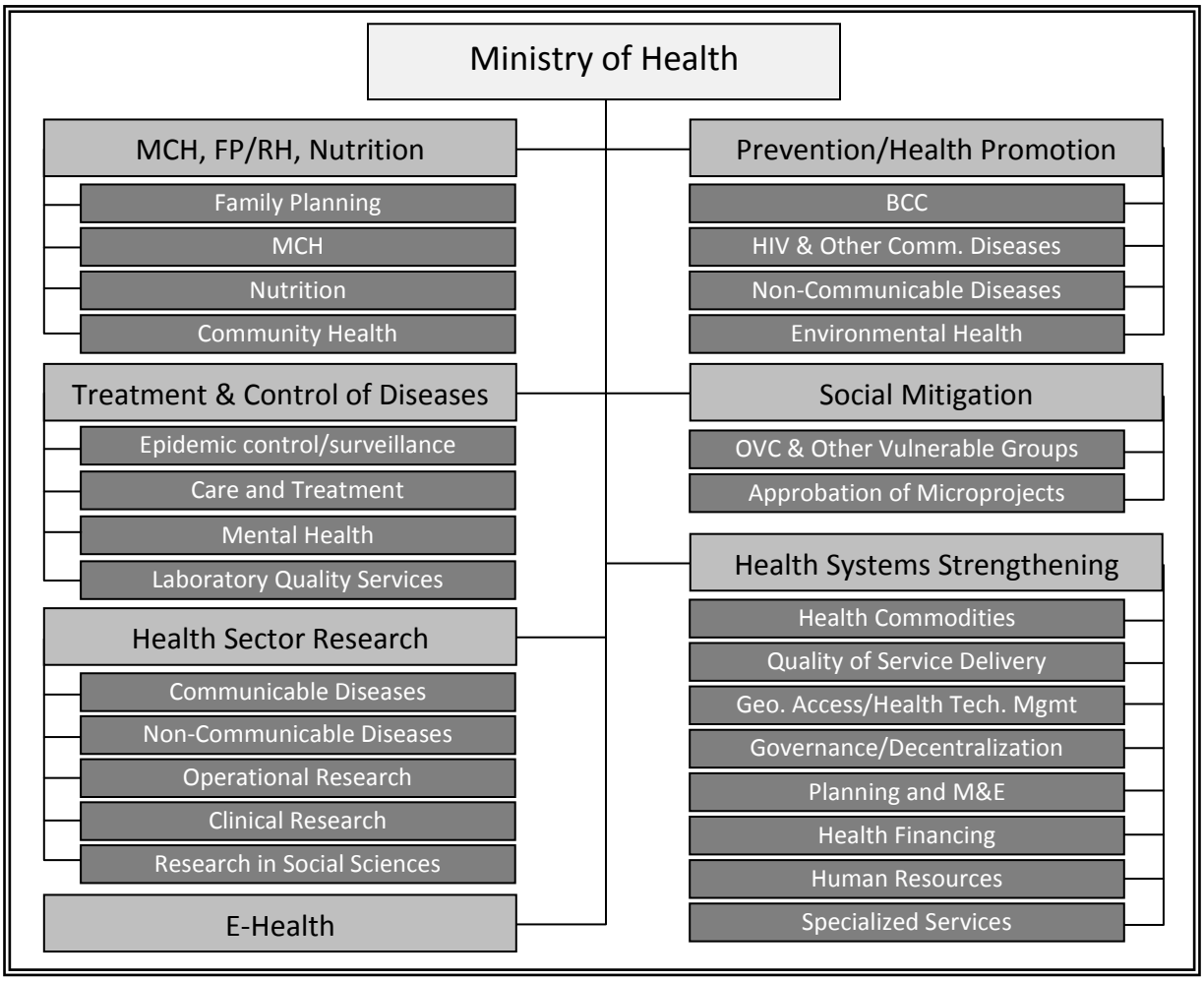
The MOH plays a strong role in coordinating donor assistance in the health sector. In 2004, the MOH established the HSWG for all development partners working in the health sector. In addition, all health sector partners, including the USG, are signatories to the SWAp. Through these mechanisms, partners have adopted a common approach for coordination and harmonization of planning, implementation, M&E under national leadership. The HSWG is chaired by the Permanent Secretary of Health and a representative of the lead donor in health (currently the Belgian Embassy). TWG reporting to the HSWG help coordinate initiatives of donors and implementing partners. A Joint Health Sector Review is also conducted twice yearly with a good track record of implementing recommendations from previous reviews. In addition, a national resource tracking database has been developed to capture commitments from all donors and facilitate coordinated planning and transparency in both donor and MOH budget allocation.

All health sector donors, including the USG, closely adhere to the GOR priorities defined in the Rwanda Vision 2020 strategy, the 2008-2012 EDPRS, the MDG, the 2009 – 2012 HSSP II, health sub-sector strategic plans, and the principles of the Monterrey and Accra Accords and Paris Declaration. In addition, the USG and other development partners are signatories to the SWAp, and participated in designing the SWAp Procedures Manual and Roadmap for the Further

Development of the Rwanda Health SWAP. In order to promote country ownership and collaboration, the SWAp and national TWGs will be the main organizational structures to strengthen coordination and provide joint planning of the GHI in Rwanda.

In the Memorandum of Understanding between the GOR and all health sector partners, some of the key responsibilities to which the GOR agrees to perform include: assume overall leadership in the development and implementation of the HSSP, ensuring that it is aligned with the EDPRS; ensure that there is consistency between health district plans and the HSSP II; ensure that the JHSR take place each year; and consult all partners on any major amendments to the health policy or strategic plan in accordance with agreed means of consultation. Some of the key responsibilities of development partners include: to align and harmonize their own planning, performance monitoring and review with the SWAp; plan, negotiate and implement future initiatives or new programs in cooperation with the GOR and other partners; and harmonize policy dialogue, consultation and information sharing. Finally, all partners and the GOR agree to fund activities related to HSSP objectives, disburse funds in a timely manner, and participate in an annual JHSR to assess progress and set priorities. The GHI implementation will utilize existing national structures, including the SWAp and TWGs, to review and discuss key programs.

## G. HEALTH SECTOR NATIONAL TECHNICAL WORKING GROUPS




## H. USG FUNDING IN THE HEALTH SECTOR

| Fiscal Year | USG/Rwanda Funding | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | HIV/AIDS | Malaria | MCH | Water | Nutrition | FP/RH | Influenza | Grand Total |
| FY04 | $30,346,503 | $1,000,000 | $1,100,000 | $0 | $0 | $2,700,000 | $0 | **$35,146,503** |
| FY05 | $55,221,870 | $1,000,000 | $1,100,000 | $0 | $0 | $2,700,000 | $0 | **$60,021,870** |
| FY06 | $72,102,434 | $1,349,000 | $2,475,000 | $0 | $0 | $3,460,000 | $0 | **$79,386,434** |
| FY07 | $103,041,870 | $20,000,000 | $1,221,000 | $0 | $0 | $7,300,000 | $300,000 | **$133,362,870** |
| FY08 | $123,468,840 | $16,862,000 | $4,459,000 | $0 | $0 | $7,351,000 | $300,000 | **$152,440,840** |
| FY09 | $147,647,313 | $16,300,000 | $6,450,000 | $400,000 | $0 | $9,000,000 | $355,000 | **$180,152,313** |
| FY10 | $131,447,313 | $18,000,000 | $6,500,000 | $2,000,000 | $2,000,000 | $11,000,000 | $400,000 | **$171,347,313** |