Republic of Rwanda

Ministry of Health

WHO COUNTRY COOPERATION STRATEGY
RWANDA, 2009 - 2013

WORLD HEATH ORGANISATION
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WHO Country Cooperation Strategy, 2009-2013
Rwanda

1. Health Planning
2. Health Plan Implementation
3. Health Priorities
4. Health Status
5. International Cooperation
6. World Health Organization

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ABBREVIATIONS

ANSP+: National Association for the support to people living with HIV/AIDS
ARV: Antiretrovirals
ATM: AIDS, Tuberculosis and Malaria
CBHIs: Community Based Health Insurances
CCA: Common Country Assessment
CCM: Country Coordination Mechanism
CDC: Centers for Disease Control
TTC: Testing and Treatment Centre
NACC: National AIDS Control Commission
NBTC: National Blood Transfusion Centre
COD: Common Operational Document
COMESA: Common Market for Eastern and Southern Africa
DMTF: Disaster Management Task Force
DPCG: Development Partner’s Coordination Group
EAC: East African Community
EB: Extra Budget
EDPRS: Economic Development and Poverty Reduction Strategy
DHS: Demographic and Health Survey
DHSRIII: Third Demographic and Health Survey in Rwanda
EPI: Expanded Programme on Immunization
FHP: Family Health Programme
GAVI: Global Alliance for Vaccines and Immunization
GFATM: Global Fund to Fight AIDS, Tuberculosis and Malaria
GLIA: Great Lakes Initiative on AIDS
GSM: Global Management System
GoR: Government of Rwanda
HAMS: Hygiene and Sanitation in School settings
HBM: Home-Based Management
HIV: Human Immunodeficiency Virus
HQ: Headquarters (WHO)
HSSP I: Health Sector Strategic Plan I (2005 - 2009)
HSSP II: Health Sector Strategic Plan II (July 2009 - June 2012)
HSP: Health System and Policies
ICT: Information and Communication Technology
IDHS: Interim Demographic and Health Survey (2007-2008)
ISHLC: Integral Survey on Household Living Conditions
OI: Opportunistic Infections
STI: Sexually-Transmitted Infections
ICT: Intercountry Support Team (WHO Sub-regional Office)
KHI: Kigali Health Institute
NRL: National Reference Laboratory
M&E: Monitoring and Evaluation
MAP: Multi-country HIV/AIDS Programme for Africa.
MINISANTE: Ministry of Health
MIP: Malaria in Pregnancy
Mini DHS: Mini-Demographic and Health Survey
MOU: Memorandum of Understanding
NTD: Neglected Tropical Diseases
MTR: Mid-Term Review
NEPAD: New Partnership for Africa’s Development
MDGs: Millennium Development Goals
WHO: World Health Organization
NGO: Non governmental Organization
IMCI: Integrated Management of Childhood Illnesses
PEPFAR: (US) President’s Emergency Plan for AIDS Relief
AFP: Acute Flaccid Paralysis
PHAST: Participatory Hygiene and Sanitation Transformation
PNILT: Integrated National Leprosy and Tuberculosis Control Programme
PRSP: Poverty Reduction Strategic Paper
MTSP: Medium-Term Strategic Plan
PMTCT: Prevention of Mother-to-Child Transmission
PLWH: Persons Living with HIV
RB: Regular Budget
CCS: Country Cooperation Strategy
AIDS: Acquired Immunodeficiency Syndrome
IDSR: Integrated Disease Surveillance and Response
HIS: Health Information System
SO: Strategic Objective
SWAP: Sector Wide Approach
TRAC: Treatment and Research AIDS Centre
TRACNET: Electronic Health Information System of TRAC
TRAC PLUS: Center for the Treatment and Research on HIV/AIDS Centre, Tuberculosis, Malaria and Other Epidemics
TSP: Technical Support Programme
UN: United Nations
UNAIDS: United Nations Joint Programme on AIDS
UNDAF: United Nations Development Assistance Framework
UNDP: United Nations Development Programme
USAID: United States Agency for International Development
USG: United States Government
VCT: Voluntary Counseling and Testing
HIV: Human Immunodeficiency Virus
WPC: WHO Presence in Country
WR: WHO Representative
PREFACE

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution’s coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO’s action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the “Harmonization for Health in Africa” (HHA) and “International Health Partnership Plus” (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO’s Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa
EXECUTIVE SUMMARY

The new context of globalization, notably the poverty reduction programmes, the global and regional financing initiatives and the initiative on reform of the United Nations system, have greatly influenced all development sectors of the countries. In the health sector, in 2000, the WHO Executive Council approved a corporate strategy for guiding the activity of the Organization’s Secretariat. This strategy underlined the essential role played by the countries in the actions of the Organization, hence the need for translating the global strategy into specific strategies adapted to the needs of each country. Over the years, the Country Cooperation Strategy has become a solid document, which harmonizes and aligns the actions of the Organization to the visions and strategic orientations of the countries, and the United Nations Development Assistance Framework.

It is in this context that WHO developed the first Country Strategic Cooperation document 2004-2007, which, in response to the health challenges of the time, proposed three strategic orientations:

i. Improving the performance of the health system;
ii. Disease control;
iii. Health promotion as well as health and environment.

However, despite the major achievements made in the first generation CCS, the lack of access to care, especially for poor populations, inadequate accessibility to quality care, insufficient number of qualified health staff and poverty of the population remain an issue of concern for national authorities.

The development of the second CCS, which will cover the period 2009-2013, is intended to be a continuation of the first CCS. The new strategy of cooperation with Rwanda aligned on the national health policy and the second Health Sector Strategic Plan (HSSPII), outlines, in the medium-term, the major orientations of WHO cooperation with Rwanda in the health sector.

It highlights, in broad terms, the major health and development challenges facing the country, where the health profile is dominated by the emergence of non-communicable and communicable diseases. The latter are the primary causes of morbidity and mortality, led by malaria, STIs/HIV/AIDS and opportunistic infections, which alone, account for 35% of hospital mortality (IDHS, 2007-2008).

Rwanda, like the other countries in the sub-region, is still threatened by natural or manmade disasters. Mortality and morbidity due to diseases are aggravated by problems associated with water and sanitation, high level of poverty and low level of education of the populations.

Health financing is mainly external but contributions from Government and especially the population, through mutual health schemes, are on significant increase. External funding facilities now follow the national aid policy, which advocates budget support and the sector approach. Several partners have adopted this approach, including UN agencies, by signing the memorandum of understanding of the SWAP health in 2007, and through their active participation in its operationalization.
To better apprehend the health problems facing the population, Rwanda carried out administrative reforms of the health system, in response to the national policy on decentralization. It recently adopted the second Health Sector Strategic Plan as the tool for operationalizing the EDPRS and Vision 2020.

For the coming years, WHO will focus its intervention not only on support for collective response to the health challenges mentioned above, but also on consolidation of the major achievements of the health sector. Its efficiency in Rwanda will be strengthened by this new Cooperation Strategy based on the core functions of the WHO, the global health action programme and, the global and regional priority areas.

Hence, in conjunction with the Ministry of Health, 13 intervention areas have been identified. All these are aligned with the country priorities as defined in the framework documents, specifically the second Health Sector Strategic Plan, which is inspired by the Poverty Reduction and Economic Development Strategy, Vision 2020 and UNDAF in the context of “Delivering as One”.

Four priority strategic areas will be supported by WHO during the next four years. They are:

I. Reduction of maternal and child mortality;
II. Control of communicable and non-communicable diseases;
III. Health promotion, food safety and nutrition, health and environment;
IV. Improvement of health system performance.

To honour its commitments to the Government of Rwanda, represented by the Ministry of Health, the WHO Country Office supported by the Regional Office and headquarters, will enhance its management and financial capacities in terms of human, technical and material resources to address the challenges expressed in the WHO Country Cooperation Strategy for Rwanda.
SECTION 1: INTRODUCTION

The Country Cooperation Strategy was developed through extensive consultations with national and international partners, through common discussion sessions, brainstorming and individualized meetings. It was also based on fruitful exchanges between the staff of the WHO Country Office through reflection and documentary analysis sessions, with contribution from the intercountry support team of Central Africa and from headquarters. The strategic orientations were developed during a one-day workshop, in which a WHO/Ministry of Health working group participated. The document was the subject of a consensus with the participation of top-level officials from the Ministry of Health and development partners. The WHO cooperation strategy with Rwanda, takes into account the changes that occurred in the health sector these past years, following the adoption of new development strategies at the international, regional and national levels. These strategies comprise notably:

i. The poverty reduction strategies developed by developing countries and on which all the cooperation programmes must be aligned;
ii. The initiatives of the rich countries to reduce or cancel the debt of certain poor countries;
iii. The establishment of new global initiatives for health financing, including the creation of the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis (GFAMT), the Global Alliance for Vaccines and Immunization (GAVI), etc.

To adapt to this new situation, Rwanda, like many countries in the African region, made changes, especially in the management and coordination of external aid. One of the first changes is the establishment by Rwanda of a Sector-wide approach (SWAP), through which the Government has enhanced its leadership and coordination role in the mechanisms for joint programming and management of development aid.

The United Nations system Reform Initiative, “One UN” was materialized by the establishment of the Common United Nations Programme (COD), as operationalization tool of the United Nations Development Assistance Framework (UNDAF).


Similar to the previous CCS, it is also based on the National Health Policy of Rwanda, adopted in 2005, as well as the second National Health Sector Strategic Plan (HSSPII 2009-2012). The HSSP II is for Rwanda, the operationalization tool and in the health sector in the medium-term, of the Economic Development and Poverty Reduction Strategy (EDPRS 2008-2012), the Government’s Vision 2020, the Millennium Development Goals, the Common Country Assessment (CCA, 2000), and the United Nations Development Assistance Framework (UNDAF).

