

REPUBLIC OF RWANDA



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HEALTH SECTOR POLICY

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TABLE OF CONTENT

FOREWORD	Error! Bookmark not defined.
ACRONYMS AND ABBREVIATIONS	iii
1. INTRODUCTION	1
2. SITUATION ANALYSIS	2
2.1 Country context	2
2.2 Population Health status	3
2.3 Main achievements and challenges for key health programs.	4
2.4 Assessment of Health system strengthening building blocks.....	6
3. POLICY ORIENTATION	13
3.1 Vision	13
3.2 Mission statement.....	13
3.3 Values and guiding principles.....	14
3.3.1 People-centered services.	14
3.3.2. Integrated services	14
3.3.3 Sustainable services.....	14
3.4. General Policy Objectives	15
3.5. Policy Directions	16
3.5.1. Objective 1: Improve demand, access and quality of essential health services.....	16
3.5.2. Objective 2: Strengthen policies, resources and management mechanisms of health support systems to ensure optimal performance of the health programs	19
3.5.3. Objective 3: Strengthen policies, resources and management mechanisms of health.services delivery systems.....	23
3.5.4.Objective 4: Strengthen the Health Sector Governance mechanisms	25
4. GOVERNANCE FRAMEWORK	27
4.1 Organization of Health care delivery system	27
4.2. Governance.....	29
4.3. Monitoring & Evaluation Mechanism.....	33
4.3.1 Indicators, data sources and review	33
4.3.2 Reporting, monitoring, and evaluation.....	34
4.3.3. Mechanisms for sector performance assessment.....	34
BIBLIOGRAPHY	35

FOREWORD

The Health Sector Policy is guided by the overall vision of the Government of Rwanda aimed at developing the health sector as indicated in Rwanda's vision 2020. It is aligned to the EDPRS II, and the national decentralization policy taking into account lessons learned from the implementation of the previous health sector policy.


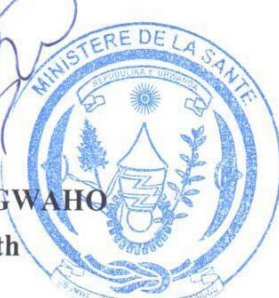
Over the last 20 years, as a result of the implementation of the previous policy through the Health Sector Strategic Plan I and II, Rwanda has improved the health status of its population. The life expectancy has increased to 64.5 in 2012, the maternal mortality decreased from 750/100,000 in 2005 to 476/100,000 in 2010 and child mortality rate has been reduced from 152/1000 live births in 2005 to 76/1000 live births in 2010.

Again, during the same period governance mechanisms in the health sector have changed to ensure better management and allocation of resources. Being one of the priorities in the EDPRS II (2013-2018), the health sector contributes to the thematic priorities that are an economic transformation for rapid growth, rural development, productivity, youth employment, and good governance. The health sector also plays an important role toward achieving Rwanda's ambitious growth targets in order to be a mid income country.

The previous policies elaborated in the first decade were developed to address the predominant health problems of that time and the challenges set by the HIV/AIDS pandemic, Malaria, TB and other infectious diseases. Time has come to take stock of the important changes in epidemiology, maternal and child health, human resource for health, infrastructure, health financing, service delivery etc and design a new Health Sector Policy. In this policy, the guiding principles of the Sector are reformulated to ensure that health interventions are people-centered, integrated and sustainable while enhancing self-reliance of the sector, and adapted to the transition of epidemiology.

This new National Health Sector Policy is presenting new priority orientations taking into account this evolution and showing the pathway for future developments.

Among other important elements highlighted in this new policy, the health sector has to support the increasing role of the community and of the private sector that need to be enhanced in a manner that ensures increased accessibility and quality of health services.



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ACRONYMS AND ABBREVIATIONS.