For the period 2009-2013, the WHO will support the Ministry of Health to implement its biennial action plans and will focus its intervention on 4 priority areas:

i. Reduction of maternal and child mortality;
ii. Control of communicable and non-communicable diseases;
iii. Health promotion, food safety, health and environment;
iv. Improvement of health system performance.
SECTION 2: HEALTH AND DEVELOPMENT CHALLENGES

2.1 COUNTRY PROFILE

Rwanda is a landlocked country in Central Africa, situated in the Great Lakes region. Its landscape is mainly constituted by high hills, hence the name “Country of a Thousand Hills”. The population of Rwanda is estimated at 9.3\(^1\) million inhabitants, with a surface area of 26,338 km\(^2\) and an average density of 368 inhabitants/km\(^2\). The annual population growth rate is currently estimated at 2.6%: the population of Rwanda is expected to reach 16 million inhabitants in 2020, if the growth rate remains unchanged\(^2\). Total fertility rate is estimated at 5.5 (IDHS 2007). Women are estimated to represent 52.2% of the population, with a life expectancy at birth of 53.3 years, compared to 49.4 years for men. Total average life expectancy at birth is 52.7 years\(^3\) and the population aged below 15 years represents about 41.9%\(^4\) (NIS figures, 2008).\(^2\)

According to the 2005 Demographic and Health Survey, EDSIII, child mortality rate was respectively 37/1000 live births for neonatal mortality, 86/1000 live births for infant mortality and 152/1000 for under 5 mortality. This represents an improvement compared to the figures for 2000, which were respectively 45/1000, 107/1000 and 196/1000. Recent data from the Interim Demographic and Health Survey indicators (IDHS 2007-2008) show a net reduction in neonatal, infant and under-five mortality rates, which are respectively 28/1000 live births, 62/1000 live births and 103/1000 live births. Maternal mortality is estimated at 690/100,000 live births (NIS figures, 2008) and, according to the IDHS 2007-2008, 52% of births were assisted by a health staff.

Rwanda has carried out administrative reforms to enhance the decentralization and participation of the population in decision-making. Hence, the administrative division has been reviewed and, presently the country is subdivided into 4 administrative provinces plus Kigali city, which are in turn subdivided into 30 administrative districts, 416 sectors, and again into 2,148 villages and 14,980 10-unit cells /imidugudu\(^5\). The administrative district is the basic politico-administrative unit.

In the area of foreign policy, Rwanda has subscribed to regional politico-economic entities, including the New Partnership for Africa’s Development (NEPAD), the Common Market for Eastern and Southern Africa (COMESA) and the East African Community (EAC).

The country’s socio-economic situation has been greatly influenced by the consequences of the genocide up to the years 2000, and presently, the situation keeps improving. The impact of the genocide was most visible in the social sector. Hence, in 2006, after 12 years of efforts, the Ministry of Gender and Family Promotion provided the following estimates: number of children in foster families, 22,535; number of street children, 7000; number of children in

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1 IDHS, Rwanda (RDHS 2007).
2 The Population was estimated at 9.3 million inhabitants in 2007 (based on projections of the 2002 Census).
4 MINISANTE, MINECOFIN: Demographic and Health Survey, 2005
5 Website of the Ministry of Local Administration (MINALOC).
centres for unaccompanied children (CENA), 3751; and number of children living in child-headed households\textsuperscript{6} 100,956.

GDP growth was estimated at 5.7\% in 1999, and 8\% in 2007\textsuperscript{7}. Consumption demand has increased, especially that of households. Over the period 2001-2006, the services sector assumed greater importance, although agriculture remains the main component of GDP (43.8\% against 36.4\% for the service sector) and mobilizes more manpower. Industry contributed 14.2\% over this period\textsuperscript{8}.

The incidence of poverty is still high in the country, with 57\% of the population living below the poverty line, and 37\% of them living in extreme poverty\textsuperscript{9}. Annual per capita income increased from US$ 235 to US$ 291.3 between 2002 and 2008\textsuperscript{10}. Eighty per cent of the population of Rwanda lives in rural areas and is engaged in agriculture (ISHLC2 2005-2006).

In order to reduce inequalities in access to education, health care, employment and decision making, the gender concept was adopted. To that end, the Rwandan legislation has also been reviewed and women now occupy 54\% of the seats in Parliament, 47.5\% in decision-making bodies\textsuperscript{11} and may also inherit from their families.

In order to place greater emphasis on the improvement of the health of the population as one of the poverty reduction strategies, the second health sector strategic plan was adopted as a tool for operationalizing the EDPRS and Vision 2020.

\textbf{2.2 HEALTH PROFILE}

Despite the progress made in the fight against diseases, notably elimination of maternal and neonatal tetanus, documentation of the eradication of poliomyelitis, measles control and reduction of malaria-related mortality, the epidemiological profile of Rwanda is still dominated by communicable diseases, which constitute 90\% of chief complaints in health facilities\textsuperscript{12}. Mortality and morbidity from these illnesses are aggravated by the high level of poverty, low level of education of the population as well as problems relating to inadequate water supply, and poor sanitation systems.

The most common communicable diseases are malaria, HIV and AIDS, acute respiratory infections, diarrhoeal diseases and tuberculosis. Other diseases occur in the form of epidemics: typhus, cholera, measles and meningitis. These diseases are the subject of specific control strategies and permanent surveillance in Rwanda. The surveillance strategy proposed by WHO, called Integrated Disease Surveillance and Response (IDSR) concerning 19 pathologies, is applied in Rwanda since 2003.

\begin{flushright}
\textsuperscript{6} National conference on care, treatment and assistance to children infected and affected by HIV/AIDS, 2006.
\textsuperscript{8} ISHLC 2006
\textsuperscript{9} NISR; ISHLC2, 2005-2006.
\textsuperscript{10} U.N.
\textsuperscript{11} EDPRS, 2008-2012
\textsuperscript{12} Ministry of Health, 2007 Annual Report
\end{flushright}
However, Rwanda is also experiencing an emergence of non-communicable diseases associated with the development of high-risk behaviours and urbanization. As the other countries in the sub-region, it is threatened by natural or man-made disasters and emerging and re-emerging diseases (SRAS, avian flu, A flu (H1N1), etc.).

Malaria is considered as the primary cause of morbidity and mortality in Rwanda. However, according to the 2007 Annual Report of the Ministry of Health, both morbidity and mortality due to malaria are on a sharp decline. Compared to the first ten chief complaints in health facilities, its proportional morbidity fell from 37.9% in 2005 to 28.4% in 2006 and to 15% in 2007. Children under 5 years are the most affected, with a proportional morbidity of 31.5%. The rate of malaria mortality which was 10.1% in 2001, fell to 4.4% in 2006 and to 2% in 2007.

This reduction in malaria morbidity and mortality can be mainly explained by the use of the Arthemether lumefantrine combination (Coartem), increase in the use of insecticide-treated bed nets, implementation of the Home-Based Management of Malaria (HBM) strategy, Intermittent Preventive Treatment (ITP) strategy in the pregnant woman (43% in 2005, compared to 65% in 2006) and increase in the rate of enrolment into mutual health insurance schemes.

Rwanda is experiencing a generalized HIV/AIDS epidemic, with a national prevalence estimated at 3% in the population aged 15 - 49 years (DHS 2005). This HIV prevalence conceals disparities between urban (7.3%) and rural (2.2%) areas, between women (3.6%) and men (2.3%). The survey on sero-surveillance of HIV infection per sentinel sites, among pregnant women in prenatal consultation services, conducted in 2007, showed a median prevalence of 4.3% (as against 4.1% in 2005, and 5.1% in 2002/2003), that could vary between 3.9% and 4.6%. Prevalence of syphilis has considerably reduced among pregnant women, declining from 5.9% in 2005 to 2.4% in 2007.

According to projections made by Spectrum, the number of PLWHA was estimated at 149,000 in 2008, including 17,000 children (Source: NSP 2009). The proportion of sero-discordant couples was estimated at 3%, in 2008.

In the face of this situation, the Government strives towards the achievement of universal access to prevention, treatment, care and support services by 2010. Between 2003 and 2008, availability of HIV counselling and testing services increased from 44 to 374, representing 81% of health facilities, while the number of PMTCT services increased from 53 to 341, representing 75% of health institutions. Access to antiretroviral treatment was extended during the same period. At the end of the year 2008, the number of ARV sites was 217 (representing 43% of health facilities), while the total number of PLWHA on antiretroviral treatment was 63,149 (as against 4189 in 2003), or a coverage rate of 70%. Nearly 2/3 of PLWHA on ARVs are women and about 99% of the patients are on first-line treatment.

Despite this progress, there are still several challenges in the following areas:
- Intensification of the prevention efforts in the face of the number of new infections, the low rate of condom use, insufficient interventions targeting high-risk population groups (sex workers and their clients, MSM, sero-discordant couples), the extension of priority prevention activities like circumcision, Provider Initiated Testing and Counselling (PITC) promotion of condom use and sensitization of the communities;
- Antiretroviral treatment, where the coverage rate remains low (43%) as compared to that of VCT and PMTCT services, including the intensification of the support;
- Strengthening of the health system, with adequate human resources, task shifting for antiretroviral treatment and monitoring, sustainability of the funding mechanisms, quality of strategic information;
- Monitoring of drug resistance.

To reverse the trends of HIV infection by 2015, WHO, in collaboration with the other UNAIDS co-sponsors and partners, have pledged to consolidate and strengthen the process of going on scale towards universal access, in the framework of the “ONE UN” pilot experience in Rwanda.

According to WHO, the annual incidence of tuberculosis in Rwanda is estimated at 2.6%. The most recent epidemiological data show a net increase in the prevalence of this disease. According to the reports of the Ministry of Health, the number of tuberculosis cases detected and treated increased from 3,205 in 1995 to 8,014 in 2007. More than 50% are mycobacterium-positive tuberculosis cases. This increase can largely be explained by the AIDS epidemic and the improved capacities for detection.

All the 183 testing and treatment centres (TTC) apply the DOTS, and the community DOTS presently covers 16 administrative districts out of the 30 in the country. In 2007, the testing rate was 48% and the therapeutic success rate 89%. The rate of HIV testing in tuberculosis patients was 89%, with a co-infection rate of 37%, in 2007. The rate of multi-drug resistant tuberculosis was 3% for the primo-treatment cases, and 9.4% for re-treatment cases. At the end of 2007, more than 173 multi-drug resistant tuberculosis cases were on second-line treatment in a specialized centre. As soon as a multi-resistant case becomes negative, it is managed in other health facilities in ambulatory care.

For diseases targeted for eradication or elimination, Rwanda has subscribed to all the WHO recommendations aimed at eradicating poliomyelitis, eliminating maternal and neonatal tetanus and controlling measles. Highly-encouraging results have been achieved in the fight against these diseases. Rwanda documented the certification of the eradication of poliomyelitis in 2004, and since then, the indicators of surveillance of acute flaccid paralysis are maintained at the certification level.

Rwanda officially eliminated maternal and neonatal tetanus in 2004. The Expanded Programme on Immunization has already initiated the process of integrating other interventions in favour of child survival into its regular immunization programme, such as the distribution of an insecticide-treated bed net to every 9-month old baby who has just received his anti-measles vaccine and the integration of vitamin A supplement during regular vaccination activities. Since 2002, the year Rwanda introduced two new vaccines (HepB and Hib), the vaccination coverage DPT3 increased from 82% in 2002 to 97% in 2007, according to administrative data from the EPI. The report of the Interim Demographic and Health Survey (2007-2008) shows an improvement in the vaccination coverage since 2000, with the rate of fully immunized children increasing from 76% to 80%. In April 2009, Rwanda became the first developing country to introduce vaccination against pneumococcal infections in its national programme.
In the framework of vaccine independence, the Government fully finances traditional vaccines and injection materials, and has been doing so since 2000. It also started co-financing of new vaccines in 2006.

Concerning child health, although morbidity and mortality attributable to vaccine-preventable diseases have significantly declined during the past five years in Rwanda, infant mortality is still among the highest in the world (107 for 1000 LB in 2000, and 86 for 1000 LB in 2005, according to the DHSR-III and 62 for 1000 LB in 2007, according to the Mini DHS).

The challenges to be met would be the consolidation of the achievements of the vaccination programme and mobilization of financial resources to deal with the high cost of new vaccines largely financed by GAVI.

The country is confronted with periodic epidemics of cholera, meningitis, measles and bacillary dysentery. Over the period 2006-2007, Rwanda experienced two epidemics of cholera and two epidemics of measles. In 2007, a cholera epidemic affected 3 regions and 918 cases were notified, including 17 deaths (case fatality rate: 1.85%).

The country is also exposed to natural disasters such as volcanic eruptions, floods and especially man-made disasters such as conflicts and wars, leading to massive population displacements. Indeed, in 2006, there was a repatriation of 19,000 Rwandans who had taken refuge in Burundi and 65,000 Rwandans from Tanzania. An earthquake occurred in Rwanda in February 2008, causing the death of 37 people and injuring 600 others in the South-Western part of the country. These emergency problems are quite common in the sub-region, hence the need to put in place mechanisms for their prevention and management at the national and sub-regional levels.

According to the DHSR-III, 45% of children under 5 years of age suffer from chronic malnutrition, 19% of whom in the severe form. At the national level, 33% of women of reproductive age suffer from anaemia. Micronutrient deficiency in children under 5 and pregnant women is mainly due to iodine, iron and vitamin A deficiencies. The basic reasons for this situation are inadequate diet, high prevalence of infectious and parasitic diseases and high level of poverty affecting particularly women and child-headed families.

Mental health remains a public priority in Rwanda. The national policy and mechanism of care should target and ensure not only basic mental health care but should also deal with the consequences of the genocide, which remain a key factor and cause of morbidity and invalidity, in the area of mental health. In addition, it is important to document the frequency of epilepsy and neurological diseases in the population in Rwanda.

The most frequently reported mental problems are epilepsy (46.9%), psychiatric disorders (21%), psychosomatic disorders (15%), neurological disorders (7.4%), and psycho-traumatic disorders (3.6%). To deal with this situation, several strategies have been adopted and put in place:

- Decentralization of mental health care: establishment of six mental health operational units in 6 district hospitals and integration of mental health care into the package of care of district hospitals. Hence, 30 district hospitals have a mental health activity ensured mainly by specialized mental health nurses, supported by general practitioners;
- Establishment of regular on-going in-service training programme for health staff in the area of mental health, oversea training for specialization in psychiatry and neurology;
- Establishment of regular supervision programme at the central level and in district hospitals;
- Supply and distribution of psychotropic drugs;
- Community management of mental health problems.

**Consumption of tobacco** and other drugs by young people, particularly teenagers, is becoming increasingly worrisome. A survey conducted in 2004 showed that 24% of secondary school children were smoking. The “Global Youth Tobacco Survey”, conducted in 2008, in secondary schools in the country among the 13-15 years age group, showed that 12.3% of students were smoking or using tobacco products. During these past years, observations in psychiatric clinic circles show an increase in hospital admissions and requests for consultation for drugs and tobacco abuse problems.

Hypertension, diabetes, breast cancer and cervical cancer constitute increasing public health problems, but their burden is not known.

Oral health, pathologies associated with blindness, disabilities caused by wars and road accidents constitute a major socio-economic burden. The country is facing an increase in non-communicable diseases, the prevalence of which must be evaluated so as to develop appropriate intervention strategies.

Maternal mortality rate decreased from 1071/100,000 live births in 2002, to 750/100,000 live births, in 2005, according to the DHSR-III. The most frequent causes of maternal death are infections, haemorrhages and eclampsia. The illegal abortions, frequent pregnancies and early pregnancies increase the risk of mortality.

The 2006 annual report of the Ministry of Health showed an increase in the number of deliveries in health facilities, which went from 39% in 2005 to 52% in 2007. The rate of modern contraceptive use increased from 4% in 2004 to 10.3% in 2006 and 27% according to the results of the IDHS (2007-2008).

**In 2007, the national rate of safe water supply** was 69%. In the same year, an estimated 85% had latrines, 38% of which met the required standards. Poor management of wastes and dangerous and toxic chemical products constitute threats to the environment and public health. The main challenge is, therefore, improving the quality of drinking water supply systems and its accessibility for the population and promoting a safe, sustainable and enabling environment for health.

**Food safety** is marked by the lack of a regulation system, and an efficient legislation and coordination system. The main challenge is to ensure food safety at all levels.

**The improvement of the capacities of the communities**, the creation of an enabling environment for health and advocacy constitute the pillars of health promotion. Health promotion in general and management of care by the communities in particular do not occupy a place of choice in health improvement as yet, whereas 70% of the most common diseases are avoidable through prevention. Community health workers in village/Umudugudu are
organized in pairs (one woman and one man), representing one pair of volunteers for 600 inhabitants.

**To improve its health system,** Rwanda has adopted a health policy based on decentralization and community participation.\(^{13}\)

In 1996, with the support of WHO, a national health policy document, based on primary health care and health district, was developed and adopted. In 2000, the national authorities initiated the review of the policy adopted in 1996. The reasons for this review were, on the one hand, certain successes made, including the establishment of health districts, the extension of health coverage, capacity building, promotion of community participation, gradual return to greater socio-political stability and, on the other, the transition of the country from an emergency phase to that of sustainable development.

In 2006, a national administrative reform was carried out to enhance the decentralization up to the community level. Hence, the administrative district has responsibility for all sectors, including health. This decentralization takes inspiration from Vision 2020 of the Government of Rwanda as stressed in the EDPRS 2008-2012, where health features prominently among the major priorities.

The strategic orientations for implementing this health policy are based on:

i. Primary health care through its eight main components;

ii. Decentralization, with the health district as the operational unit of the health system;

iii. Strengthening of community participation in the management and financing of health services;

iv. Development of human resources;

v. Supply of essential drugs;

vi. Strengthening of the health information system;

vii. Intersectoral collaboration.

The current Rwandan health system is a 3-tier pyramidal system, with central, intermediate and operational levels:

- **The central level** is composed of the central departments of the Ministry of Health as well as the national reference hospitals. It is responsible for the formulation of health policies, strategic planning, high-level technical supervision, monitoring and evaluation of the health situation as well as the coordination of resources at the national level.\(^{14}\)

- **The intermediate level** is represented by the department of health within the administrative district. The task to be performed at this level is primarily to facilitate and guide the process of development of the operational level, for which it ensures the administrative, logistical, technical and political supervision.

- **The operational level** is constituted by district hospitals and health centres. This level is facing problems of quality and quantity of human resources, thus limiting its functionality. The shortage of human resources constitutes a major challenge for this health level, following the migration of staff from rural areas to the cities.

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\(^{13}\) Health sector policy in Rwanda, 2005.

\(^{14}\) Strategic plan for Development of Human Resources in Health, 2006-2010
The faith based organizations play an important role in the health system. In 2007, out of the entire primary and secondary health facilities, 38.4% of them were congregational structures (44% of functional hospitals and 35% of first level health facilities). The authorized structures pledge to follow the policy of the Ministry of Health to which they are linked by an agreement\textsuperscript{15}.

The private sector is mainly involved in curative activities and is mostly located in urban areas. The services offered do not always take into account the needs of the population, but rather the capacity of the latter to pay for the care provided. This sector is poorly organized and controlled and its relationships with the public sector are still poorly defined.

The Ministry of Health and the Institute for Scientific and Technological Research (ISTR) are trying to regulate traditional medicine and organize traditional healers into associations so as to better supervise them, but, so far the functional associations are not many.

For the health system and provision of health services, the challenges are notably: insufficiency and inequitable distribution of health staff, insufficiency of the technical capacities of health facilities (30% meet the minimum standards in equipment) and the structural and functional weakness of the Health Information System (HIS).

Concerning the financing of health, there is certainly an increase on the part of the Government, but it is still highly dependent on external funding.

The main sources of health funding are the State, contributions from the population and external aid. The share of the budget allocated to the health sector increased from 3.2% in 1996 to 4.2% of the national budget in 1999\textsuperscript{16} to reach 6%, in 2006\textsuperscript{17} and 9.7% in 2008\textsuperscript{18}. The Health Sector Plan provides that this share will reach 12% in 2009.

Even if there has been an increase in the share of the budget allocated to health, the latter is still inadequate and below the 15% target set by the Abuja Conference, when compared to the other sub-Saharan African countries that have nearly the same levels of income. It is, however, interesting to note that more than 4/5 of the budget is devoted to the provision of services; and only less than one-fifth to administration.