AIDS / SIDA	acquired immune deficiency syndrome
ANC	Antenatal care (=CPN)
ARI	ACUTE RESPIRATORY INFECTIONS (=IAVRI)
ART	antiretroviral therapy
ARV	antiretroviral (medicine)
ASRH&R	Adolescent Sexual and Reproductive Health and Rights
C-IMCI	Community Integrated Management of Childhood Illness
C-PBF	Community Performance-Based Financing
CBOs	Community-Based Organizations
CBHI	Community-Based Health Insurance schemes (= Mutuelles)
CCM	Community Case Management (= Community IMCI)
CHUB	Butare University Hospital (teaching hospital)
CHUK	Kigali University Hospital (teaching hospital)
CHW	community health worker
CPAF	Common Performance Assessment Framework (used for GBS and SBS donors)
CPD	Continuing Professional Development
CSO	civil society organization
DALYS	disability-adjusted life years
DAD	Disaster Preparedness and Response (DP&R)
DH	District Hospital
DHS	Demographic and Health Survey
DHU	District Health Unit
DP	Development Partner
DP&R	Disaster Preparedness and Response
DPAF	Development Partner Assessment Framework
DRG	Diagnosis Related Groups
EICV	Integrated household living conditions surveys
EAC	East African Community
EDPRS	Economic Development and Poverty Reduction Strategy
EID	Epidemic and Disaster Prevention, Management and Response
EML	Essential Medicine List
EmOC	emergency obstetric care
EMR	Electronic Medical Records
EMTCT	elimination of mother-to-child transmission
FBO	Faith-Based Organization
GOR	Government of Rwanda
GDP	Gross Domestic Product
HC	health center (= CS)
HF	health facilities
HFU	Health Financing Unit

HIS	health information system
HIV	human immunodeficiency virus
HMIS	health management information system(s)
HP	health post (= dispensary)
HRH	human resources for health
HSP	Health Sector Policy
HSSP	Health Sector Strategic Plan
HSWG	Health Sector Working Group (new name for HSCG)
I-DHS	Interim (or mini) Demographic and Health Survey (done in 2007)
IDSR	Integrated Disease Surveillance and Response
IHDPC	Institute of HIV/AIDS, Disease Prevention and Control
IHR	International Health Regulations
IMCI	Integrated Management of Childhood Illness
IMNCI	Integrated Management of Neonatal and Child Illness
IMR	Infant Mortality Rate (/ 1,000 live births)
IRS	Indoor (intermittent) Residual Spraying
IHRIS	(Integrated Human Resource Information System)
ITN	Insecticide / Impregnated Treated (bed) Nets
JADF	Joint Action Development Forum
KFH	King Faisal Hospital
LLIN	long-lasting insecticidal nets
LMIS	Logistic Management Information System
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MINALOC	Ministry of Local Administration, Community Development and Social Affairs
MINECOFIN	Ministry of Finance and Economic Planning
MINISANTE	Ministry of Health
MOH	Ministry of Health
MPDD	Medical Procurement and Distribution Department
MPPD	Medical Production and Procurement Division
MTEF	Medium-Term Expenditure Framework
NCD	Non Communicable Disease(s)
NGO	Non Governmental Organization
NHA	National Health Accounts
NISR	National Institute of Statistics of Rwanda
PBF	performance-based financing
PEPFAR	President's Emergency Plan for AIDS Relief
PH	Provincial Hospital
PHECS	Pre-hospital Emergency Care Services
PPCP	Public-Private-Community Partnership

PTF	Pharmacy Task Force
PW	pregnant women
PWD	People With Disabilities
RBC	Rwanda Biomedical Center
RDHS	Rwanda Demographic and Health Survey
RFMA	Rwanda Food and Medicines Authority
RHCC	Rwanda Health Communication Center
RHMIS	Rwanda Health Information Management
RSSB	Rwanda Social Security Board
RTT	Resource Tracking Tool
SISCom	Système d'Information Sanitaire des Communautés
SPIU	Single Project Implementation Unit
SWAp	Sector Wide Approach
TFR	Total Fertility Rate
TB	Tuberculosis
THE	Total Health Expenditure
TI	Teaching Institution

1. INTRODUCTION.

Rwanda's Health Sector Policy translates the Government's overall vision of development in the health sector, as set out in Vision 2020 and the Economic Development and Poverty Reduction Strategy (EDPRS II 2013-2018). Since the adoption of the previous Health Sector Policy in 2005, much has changed in terms of national socio-economic development and more specifically in the health sector. This new Health Sector Policy thus takes into account new orientations in the national development agenda and changes in the socio-economic and epidemiologic situation of the Rwandan population and in the institutional environment of the country and specifically in the health sector.