According to the annual review of the health sector, the share of the 2008 national budget for health amounted to 58.6 billion Rwandan francs\textsuperscript{19}, of which 49.8 billion (85%) would go to the administrative districts, which now integrate the health service and are responsible for the district hospitals and health centres, 7 billion francs (12%) will be spent on financing national level reference hospitals and only 1.8 billion (3%) on operations of the Ministry of Health.

However, the trend of the financing by source shows that funds from external aid declined from 64% to 62% in 2006. Financing by the population through mutual health schemes is another source of funds for health. At the end of the year 2007, the rate of subscription to mutual health schemes was 73% of the population.

\textsuperscript{15} Data from the Ministry of Health, December 2007
\textsuperscript{16} Ministry of Health (1999), Public Expenditure Review - Health Sector
\textsuperscript{17} Ministry of Health, 2006 Annual Report, March 2007
\textsuperscript{18} Rwanda 2007, Joint Health Sector Review
\textsuperscript{19} 545 Rwandan francs are worth US$ 1, according to the average official rate of the National Bank of Rwanda, in January 2008
To finance the priority interventions of the EDPRS 2008-2012, the most probable scenario, which gives priority to interventions that have a deeper and long term impact provides for a cost of US$ 12.80 per person. This scenario takes into consideration the funding available in 2007. On the other hand, the health sector plan, more optimistic than the EDPRS, provides for an increase in health expenditures per inhabitant, from US$13.6 in 2005 to US$ 15.3 in 2009.

Human resources constitute a major challenge but have been improving. By the end of the year 2006, Rwanda had 1 doctor for 50,000 inhabitants. 13% of positions planned for specialized doctors were filled compared to 32% of posts for general practitioners and 4% for midwives.

A strategy document on development of human resources in health for 2006-2010 has been produced. Its implementation has produced several results, including the direct or indirect increase in salaries, through the contractual approach, development of capacities through the postgraduate training (Masters) in medicine and the training of A0 and A1 nurses at the Kigali Health Institute and A1 nurses in several nursing schools.

According to the results of the IDHS20 (2007-2008), targets for the 2005-2009 Health Sector Strategic Plan, concerning availability of human resources in health were exceeded, for the doctor/population ratio was 1/33,000 (target: 1/37,000), nursing staff/population ratio, 1/1700 (target: 1/3900). However, only 46 midwives are working in the public sector and 75% of doctors were in the city of Kigali, where only 15%-20% of the entire population lives21

The situation analysis of the pharmaceutical sector of Rwanda revealed significant progress. The country has a substantial number of regulatory laws and other bills are being developed. Though not yet quite operational, the implementation bodies are in place, notably a Pharmaceutical Inspection Services, Pharmaceutical Information and Registration services. The country has an autonomous drug purchasing agency (CAMERWA). In order to reinforce the capacity of the above-mentioned bodies, a National Drug Agency is being put in place. The country has some local production of drugs, but this is of low capacity.

Concerning the accessibility, use and quality of services, the public health system is based on the primary health care strategy, with 433 health facilities. 75% of the population lives within less than 5 km of a health facility and the average coverage of hospitals is 190,000 inhabitants per hospital. Five national hospitals are used as referral hospitals: two university teaching hospitals, one military hospital, one psychiatric hospital and a hospital whose mission is to provide specialized services not available in the other reference hospitals in order to limit the cost of evacuations outside the country. To improve geographical accessibility, 4 new hospitals and 7 health centres were built in 2006.

To improve the accessibility to services rendered to the population, 51 ambulances have been purchased and distributed to hospitals and health centres, 370 motorcycles have been distributed to the health centres and vehicles for supervision of health activities have been provided to the districts. The SAMU (Service d’Aide médicale d’Urgence) has just been put in place to provide emergency medical assistance. A national programme for improving the quality of care and health services has been instituted and a 5-year strategic plan has also been developed. The modules for training of trainers in this area have been reviewed and adapted.

20 Mini DHS (April 2008).
21 MTR HSSP I, Final Report.
2.3 ASSESSMENT OF IMPLEMENTATION OF THE PREVIOUS CCS 2004 - 2007

The major challenges of the previous CCS that were identified in the sector were:
- Dealing with the persistence of the most prevalent communicable diseases (HIV/AIDS, malaria, tuberculosis, childhood diseases) and problems associated with pregnancy and delivery;
- Strengthening the capacities of the Ministry of Health in its role of overall management of the sector, coordination of interventions of the partners and advocacy for allocation of resources, their rational use and placing health at the centre of socio-economic development;
- Improving the production and management of human resources for health, with the aim of making up the current shortage in both quantity and quality;
- Strengthening the health system so as to improve access to quality health care, especially for the most disadvantaged population groups;
- Improving the quality of water supply and sanitation systems and their accessibility to the populations, and promoting an enabling environment for health;
- Strengthening the mechanisms for community participation in care and treatment, and promotion of its health.

To meet these challenges, WHO proposed the following strategic orientations:
  i. Improving health system performance;
  ii. combating diseases;
  iii. Promoting health as well as health and environment.

The different programmatic evaluations carried out show that WHO areas of intervention in Rwanda were aligned with those of the Government of Rwanda, and regional and international priorities.

The main national achievements to which WHO contributed, during the period 2004-2007, were the following:

The strengthening of the capacities of the Ministry of Health in the management of the sector, coordination of the interventions of partners and advocacy, allocation of resources and their rational use, marked by the pursuit of the decentralization process that was instituted at the level of the National Public Administration in early 2006. Technical support was provided to highlight the place of health in the country’s development. Indeed, the assessment of the PRSP I (Poverty Reduction Strategy Paper), specific to the health sector, was done and the results guided the ongoing process of development of the EDPRS (Economic Development and Poverty Reduction Strategy), which was validated in September 2007.

WHO also contributed to the production of the 2006 report on the National Health Accounts, the improvement of the production and management of human resources in terms of both quality and quantity, the improvement of access to quality health care, notably with the establishment of mutual health and financing schemes based on performance, the improvement of the quality of the water supply system, the preparation and response to the most prevalent communicable diseases.
WHO contributed to the strengthening of the capacities of the health financing component of the health system, improvement of the integrated management of mutual health schemes (MH), with a view to ensuring maximal performance of MHs, and, strengthening of the capacities for analysis, monitoring and evaluation of financial resources invested in health. It also contributed to the integration of the “Health Metrics Network” (HMN) approach for strengthening the Health Information System (HIS), the improvement of access to quality drugs and institutionalization of traditional medicine.

The contribution of WHO was in several areas, including advocacy, sensitization and partnerships, direct support, development and dissemination of action plans, guidelines and tools, strengthening of capacities of staff, accompaniment, epidemiological surveillance, and monitoring/evaluation and research in the framework of HIV/AIDS, malaria and tuberculosis control. Thanks to the concerted efforts of the country and its partners, the implementation of the priority interventions associated with HIV/AIDS in the health sector accomplished substantial progress in the framework of universal access to prevention and treatment services.

WHO also provided technical and financial support in all stages of implementation of facility IMCI, community IMCI and the development of the strategy for accelerating the reduction of maternal and neonatal mortality. WHO contributed to the development of the policy, the nutrition strategic plan and its implementation.

2.4 WEAKNESSES IN THE IMPLEMENTATION OF THE STRATEGIC AGENDA

The different strategic orientations have been developed. However, the health system of Rwanda is still confronted with major problems:
- Low accessibility to quality health care, notably for the poorest population groups;
- Persistent insufficiency of human resources in terms of quality and quantity, partly due to poor management (production, utilisation, etc.);
- Extreme poverty of a big section of the population;
- Inadequate funding of the sector and strong reliance on external contributions.

It is thus more than ever necessary to pursue WHO actions in the support for development of human resources for health, extension of the coverage of the populations by community health insurance schemes, preparation and response to disasters and epidemics, and the institutionalization, regulation and legislation in the pharmaceutical sector. WHO support will also be intensified in the areas of health research and health information system.

2.5 CURRENT CHALLENGES

Despite the major achievements the health system still faces challenges.

Therefore under the new CCS 2009-2013, WHO will concentrate its efforts on providing support in the following areas:
- Strengthening the managerial and technical capacities at the different levels of service;
- Supporting the restructuring of the Health Information System in order to improve timely production of reliable and usable data to guide decision-making in health;
- Improving the production and management of human resources for health, with a view to addressing the present shortage both in quantity and quality;
- Strengthening the health system with a view to improving access to quality health care, especially for the most vulnerable population groups;
- Improving the quality of sanitation and water supply systems to ensure better accessibility for the populations and, thereby, promoting an enabling environment for health;
- Tackling the persistence of communicable and non-communicable diseases, epidemics and disasters, particularly HIV/AIDS, malaria, tuberculosis, childhood diseases and problems associated with pregnancy and delivery;
- Strengthening the mechanisms for community participation in care and treatment and health promotion;
- Strengthening the system for the supply of quality essential products and technologies and mechanisms for monitoring their use and utilisation.
SECTION 3: DEVELOPMENT ASSISTANCE AND PARTNERSHIP

3.1 GENERAL TREND OF DEVELOPMENT ASSISTANCE

During the period that followed the genocide in Rwanda, from 1994 to 1999, the assistance granted to this country by donor countries was channelled mainly through non-Governmental organizations from donor countries. Only a few countries continued to provide direct assistance or budget support. This aid was intended mainly for meeting emergency humanitarian situation and rehabilitation.

Since the end of the year 1999, the trend has been reversed and as the country is coming out of the emergency period and acquires political and economic stability, assistance from donor countries and international organizations started going directly to the Government, represented by the Minister of Finance and Economic Planning. This was facilitated by the new aid policy developed by the Ministry of Finance and Economic Planning and adopted by the Government. It reflects the desire of the Government of Rwanda to see partners directly supporting the Government instead of directing their support through projects or NGOs.

In 2006, 26% of external assistance was in the form of budget support, increasing to 30% in 2007 as a result of greater emphasis on budget support. The United States of America is the biggest donor in Rwanda with 100% of their support channelled through projects.

In the health sector, the development was the same as in the other sectors, and between 2002 and 2005, the three sources of public health funding increased significantly (see graph). The annual growth rates over the period were largely higher than the GDP deflator rate (+8.9% per annum) and the population growth rate (+2.75% per annum), which represents a significant improvement of the resources and expenditures per capita.

The contribution of donors represents nearly two-thirds of the total resources of the sector for the two years 2004 and 2005, complementing well the government efforts. Incomes from health facilities have also registered sustained growth although at a less rapid pace. It is probable that the contractual approach and subscription to mutual health schemes were the main reasons for the increase in visits to health facilities.

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22 Strengthening partnerships, Annual report of the Government of Rwanda and development partners, 2006
23 Rate by which the GDP is adjusted to obtain real GDP
3.2 MODALITIES OF DEVELOPMENT ASSISTANCE

The modalities of assistance follow the principles highlighted in the policy assistance and these principles facilitate the evaluation of the progress made in terms of donor policy, practices and procedures:

- A declaration of the Government on its choices in terms of modalities of assistance with a generalized budget support and suspension of the sector support through projects;
- A requirement for alignment to Sector Strategic Plans;
- A desire of the Government to see the partners enhance the use of the public financial management system, which will, in turn, be strengthened;
- A pooling of the funds and increased use of the delegation of powers between donors;
- Donors are invited to use a lot more their comparative advantages in their offer of support to the sectors and sub-sectors, with the Government of Rwanda playing the role of a guide;
- The Government of Rwanda will clearly determine the responsibilities of Ministries and public institutions in the negotiation and management of assistance.

The support structures comprise a budget support harmonization group, which serves as a forum for discussion and negotiation of budget support. This group constitutes the basis of a strong partnership between the Government and the partners and between the partners themselves.

There are also cluster and sector working groups, which facilitate dialogue between the Government and its development partners. In this regard, the annual review of the health sector helps to assess the progress made and determines the way forward.

3.3 MAIN PARTNERS AND AREAS OF INTERVENTION

The main partners of the Government of Rwanda in terms of funds released are the United States of America, the World Bank, the United Kingdom, the European Union and the United Nations system.

In the health sector, 16 actors are operating in Rwanda: 7 bilateral cooperation agencies, 3 international institutions and 6 UN agencies.

3.4 COORDINATION MECHANISMS OF THE INTERVENTIONS

These mechanisms concern the coordination of the public sector as well as that of development partners. All the coordination mechanisms are built around the implementation of the Economic Development and Poverty Reduction Strategy (EDPRS) under the guidance of the Ministry of Finance and Economic Planning. In the case of public institutions, the coordination takes place at three levels:

**Intersectoral coordination:**
In the public sector, three approaches are used namely exchange of information, establishment of confidence and strengthening accountability. Information exchange is done through the
national planning forum, which regroups all the directors of planning in the Ministries and meets twice a year. To establish confidence, the stakeholders are requested to respect the deadlines, more particularly for activities involving several actors.

To enhance accountability, it is envisaged to sign a formal agreement, based on priorities of the EDPRS, between the Ministry concerned and the public institutions involved in the implementation. This agreement is signed at the decentralized level (local level coordination agreement\textsuperscript{25}), which will help raise awareness on the mutual obligations of the parties concerned.

**Strengthening of public finance management:**
The national Steering Committee has been put in place and it is supported by a Secretariat. To strengthen this committee, a “trust-fund” regrouping several donors has also been constituted.

The promotion of harmonization and alignment of donors on the priorities of the EDPRS are ensured by the Development Partners Coordination Group (DPCG) and SWAP/Health.

**Coordination within the Ministry of Health:**
In addition to the current efforts deployed by the Government and donors to harmonize their assistance, a common agreement has been signed between the Ministry of Health and development partners of the sector. This agreement concerns the use of the sector-wide approach (SWAP) in the health sector, in the framework of implementation of the Health Sector strategic plan, the EDPRS and Vision 2020.

All actors in the health are coordinated by the Health Sector Cluster Group, chaired by the Permanent Secretary in the Ministry of Health and the Belgian Cooperation Agency. For the actors and interventions in HIV/AIDS, the National AIDS Control Commission ensures the coordination, mobilization of partners and the community.

The Centre for Treatment and Research on HIV/AIDS, Malaria and other Epidemics (TRAC PLUS) ensures coordination of the fight against HIV and AIDS, malaria, tuberculosis and other epidemics, within the health sector.

**Interagency coordination:**
The “Steering Committee” of the ‘One UN’, chaired by the Minister of Finance and composed of representatives of the heads of UN agencies, representatives of the Government and other development partners of the country, contributes to the coordination of all actions of the United Nations system in the country, including in the health sector.

Interagency coordination is carried out through the United Nations in Rwanda (UN Country Team/UNCT), a coordination forum, where representatives of all the agencies meet to discuss their joint action in Rwanda. This forum is supported by six thematic groups, two of which are HIV/AIDS and Health/Population/Nutrition. In the framework of the implementation of its new reform (“One UN”), the United Nations system has developed a programming

\textsuperscript{25} The equivalent of this concept in Kinyarwanda is “Imihigo” or commitment, a concept, which is of capital importance in the Rwandan culture since you have to honour your commitments at the risk of being excluded from the group of honest men.
document called Common Operational Document (COD), which explains how its Development Assistance Framework (UNDAF) in the country is coordinated and operationalized.

The UNDAF provides a coherent, collective and integrated approach for the United Nations to respond to the needs and priorities expressed by the Government through the HSSPII (an operational tool in the health sector of the EDPRS, Vision 2020 and MDGs).

SECTION 4: WHO INSTITUTIONAL POLICY FRAMEWORK: GLOBAL AND REGIONAL ORIENTATIONS

The policy directs WHO operations in the country to be based on the needs of Member State as defined in the WHO Medium-Term Strategic Plan 2008-2013 (MTSP). Its objective is to ensure that the Secretariat of the WHO assists more efficiently the countries to strengthen their health system, improve their health outcomes and attain the health-related Millennium Development Goals.

The WHO Country Cooperation Strategy (CCS) defines the medium-term framework of WHO cooperation with a given country. It is one of the main tools used by WHO to align its cooperation on national strategies and action plans and harmonize its action with that of organizations of the United Nations system and its other development partners.

4.1 GOAL AND MISSION OF WHO

The mission of WHO remains “the attainment by all peoples of the highest possible level of health” (Article 1 of WHO Constitution). The WHO Corporate Strategy, the 11th General Programme of Work 2006-2015 and the Strategic Orientations for WHO action in the African Region 2005-2009 outline key features through which WHO can make the greatest possible contribution to health improvement.

WHO, indeed, strives to intensify its leadership role in the health sector, at both the technical and political levels, just like its management capacity to address the needs of Member States, including attainment of the MDGs.

4.2 CORE FUNCTIONS

The work of WHO is guided by the following six core functions, which are based on its comparative advantage:

1. Providing leadership in matters critical to health and engaging in partnership where joint action is needed;
2. Shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;
3. Setting norms and standards, and promoting and monitoring their implementation;
4. Articulating ethical and evidence-based policy options;
5. Providing technical support, catalyzing changes, and building sustainable institutional capacity;
6. Monitoring the health situation and assessing health trends.

4.3 GLOBAL HEALTH AGENDA
In order to address policy-related gaps in social justice, responsibility, implementation and knowledge, the global health agenda identifies seven priority areas, namely:
1. Investing in health to reduce poverty;
2. Building individual and global health security;
3. Promoting universal coverage, gender equality and health-related human rights;
4. Tracking the determinants of health;
5. Strengthening health systems and equitable access;
6. Harnessing knowledge, science and technology; and
7. Strengthening governance, leadership and accountability.

In addition, the Director General of WHO has proposed six essential issues - concerns on which the emphasis should be placed in order to achieve these outcomes: Health Development, Health Security, Health Systems, Evidence for Strategies, Partnerships and Improving the Performance of WHO. In addition she indicated that the success of the Organization should be measured in terms of results on the health of women and the African population.

4.4 GLOBAL PRIORITY AREAS
The Global Priority Areas have been outlined in the 11th General Programme of Work. They include:
- Providing support to countries in moving to universal coverage with effective public health interventions;
- Strengthening global health security;
- Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
- Increasing institutional capacities to deliver public health functions, under the strengthened governance of Ministries of health; and
- Strengthening WHO’s leadership at the global and regional levels and supporting the work of governments at country level.

4.5 REGIONAL PRIORITY AREAS
The regional priorities have taken into account the global documents and resolutions of the WHO governing bodies, the health-related Millennium Development Goals, and the NEPAD health strategy, resolutions on health adopted by Heads of State of the African Union and the organizational strategic objectives, which are outlined in the Medium-Term Strategic Plan (MTSP) 2008-2013.

These regional priorities are presented in the “Strategic Orientations for WHO Action in the African Region 2005-2009”. They include prevention and control of communicable and non-communicable diseases, child survival and maternal health, emergency and humanitarian
action, health promotion, and policy-making for health in development and other determinants of health.

Other priority objectives cover health and environment, food safety and nutrition, health systems (policy, service delivery, financing, technologies and laboratories), governance and partnerships, and management and infrastructure.

In addition to the priorities mentioned above, the Region is committed to support countries to attain the health-related Millennium Development Goals and assist in tackling its human resource challenges.

In collaboration with the other agencies concerned, the problem of how to assist countries source financing for their goals will be addressed under the leadership of the countries. To meet these added challenges, one of the important priorities of the region is the decentralization and installation of intercountry support teams to further support countries in their own decentralization process, so that communities may derive maximum benefit from the technical support available to them.

To effectively address these priorities, the Region is guided by the following strategic orientations:
- Strengthening WHO Country Offices;
- Improving and expanding partnerships for health;
- Supporting the planning and management of district health systems;
- Promoting the scaling-up of essential health interventions related to priority health problems; and
- Enhancing awareness and response to key determinants of health.

4.6 MAKING WHO MORE EFFECTIVE AT COUNTRY LEVEL
The outcome of the expression of WHO’s effectiveness at country level will vary from country to country, depending on country-specific context and health challenges. But building WHO’s mandate and its comparative advantage, the six critical core functions of the Organization, as outlined in Section 4.2, may be adjusted to suit each individual country.