The Health Sector Policy gives general orientations for the sector which are further developed in the various sub-sector policies guiding key health programs and departments. All health sub-sector policies will be updated in line with this new policy.

The Health Sector Policy is the basis of national health planning and the first point of reference for all actors working in the health sector. The overall aim of this policy is to ensure universal accessibility (in geographical and financial terms) of equitable and affordable quality health services (preventative, curative, rehabilitative and promotional services) for all Rwandans. It sets the health sector's objectives, identifies the priority health interventions for meeting these objectives, outlines the role of each level in the health system, and provides guidelines for improved planning and evaluation of activities in the health sector. A companion Health Sector Strategic Plan (HSSP) elaborates the strategic directions defined in the Health Sector Policy in order to support and achieve the implementation of the policy, and more detailed annual operational plans describe the activities under each strategy.

This Health Sector Policy was developed through an extensive consultative process with stakeholders, including the social cluster ministries, the others ministries concerned by the social determinants for health, the multilateral and bilateral development partners, civil society, faith based organizations, private sectors] and health professionals councils. Before drafting this policy, a thorough consultative process was undertaken to collect inputs and to define a common vision, clear policies objectives and directions based on existing health issues.

The first draft have been circulated among stakeholders and presented to different coordination organs of the Health Sector including the General Senior Management Meeting (GSMM), the Health Sector Technical Working Group (HSWG), the Joint Health Sector Review (JHSR) and the Social Cluster Meetings. The final policy document was then submitted to the cabinet for consideration.

2. SITUATION ANALYSIS

2.1 Country context

2.1.1 Demographic and geographic situation

Rwanda is a small mountainous and land locked country of 26,338 square kilometers and lying just south of the equator with an average elevation of 1,700 meters. Approximately 35 percent of the land is fit for cultivation.

Rwanda's population is growing rapidly with implication on the demographic situation. The most recent population census conducted in 2012 estimated the population to be around 10.5 million people and the population density is the highest in Sub-Saharan Africa (416 inhabitants per square kilometer). The population is essentially young, with 52 percent of all Rwandans under the age of 20. In terms of gender, the 2012 census shows females to be in the majority (52 percent) while males make up 48 percent of the population (NISR, 2012) (1).

The illiteracy rate declined from 34 percent to 15.5 percent among women and from 24 percent to 10.3 percent among men between 2005 and 2010 (DHS 2005 and 2010) (2, 3).

2.1.2 Socio-economic situation

Efforts have been made to develop the service sector and stimulate investment in the industrial sector; however, the Rwandan economy remains dominated by agriculture. In 2012, the service sector accounts for the largest share of Rwanda's Gross Domestic Product (GDP), 46 percent, followed by agriculture with 32 percent and industry with 22 percent (NISR, 2012) (4).

According to EDPRS II, average GDP Growth during the 2008-2012 period was 8.2% and the GDP per capita in 2012 was \$644. Data from integrated household living conditions surveys (EICV) show that the percentage of people living below the poverty line was 44.9% in 2010-11, down from 56.7% in 2005-06. In 2010-11, net primary school and secondary school attendance were respectively at 91.7% and 20.9%. The percentage of people having access to safe drinking water was 74.2% while it was 10.8% for people having access to electricity for lighting (EDPRS 2, 2012) (5).

The health sector has a crucial role to play in the achievement of the national mid-term (EDPRS 2) goal of 11.5% economic growth rate. Continuous progress in the coverage and quality of promotive, preventive, curative and rehabilitative health interventions and in the health seeking behavior of the population ensure improvements in the health status and productivity of the Rwandan population. The health sector also has an influence on the enabling environment for economic and social transformation as envisioned by the EDPRS II, aiming to contribute, among others, to a reduction in the fertility rate, which will help ease the demographic pressure in the country. Availability of high quality health

services, as an important element of the service sector, contributes to the generation of collective wealth and is crucial to attracting investors and tourists.