SECTION 5: CURRENT WHO COOPERATION WITH RWANDA

5.1 COUNTRY OFFICE

5.1.1. Background
The technical cooperation agreement between the World Health Organization and Rwanda was signed in June 1964. This cooperation is based on a biennial planning established on the basis of priorities of the country, orientations of the WHO African Region and global priorities.

5.1.2. WHO areas of work for the 2008-2009 biennial period
The current cooperation strategy takes into account both the achievements on previous strategies and resolutions of the 50th session of the Regional Committee and the 54th World Health Association as well as the 13 strategic objectives defined in the Medium-term Strategic
Plan (MTSP). For the 2004-2005 and 2006-2007 biennial periods, 19 areas of intervention were retained at the end of a joint WHO/Ministry of Health planning.

The 2008-2009 work plan covers 13 strategic objectives (SO) with a total budget of US$ 9,749,685, of which US$ 3,271,000 are devoted to regular budget and US$ 36,478,685 from voluntary contributions. Under these strategic objectives, 15 outcomes expected at country level and to which the budget was distributed were defined.

Table 1: WHO areas of intervention and amounts allocated (RB+EB), 2008-2009, Amounts allocated in US$

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Amount allocated in US$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RB</td>
</tr>
<tr>
<td>SO1 Reducing the health, social and economic burden due to communicable diseases.</td>
<td>335,000</td>
</tr>
<tr>
<td>SO2 Combating HIV/AIDS, Tuberculosis and Malaria</td>
<td>133,000</td>
</tr>
<tr>
<td>SO3 Preventing and reducing the morbidity, disability and premature mortality due to chronic non-communicable diseases, mental illness and violence</td>
<td>140,000</td>
</tr>
<tr>
<td>SO4 Reducing the morbidity and the mortality and improving health in the main stages of life (pregnancy, delivery, neonatal period, childhood, including adolescence), while improving sexual and reproductive health and helping all individuals to grow old while remaining active</td>
<td>287,000</td>
</tr>
<tr>
<td>SO5 Reducing the effects on health of emergency situations, disasters, crises and conflicts, as well as their social and economic impacts</td>
<td>53,000</td>
</tr>
<tr>
<td>SO6 Promoting health and development, and preventing or reducing the risk factors for health, due to tobacco, alcohol, drugs and use of other psychotropic substances, imbalanced feeding, sedentary life style and high-risk sexual relations</td>
<td>147,000</td>
</tr>
<tr>
<td>SO7 Dealing with the social and economic determinants of health, through policies and programmes that promote equity in health and integrate approaches that are favourable to the poor, respectful of gender differences and human rights.</td>
<td>84,000</td>
</tr>
<tr>
<td>SO8 Promoting a healthier environment, developing primary prevention and reorienting public policies in all sectors, so as to tackle the underlying causes of environment-related threats to health</td>
<td>93,000</td>
</tr>
<tr>
<td>SO9 Improving nutrition, food safety, food</td>
<td>183,000</td>
</tr>
</tbody>
</table>
### 5.1.3. Human resource development

In the framework of reprofiling of the Country Offices and with a view to enhancing team spirit and ensuring greater efficiency, the different technical programmes had been grouped into four clusters: Health Systems, Disease Prevention and Control, Maternal and Adolescent Health, Health Promotion and Health and Environment. According to the last recommendations by the Regional Director and requirements of adaptation of the implementation of the work plan to the requirements of adaptation to the Global Management System (GMS), the 13 strategic objectives have been grouped into 4 new clusters: WHO’s Presence in the Country (WPC), Health System and Policies (HSP), Technical Programme Support (TPS) and Support for the Control of AIDS, Tuberculosis and Malaria (ATM).

At the end of the year 2008, the WHO Rwanda country office had a staff of 31 people: 4 international civil servants, including the Representative), 12 national professional staff and 15 administrative and support staff, to implement its cooperation activities. The total number of staff of the Office has not changed during the past three years. The recent evaluation of capacities, conducted in the framework of the “One UN” imitative, showed a need for strengthening the technical staff with two new posts: a Policy Adviser and an M&E Adviser.

### 5.1.4. Development of financial resources

The total budget has increased from US$ 7,820,000 during the 2006-2007 biennial period to US$ 9,749,685 for the 2008-2009 biennial period, representing an increase of 25%. This increase concerns voluntary funds alone whereas the regular budget did not change.

### 5.2 SUPPORT FROM HEADQUARTERS AND REGIONAL OFFICE

The 2006-2007 biennial period was marked by the visit of the WHO Regional Director for Africa. At the request of the country, missions from headquarters, the Regional Office and Inter-country Support Team for Central and East Africa were conducted in the different areas of WHO intervention.

### 5.3 STRENGTHS, WEAKNESSES, CHALLENGES, OPPORTUNITIES AND THREATS OF COUNTRY COOPERATION
Strengths:
- Excellent collaboration with the Ministry of Health;
- Technical support reflected by the existence of focal points from the Country Office and international consultants from the ICSTs, Regional Office and headquarters;
- Availability of quality technical documentation;
- Joint programming and evaluation with the Ministry of Health;
- Financial support for implementation of activities.

Weaknesses:
- Ineffective availability of voluntary funds for certain programmes;
- Inadequate monitoring of the implementation of the work plan by the two parties (WHO and Ministry of Health);
- Delays in the administrative and financial procedures.

Threats/challenges:
- High proportion of poor people in the country;
- Insufficient staff;
- Unstable socio-political situation in the Great Lakes Region;
- Risks of importation of epidemic diseases in the process of eradication/elimination;
- Risks of occurrence of natural disasters (volcanic eruptions, earthquake, flooding, drought, etc.).

Opportunities:
- Existence of a health policy and a clear vision of health priorities;
- Existence of high-level political will and confidence on the part of donors;
- Adoption of the second Health Sector Strategic Plan (HSSPII) as operationalization tool for health of the EDPRS and Vision 2020 of the Government;
- Acknowledgement by the partners of WHO’s technical leadership role in the health sector;
- Existence of an operational communication infrastructure in the country;
- Context of “Delivering as One”, which enhances harmonization, resource mobilization;
- Operationalization guide of the SWAP and community SWAP ongoing.

SECTION 6: STRATEGIC AGENDA: CHOICE OF PRIORITIES FOR WHO COUNTRY COOPERATION

The strategic agenda of WHO cooperation with Rwanda for the period 2009-2013 is in line with the different reforms for the development of the country in general and the health sector in particular. The cooperation between WHO and Rwanda during this period is in line with the framework of the 11th General Programme of Work (2006-2015) of the Global Health Action Programme and also the operationalization of the WHO Medium-Term Strategic Plan.
The WHO strategy for cooperation with Rwanda for the period 2009-2013 aims at guiding the support interventions of WHO for implementation of the second Health Sector Strategic Plan (HSSP II), a tool for operationalization of the EDPRS and Vision 2020. It is also in harmony with the common programme of the United Nations (COD), which, in the framework of the “One UN”, operationalizes the United Nations Development Assistance Framework (UNDAF).

The strategic orientations of WHO support for the coming four years are:

i. Reduction of maternal and child mortality;
ii. The fight against communicable and non-communicable diseases;
iii. Health promotion, food security, health and environment;
iv. Improvement of health system performance.

6.1 REDUCTION OF MATERNAL AND CHILD MORTALITY

Reduction of maternal and child mortality is one the highest priorities of the Government. In that regard, WHO will intervene in the following areas:

6.1.1 Implementation of the road map for accelerating the reduction of maternal and neonatal mortality

WHO will support:
- The finalization and implementation of the strategic plan for accelerating the reduction of maternal and neonatal mortality;
- The development of operationalization plans for the strategic plan at district level;
- The scaling-up of emergency obstetrical and neonatal care;
- The implementation and monitoring of the audit of maternal and neonatal deaths;
- The strengthening of the capacities of the communities in the area of safe motherhood and child survival.

6.1.2. Implementation of the reproductive health policy

WHO will intervene in the following support areas:
- Review of the reproductive health policy, development and implementation of the reproductive health strategic plan, including reproductive health of adolescents;
- Establishment of mechanisms and initiatives for improving accessibility, demand and quality of family planning services;
- Strengthening the implementation of the family planning policy;
- Improvement of the accessibility and quality of FP services, more specifically INGO-term contraceptive methods;
- Development of a minimum package of reproductive health services of adolescents;
- Strengthening of the capacities of health staff and health workers.

6.1.3. Implementation of child survival interventions

WHO will provide support for:
- Implementation of the child survival strategic plan;
- Updating the malnutrition control strategic plan;
- Implementation and monitoring of the interventions defined in the child survival strategic acceleration plan through:
- Continued support to routine EPI, introduction of new vaccines, as well as all initiatives aimed at accelerating the eradication of poliomyelitis,
- Elimination of measles and control of other vaccine-preventable diseases;
- Intensification of the strategy for integrated management of childhood illnesses (IMCI), including its community component, the strengthening of the management of paediatric emergencies, prevention, care and treatment of child malnutrition.
- Strengthening capacities in management of malnutrition.

For each of these areas, WHO will pursue its technical support and advocacy roles for the strengthening of the integration of services, review, development and implementation of new policies, strategies, standards and norms, strengthening of family and community initiatives.

6.2 CONTROL OF COMMUNICABLE AND NONCOMMUNICABLE DISEASES
The control of communicable and non-communicable diseases features as one of the priorities of the second Health Sector Strategic Plan (HSSP II, 2009-2012). In that regard, WHO will provide expertise and support in the following areas:

6.2.1 Integrated Disease Surveillance and Response (IDSR)
Emphasis will be placed on:
- Strengthening the implementation of the integrated disease surveillance strategy;
- Implementation of the new international health regulation;
- Strengthening of capacities of the response teams and laboratories at the different levels of the health system;
- Preparation and response to other major epidemics and pandemics (cholera, meningitis, haemorrhagic fever, pandemic flu);
- Promotion and integration of the surveillance of non-communicable chronic diseases and their risk factors;
- Advocacy among the other partners for mobilizing the necessary resources for implementing the SIMR strategy.

6.2.2 Combating HIV/AIDS, malaria and tuberculosis
The fight against HIV/AIDS, malaria and tuberculosis is one of the major priorities of the Government and are taken into account in the strategic objectives of the HSSP II (2009-2012).