2.1.3 Policy environment

In the last 15 years, the Government of Rwanda (GoR) successfully designed and implemented a broad set of policies and programs of economic reform and decentralization to enhance local capacity. High level commitments of GoR are highlighted in the 7years Government program (2010-2017). GoR has recently developed a new “Economic Development and Poverty Reduction Strategy” (EDPRS 2, 2013-2018) as mid-term plan for implementation of Rwanda’s “Vision 2020”, reference document giving the long term orientation for the country’s development.

Rwanda is also committed to the international and regional agreements for which it is a signatory such as the MDGs and is on track for achieving most of the targets set for 2015. New global objectives will be determined for the next period after 2015 and Rwanda will continue to use these international goals to guide its development efforts. Other important international policies and commitments guiding Rwanda health policy are the Abuja Declaration, the African Health Strategy (2007–2015), the Paris Declaration (2005), the Accra Agenda for Action (2008) and more recently and the Rio Political Declaration on Social Determinants of Health (October 2011).

To reach these national and international goals, and on the basis of recent health sector assessment, Rwanda has decided to update the Health Sector Policy developed in 2005, as well as the sub-sector policies for specific programmatic areas and to align the Health Sector Strategic Plan to this new policy.

2.2 Population Health status.

2.2.1 According to the HMIS report (2013) (6), infectious diseases are the primary cause of outpatient morbidity in health centers: ARI, Respiratory infections acute other and malaria account for well over half of the outpatient morbidity (61,9%), although there has been an important decrease in recent years of the burden of disease related to infectious diseases. In 2013 the most frequent causes of death in health facilities were neonatal illness which counts 33,3%. Regarding other highly lethal infectious diseases, 2010 Rwanda Demographic and Health Survey (RDHS) shows that HIV prevalence has remained stable at 3% of adults aged 15-49 (3). The TB notification rate decreased from 89 to 72 per 100,000 between 2008 and 2010 (7).

2.2.2 Mortality related to obstetrical and perinatal problems has also decreased markedly: Maternal mortality decreased from 750/100,000 in 2005 to 476/100,000 in 2010 and child mortality rate has been reduced from 152/1000 live births in 2005 to 76/1000 live births in 2010 (with respective reduction in infant mortality from 86 to 50/1000 and in neonatal mortality from 37 to 27/1000). The Total Fertility Rate (TFR) declined from 6.1 children per woman (RDHS 2005) to 4.6 in 2010 (RDHS 2010). Over

the same 5 year period (2005-2010), there have been marked improvements in nutritional status of children under 5 years of age (underweight from 18% to 11%; stunting from 51% to 44% and wasted from 5% to 3%). Malnutrition however remains one of the major health problems confronting the Rwandan population (2, 3).

2.2.3 With these achievements in reduction of mortality from infectious diseases and other causes related to maternal and child health, the burden of disease associated with non communicable diseases (NCD) takes more importance. Generally, population-based data on the non-communicable diseases are missing in Rwanda. The 2010 Global Burden of Disease Study shows that although infectious diseases are still the leading causes of premature deaths and of disability-adjusted life years (DALYs) lost, the proportion of DALYs due to Non Communicable diseases (NCDs) is growing, particularly due to mental disorders, cardiovascular diseases and cancers (8).

2.3 Main achievements and challenges for key health programs.

2.3.1 The most important achievements in the area of maternal and child health since 2005 are:

(i) The increase in facility based deliveries (from 45% in 2005 to 69% in 2010) (2, 3), Emergency Obstetrical and Neonatal Care (EmONC) in all District Hospitals (DH), Clinical Integrated Management of Childhood Illnesses (IMCI) in all health facilities (HFs) and the start of maternal and child death audits in all HFs which is evolving to maternal death surveillance and response,

(ii) The increase in vaccination coverage from 2005 to 2010 (Measles from 75% to 95% and fully vaccinated from 80% to 90%) (2, 3),

(iii) Integration between MCH and HIV services, supported by strong political commitment,

(iv) Community participation through Community Health Workers (CHW) follow-up of pregnant women, Community-IMCI interventions and Community Based Program for Family Planning (CBP/FP).

2.3.2 The **community health programme** has achieved nationwide coverage. All villages (14,837) have three Community Health Workers (CHW), each with well-defined tasks, and an innovative e-Health system with mobile phones is used by all CHWs to connect them with Health Facilities. New interventions supported by mobile phone communication are undertaken in Adolescent Sexual and Reproductive Health and Rights and Gender Based Violence.