WHO will pursue its support for the consolidation, extension, strengthening of the scaling-up of interventions aimed at promoting universal access to STIs/ HIV/AIDS, malaria and tuberculosis as well as prevention, treatment, care and support services. WHO contribution will focus on the following actions:
- Development/updating of national policies and strategic plans for the control of HIV/AIDS, tuberculosis and malaria, as well as national guidelines, training tools, norms and procedures in the area of prevention, care and treatment;
- Intensification of the core prevention activities aimed at reducing the incidence of HIV within the general population. WHO support will concern inadequately covered areas,
such as targeted interventions for population groups most at risk (sex workers and their clients, sero-discordant couples and others), scaling-up of circumcision and PIT services, promotion of condom use and improvement of the quality of care and treatment of STIs and opportunistic infections;
- Consolidation and strengthening of the “DOTS” strategy for tuberculosis control, including, at the community level, and public-private joint approach. The scaling up of TB/HIV collaboration activities and management of multi-drug resistant tuberculosis (MDR-TB) will be enhanced;
- Intensification of the implementation of strategies for malaria pre-elimination strategies: integrated vector control, with particular emphasis on universal coverage, as well as surveillance and response to epidemics, detection of all suspicious cases and early care and treatment, including at the community level;
- Strengthening of capacities of staff and community workers to ensure efficient contribution to HIV and AIDS, malaria and tuberculosis prevention, testing, care and treatment services. Support will be provided in collaboration with the other partners in the framework of the implementation and monitoring of the task transfer plan in care and treatment;
- Promotion of efforts for improving strategic information targeting the control of the three diseases and response capacities: strengthening of the health system, intensification of the monitoring and evaluation, improvement of the disease surveillance system and monitoring of drug resistance. The support for operational research will be geared towards validation of best practices with a view to promoting evidence-based decision making; intensification of partnership by contributing actively to the mobilization of financial resources and the absorption capacity by involving the communities more in prevention, care and treatment activities and intensifying joint development and review of the plans for controlling the 3 diseases.

6.2.3 Control of Neglected Tropical Diseases (NTDs):

WHO will provide support for:
- Updating the mapping of NTDs;
- Developing and implementing the integrated strategy for combating Neglected Tropical Diseases;
- Mobilizing partners for support to the national NTD control strategy.

6.2.4 Prevention, care and treatment of non-communicable diseases

WHO will provide guidance and support for:
- Adaptation and implementation of WHO’s framework for surveillance of non-communicable chronic diseases and their risk factors;
- Implementation of the strategies for prevention and integrated control of common risk factors of the main non-communicable chronic diseases;
- Development of a policy for prevention of violence and traumas and management of disabilities;
- Review of the national mental health policy and strategies for prevention and management of mental health, drug and tobacco abuse problems;
- Intensification of the integration and decentralization of services for management of mental health problems (including at the community level) in the primary health care
strategy. WHO will provide support in the development of a plan for strengthening capacities in the area of mental health.

6.2.5 Management of health consequences of emergencies and disasters

WHO will intervene in the strengthening of the preparation and response to emergency situations, including those created by epidemics. This support will be focused on development of a national emergency preparedness and response plan, strengthening of national capacities in disaster management and also on support for sub-regional strategies for the prevention and response to emergencies and epidemics.

6.3 HEALTH PROMOTION, FOOD SAFETY AND NUTRITION, HEALTH AND ENVIRONMENT

Health promotion, food safety and nutrition, health and environment form part of the second strategic objective of the Health Sector Strategic Plan (2009-2012), on the consolidation, extension and improvement of disease prevention and health promotion services. WHO will continue to play a leadership role in the support for development of norms and standards in the area of water quality, hygiene and sanitation and food safety and nutrition. This support will also cover the following different areas:

6.3.1 Promotion of healthy lifestyles

WHO will intervene in:
- The implementation and monitoring of the school health policy as well as the development of the school health guide;
- Technical support for strengthening the school health programme and in advocacy actions with the other partners;
- Support for the development of a health policy and promotion plan, with the emphasis on family planning, adolescent health, non-communicable diseases, HIV and AIDS, malaria and tuberculosis, and coordination of health promotion activities.

6.3.2 Promotion of the management of the health of communities

The action of WHO will concern:
- Technical and financial support, and advocacy for strengthening the capacities of community health workers within a partnership;
- Support for dissemination of good community health practices.

6.3.3 Promotion of an enabling physical health environment

WHO will focus its efforts on:
- Support for implementation of health policies and strategic plans on the environment and management of biomedical wastes;
- Support for improvement of health and environment conditions, hygiene and sanitation in favour of the population;
- Support for promotion of health and the environment at community level;
- Support for improvement of the management of data on health and the environment;
- Strengthening of the capacities of health and environment professionals;
- Advocacy with the partners for resource mobilization.

6.3.4 **Food safety and nutrition**
WHO will intervene in:
- Support for capacity building, at the level of the districts, for the inspection food safety and nutrition;
- Support for implementation of the strategic policy and plan on food safety and nutrition.

6.4 **STRENGTHENING HEALTH SYSTEM PERFORMANCE**
With a view to improving the health system, WHO will provide support in the following areas:

6.4.1 **Health system policies and delivery of services**
WHO will provide support for:
- Strengthening of managerial and technical capacities at the different levels;
- Developing and reviewing the strategic policies and plans of the different health sectors;
- Strengthening the coordination of the health sector in the framework of the sector approach;
- Implementing Global and African recommendations, notably those of Ouagadougou on Primary Health Care, Algiers on Health Research and Libreville on the Environment.

6.4.2 **Health Financing and social protection**
WHO will provide support for:
- Development and implementation of the sustainable health financing policy;
- Strengthening the integrated management and performance of community based (mutual)health insurance schemes (CBHIs);
- Strengthening the contractual approach “Performance-Based Financing” (PBF);
- Analysis, monitoring and evaluation of financial resources invested in health, notably, through development of reports on national health accounts.

6.4.3 **Production and management of human resources for health**
WHO will provide technical and financial support for:
- Monitoring, evaluation and review of the policy and strategic plan for developing human resources in health;
- Strengthening of capacities for implementing the Human Resources for Health Strategic Plan;
- Integration of the teaching of national programmes into the curricula of basic training in health schools. WHO will pursue its support for strengthening the skills of teachers of schools for training health professionals;
- Development and implementation of task shifting, policy and strategic plan.

6.4.4 Capacity building in the integrated management of the Health Information System (HIS)
WHO support will concern:
- Development and implementation of a national policy on the Health Information System;
- Promotion of operational research in the priority health areas;
- Strengthening of the national Health Information System, epidemiological surveillance and capacities in management of knowledge.

6.4.5 Strengthening of the policy on access to medical technologies and products
WHO support will cover:
- Development and review of national policies and regulatory texts in the pharmaceutical domain, traditional medicine, blood transfusion and laboratory areas;
- Adaptation and implementation of international norms, guidelines and standards for the quality, innocuousness, efficiency and effectiveness of pharmaceutical and health products and technologies;
- Promotion of traditional medicine and strengthening of the national pharmacovigilance system;
- Promotion of the use of factual and scientific data to render more efficient and effective health and pharmaceutical technologies and products, by care providers and consumers;
- Development and review of basic documents for ensuring rational use of health products and technologies.

SECTION 7: IMPLICATIONS OF IMPLEMENTATION OF THE STRATEGIC AGENDA

The implementation of the strategic agenda will require intensification of the interactions between, the WHO country Office in Rwanda and the Inter-country Team for Central Africa, the Regional Office and headquarters on the one hand, and, the Ministry of Health and the United Nations system in Rwanda on the other. To that end, prior internal arrangement at the Country Office will be necessary.

7.1 IMPLICATIONS FOR COUNTRY OFFICE, MINISTRY OF HEALTH AND UNITED NATIONS SYSTEM

The WHO Country Office will be the center of WHO cooperation with Rwanda, by coordinating the support from the different programmes and components of the Organization, while ensuring effective control of all the resources intended for the country. As has been the case since the establishment of the WHO Office in Rwanda, the Ministry of Health will continue to be the privileged interlocutor, but the action framework will be adapted to the strategies and orientations of Vision 2020, the EDPRS, 2008-2012, the HSSP II, 2009-2012.
The WHO Office in Rwanda will continue to play a reference role in the area of information and norms, while supporting the coordination of the health sector partners. In this regard, the Office will ensure the strengthening of its own capacities in order to address more efficiently the needs of the country and its partners. This will entail notably:

1. The strengthening of the technical and managerial capacities of the Country Office team in the following areas:

   - The collaboration, synergy, integration and mutual support between the different members of the WHO team will be intensified;
   - The technical and management aspects of the areas of action retained for implementation of the strategic agenda, the capacities for anticipation and adaptation to change at the different levels (national, regional and global), the initiation, analysis and monitoring of the policy as well as efficient management of the technical cooperation will be mastered to ensure greater efficiency and impact;
   - The information on implementation of the HSSP II and priority health programmes will be collected, analyzed, used and disseminated, in agreement with the concerned national officials of the Ministry of Health, for their integration into the annual reports at the regional and global levels;

2. Staff motivation through continuing training will be intensified. Improvement of the administration and management of the Country Office in the planning of activities

The present strategy of WHO cooperation with Rwanda (2009-2012), comes within the scope of the principle of alignment with the HSSP II and EDPRS. It also falls within the framework of the Global Health Action of the 11th General Programme of Work (2006-2015) and in the framework of operationalization of the WHO Medium-Term Strategic Plan.

3. Human resources:

   For an active participation of WHO in these changes imposed by the reorientation of the cooperation at the national level, the staff of the Office should devote more time to activities in support of the Ministry of Health and those carried out jointly with the other UN agencies in Rwanda, under the “ONE UN” Programme.

   The competencies of the staff will be strengthened and where necessary, the services of national and international consultants will be required, notably, for the monitoring and evaluation of activities.

4. Technical and material resources:

   The staff will be provided with more resources to enable them to efficiently respond to requests by their colleagues from the Ministry of Health and the United Nations system.

   In this regard, the mobility of staff will be intensified on both sides, through the increase and reorganization of the means of transport and communication.

5. Financial support
The Ministry of Health is hopeful that WHO will honour its financial commitments especially, for activities requiring vertical funds. This point constitutes one of the weaknesses of WHO, although the Country Office cannot overcome this difficulty without the support of the Regional Office and headquarters. WHO’s financial support, which currently targets planned activities, should be transformed into direct budget support to the Ministry of Health. A common strategy for mobilization of funds within the United Nations should provide part of the response.

7.2 INTERCOUNTRY SUPPORT TEAMS, REGIONAL OFFICE AND HEADQUARTERS

The recommendations made in the previous version of the CCS are still valid:
- Intensification of the delegation of authority of the Representatives, in the recruitment and management of certain categories of temporary staff;
- Improvement of the collaboration and coordination between the three levels of the WHO in the planning, implementation and monitoring of actions;
- Authorization and strengthening of the capacities of the Country Offices to mobilize resources (development of guidelines);
- Identification of the support from the Regional Office and headquarters, based on the needs expressed by the countries.

SECTION 8: MONITORING AND EVALUATION

The CCS will be the key tool of the Country Office for harmonizing and aligning WHO contribution in the framework of existing processes in support of the development of Rwanda like the EDPRS, the Sector-wide approaches (SWAP), the United Nations Development Assistance Framework (UNDAF), and the Common Operational Document (COD). WHO will assess its contribution to national outcomes, using the CCS as a basic reference document.

The level of achievement of expected outcomes at country level, the contribution of the WHO Country Office to the strategic objectives of the regional medium-term strategic plan, as well as WHO contribution to the achievement of the objectives of the HSSP II, will be monitored and regularly assessed.

The monitoring and evaluation of the Country Cooperation Strategy will be done through the monitoring and evaluation of work plans of the biennial periods. The present 2009-2013 CCS covers the 3 plans of the 2008-2009, 2010-2011 and 2012-2013 biennial periods. The lessons learnt from the evaluation of the previous CCS 2004-2007 are presented in Section 2.4 on assessment of its implementation.

In accordance with WHO’s management process, the implementation of the biennial plan will be monitored every six months, and an annual review/evaluation will be organized in December, to assess the level of achievement of the outcomes expected in the country, using the monitoring indicators of the biennial plan of action. An example of these indicators is presented in Annex 2, for the 2010-2011 biennial plan of action.

A mid-term evaluation will be conducted in December of the first year, and a final evaluation at the end of the second year, of each biennial period.
The mid-term evaluation will help to review the status of implementation of the plan of action and, where necessary, it will result in a re-planning of activities, in consultation with the Ministry of Health.

WHO is introducing a new management system called Global Management System (GMS). This system will enable programme administrators to better monitor budget consumption and achieve the expected outcomes of the Country Office. The implementation of the GMS will require that the staff of the Country Office be trained and that a support process be put place in order to ensure that the Office has the necessary capacities to efficiently perform this basic task.

WHO contribution to the reform of the United Nations in Rwanda, and notably, its active participation in the pilot initiative, “One UN”, are subjected to periodical monitoring and evaluation, in accordance with the framework of the monitoring and evaluation defined in the COD. The “value added” attributable to WHO, within the United Nations system and with other development partners, is evaluated every 6 months.
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17. MINISANTE: Rwanda 2007, Joint Health Sector Review.
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<table>
<thead>
<tr>
<th>Name of partner</th>
<th>Type of partnership</th>
<th>Main area of intervention</th>
<th>Intervention zone</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States of America (USAID, CDC PEPFAR, USG, Foundations)</td>
<td>Bilateral</td>
<td>HIV/AIDS (prevention, care and treatment, ARV); Research; Malaria, Tuberculosis, Health System strengthening and community health, reproductive health and FP</td>
<td>Countrywide</td>
<td>150,000,000 $ in 2007</td>
</tr>
<tr>
<td>Suisse Cooperation</td>
<td>Bilateral</td>
<td>Community participation, Health system strengthening (access to and quality of services, management capacity, coordination)</td>
<td>Karongi and Rutsiro districts</td>
<td>4,050,000 CHF in 2007-2008</td>
</tr>
<tr>
<td>Luxembourg Cooperation</td>
<td>Bilateral</td>
<td>HIV/AIDS: Drug procurement, strengthening diagnosis and biological monitoring of HIV and OIs, optimisation of clinical care, research and support</td>
<td>Kigali and Rwamagana</td>
<td>4,800,000 € for 2007-2009</td>
</tr>
<tr>
<td>Germany Cooperation</td>
<td>Bilateral</td>
<td>Strengthening capacities in reproductive health, Control of blindness, Support to primary health care, HIV</td>
<td>Huye, Nyaruguru, Nyamagabe, Gicumbi</td>
<td>3,500,000 € in 2006</td>
</tr>
<tr>
<td>Belgian Cooperation</td>
<td>Bilateral</td>
<td>Institutional strengthening, Health system strengthening (CHUK, Kigali City health services, NRL capacity building), Malaria, mental health, Nursing training schools</td>
<td>Central level, Kigali, 6 districts</td>
<td>About 21,000,000€ For all the support for the period 2003 – 2009</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>Bilateral</td>
<td>SWAP ;HIV/AIDS (Community based care including ARVs and comprehensive care), access to care</td>
<td>Countrywide</td>
<td>9,250,000 £</td>
</tr>
<tr>
<td>Organization</td>
<td>Type</td>
<td>Program Description</td>
<td>Scale</td>
<td>Duration</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>----------------</td>
</tr>
<tr>
<td>GFATM</td>
<td>Multilateral</td>
<td>HIV/AIDS (Integrated VCT, decentralisation of HIV care, access to quality care, scale up of services), Malaria, Tuberculosis</td>
<td>230 millions $</td>
<td>2002-2007</td>
</tr>
<tr>
<td>European Union</td>
<td>Multilateral</td>
<td>Health system strengthening, Reproductive Health and FP, Promotion of HIV/AIDS control</td>
<td>748800 €</td>
<td></td>
</tr>
<tr>
<td>UN</td>
<td>Multilateral</td>
<td>Capacity building, Prevention and control of communicable and non-communicable diseases, Epidemic and disaster response, HIV/AIDS, Tuberculosis, malaria, Reproductive health and FP, Nutrition, Health promotion, Hygiene and sanitation.</td>
<td>120,440,000 $</td>
<td>2008-2012 For the « One UN »</td>
</tr>
</tbody>
</table>
# ANNEX 2: Table 3: Indicators for monitoring the WHO/Ministry of Health biennial action plan, 2010 - 2011

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of execution of the budget of the action plan</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>All districts will have put in place the strategy “Reaching Each District” (RED) and attained at least 90% of vaccination coverage in pentavalent 3.</td>
<td>60%</td>
<td>100%</td>
</tr>
<tr>
<td>Number of districts having maintained the indicators of surveillance of poliomyelitis at the level of certification:</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>Proportion of health districts (HD) preparing regular reports in real time, on communicable diseases (common WHO/UNICEF declaration form):</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>National action plan document for implementation of the IRS available:</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Number of epidemics managed according to standardized operating modes:</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Proportion of epidemics and/or health emergencies having benefited from WHO support at the international level:</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>National coverage for ARV treatment:</td>
<td>77%</td>
<td>90%</td>
</tr>
<tr>
<td>National coverage of PMTCT for pregnant women:</td>
<td>75%</td>
<td>90%</td>
</tr>
<tr>
<td>National coverage in MII:</td>
<td>57%</td>
<td>85%</td>
</tr>
<tr>
<td>Tuberculosis testing and treatment rates:</td>
<td>27%</td>
<td>70%</td>
</tr>
<tr>
<td>Proportion of health districts integrating at least TB-HIV interventions:</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Proportion of HDs preparing regular reports in real time, on insecticide and drug resistance, trend and resources:</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Proportion of HDs preparing regular reports in real time of the trend of the interventions and financial resources:</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Description</td>
<td>Value 1</td>
<td>Value 2</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Number of meetings of CCMs for control of HIV/AIDS, tuberculosis and malaria (STP):</td>
<td>0</td>
<td>24</td>
</tr>
<tr>
<td>Number of tools and strategies conceived and/or improved for implementation of HIV/AIDS, tuberculosis and malaria control activities:</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Multisectoral programme documents for promoting mental and behavioural health available:</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Strategic documents available for universal access to care for the mother and newborn baby, to reproductive and sexual health, and health of the elderly:</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Number of studies finalized on the health of children, young people, adolescents and the mother:</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Proportion of health districts carrying out quality SONU:</td>
<td>30%</td>
<td>60%</td>
</tr>
<tr>
<td>Proportion of health districts carrying out quality IMCI:</td>
<td>50%</td>
<td>70%</td>
</tr>
<tr>
<td>Proportion of health districts covered by IMCI:</td>
<td>99%</td>
<td>100%</td>
</tr>
<tr>
<td>Proportion of administrative districts with a document on contingency plan (ORSEC) to deal with emergency and humanitarian disaster situations;</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td>Proportion of health regions having activated the early warning and response system in emergency and disaster situation</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td>Health promotion strategic document available:</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Number of districts equipped with materials for sensitization on anti-tobacco products and trained in smoking cessation:</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>Number of members of school health committees trained:</td>
<td>0</td>
<td>800</td>
</tr>
<tr>
<td>Number of information bulletins and thematic days having received support:</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Number of income-generating projects having received financial support:</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Environmental policy documents and implementation</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>strategic plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Policy and strategy documents on food and nutrition (including the fight against nutritional deficiency) available</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Proportion of health regions and districts carrying out quality activities, in the area of nutrition in infant and the young child:</td>
<td>10%</td>
<td>50%</td>
</tr>
<tr>
<td>Number of annual coordination meetings of SWAP organized:</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Number of managers of district mutual health schemes sensitized and trained in auditing:</td>
<td>0</td>
<td>30%</td>
</tr>
<tr>
<td>Number of policy documents and legislative texts developed/revised, in the pharmaceutical sector:</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Percentage of activities carried out, of which the technical and financial reports are available within the set time-frames.</td>
<td>0%</td>
<td>80%</td>
</tr>
</tbody>
</table>