2.3.3 In the area of **disease prevention and health promotion** achievements are the stabilization of HIV prevalence, an almost 100% coverage of HIV testing during ANC visits and more than 90% of HIV+ pregnant women being on ART prophylaxis (under the Option B+ regimen) (9). The Malaria program has resulted in very high use of Long

Lasting Impregnated Nets (LLIN use by children 70% and by pregnant women 72%) with 82% of household owning at least one LLIN (3).

2.3.4 Most villages have **environmental and health promotion** activities conducted by hygienic clubs. These clubs are responsible for promoting hand washing, introduction of improved latrines and other behavior change.

2.3.5 In the area of **disease control and treatment**, ART covers 91% of HIV+ people and 465 Health facilities (out of the total of 500 HFs) provide the full package of HIV related services (93%) (9). The Home Based Malaria program has resulted in 91% of children under five treated within 24 hours. The Malaria program will now soon enter its pre-elimination phase. Currently CHWs are testing all suspected malaria cases at community level before any treatment for fever is given to children under-five (10). The national TB Control programme reports high treatment success rates (86%) and very high success rates in the treatment of Multi Drug Resistant TB Cases (89%) (7). Collaboration between the AIDS/HIV and TB programme results in 97% of suspected TB cases tested for HIV.

2.3.6 Rwanda has often faced epidemics including **emerging** and re-emerging **infectious diseases** such as Influenza A (H1N1), cholera, epidemic typhus and meningitis. Rwanda has been implementing an Integrated Disease Surveillance and Response (IDSR) system since 2000 and has developed guidelines and mechanisms to address health emergencies and epidemic preparedness in line with international health regulations although there are still challenges regarding timeliness and incompleteness of reporting. There is also a need to improve linkage of IDRS to the Health Management Information System (HMIS) and other e-Health systems.

2.3.7 While there have been many achievements, the Rwandan health sector still faces **major challenges**:

- The need to reach the whole population (global coverage) and to protect the health of the most vulnerable population (as identified by each program). Some isolated communities and under privileged populations still have problems with geographic or financial accessibility to health services;
- Sustainability of financing of the health system is a central problem as external funding is decreasing faster than internal resources are increasing. Limited resources lead to making choices in terms of cost efficient interventions and of target populations for maximum impact on the health status of the population, but this situation represents a threat to maintaining the desired availability and quality of services;
- Insufficient involvement of private sector, need for strengthening of health insurance schemes to ensure financial self-reliance of health services;
- Gaps in services adapted to marginalized key populations (discrimination from community and health care providers, self-stigma of marginalized individuals);

- Insufficient community participation in the management of health care services because of lack of knowledge by population of their rights and lack of awareness of the role they can play;
- Insufficient integration between decentralized health services (health facilities) and local government bodies for management of health care delivery;
- Coordination with several development sectors (agriculture, education, social protection) in the fight against malnutrition needs to be strengthened;
- Gaps in the integration of infectious diseases at decentralized level, particularly in supervision and mentorship;
- NCD prevention and control services are not yet available across the health care system (HR capacities, diagnostic and treatment technologies) and existing services are not affordable and accessible to all.

2.4 Assessment of Health system strengthening building blocks

2.4.1 Governance

Significant progress has been made in several areas that pertain to governance, leadership and management. More importantly, since the publication of the decentralization laws and the beginning of their implementation with the 2nd phase in 2005–2006, as well as the latest Law N°87/2013 Of 11/09/2013 Determining the Organisation and Functioning of Decentralized Administrative Entities a true health governance system became fully elaborated and operational due to a strong political will and an enabling governance system:

- At central level, technical working groups (TWG) have been established to facilitate dialogue between the main stakeholders (national institutions, representatives of civil society and development partners) involved in different programmatic areas and an overarching Health Sector Working Group (HSWG) is overseeing the implementation of a sector wide approach for the management of the health sector.
- At district level, the coordination of actors from different sectors is ensured by the Joint Action Development Forum (JADF) where all important development issues are discussed and intersectoral collaborative interventions are designed and monitored. A District Health Unit (DHU) and have recently been put in place to coordinate the different actors of the health sector at the decentralized level (DH, HC, NGOs, DPs, and community-based interventions), to clarify and allocate the tasks of the different actors, and ensure an adequate integration of the multidimensional determinants of the health status of the population.
- Health personnel and financial resources have been decentralized to the district level, with the MoH bearing responsibility for technical supervision and intersectoral coordination (interministerial & other stakeholders discussions), for technical supervision and capacity building (MOH to decentralized health facilities) as well as horizontal coordination (between all decentralized health entities) while district governments control the program implementation process. The sector, which is the administrative entity below the district, has become the point of service delivery

within the new system, with at least one health center now present in each administrative sector. The number of health posts is progressively increasing (60 in 2013) (4) with the aim of having a health post in each cell in order to bring primary health care closer to the community.

- An expanded community-based health insurance (CBHI) scheme that builds up from sector-level *mutuelles* is the main organizing and financing mechanism for health care.
- A volunteer-based system of CHWs has likewise been expanded and represents the principal point of contact for the majority of citizen-consumers.
- Civil society organizations have regrouped themselves under umbrella organizations that play the role of coordination of community-based organizations (CBOs) health interventions and advocacy for improvement of health care services at central and decentralized levels.
- Significant decision-making authority and resources have been transferred to health facilities at the district (hospital and pharmacy) and administrative sector (health center) levels. Facilities at each level have internal management committees (comite de gestion or COGES in health centers and administrative and finance committees in district hospitals) that together, with the community structures noted above, manage their day-to-day operations.
- Performance-based financing (PBF) is an important aspect of Rwanda's system for human resources for health. It provides an incentive to promote institutional performance and the management and retention of human resources for health. Rwanda's PBF program covers both personnel in formal health institutions (namely, district hospitals and sector health centers) and CHWs at the community level.
- The Zero Tolerance Policy for Corruption has strengthened Rwanda's capacity for strong governance, and the GoR's strong stance on this issue has enhanced the positive results of the decentralization process and general management of health services.
- A comprehensive system has been established by the government to ensure all levels of political and administrative authorities as well as public services agents are accountable to the general population and to the country of the degree of achievement of set individual and institutional objectives (Imihigo) on which they have to report regularly.

The main challenges encountered in implementation of these governance mechanisms are the following:

- The human and financial resources available at decentralized level are insufficient to play effectively their role for district and sector health management
- The community participation mechanisms in place (management committees of hospitals and health centers) are not fully functional, as the population's representatives are not well prepared to play their role
- The conditions for the desired increase in private sector involvement in decision making and provision of health services need to be put in place (participation in establishment

of regulations governing the health sector, conducive environment to provision of quality private health services)

-Cross-sector collaboration has to be strengthened to tackle multi-factorial determinants affecting the health of the population (poverty reduction, nutrition and food security, water and sanitation, human rights, education and social protection, empowerment of youth and vulnerable populations)

2.4.2 Health product (medicines, vaccines, lab commodities, derived blood products and consumables) management

The Government of Rwanda has over the years continued to build capacity for the provision of high quality pharmaceutical services. In terms of structures, there exist a Pharmacy Department under the structure of the Ministry of Health. A new competent body will be established that will be in charge of regulating food, health products, cosmetics and other related products and services, hospitals and pharmacies, research institutions at various levels.

Systems and procedures have been developed for Pharmacovigilance and Medicine Information system, inspections and licensing, information management (electronic and paper-based), publications at official website of MoH, coordinated procurement and distribution, district level pharmaceutical services, adaption of legislation for TRIPS implementation, and Harmonization of registration and other regulation of medicines in East African Community.

Most national documents have also been developed for legislation, policy direction, quality assurance for health products and promotion of their rational use and related procedures.

Currently, the organizational structure for pharmacy services at the MoH is a challenge. The Ministry of Health established a pharmacy desk in charge of policy formulation and at the same time, this desk is responsible of health product regulations. An autonomous national pharmaceutical regulatory authority separating the functions of implementation and regulation from policy was approved and the law establishing the RFMA was published in the gazette since January 2013.

There are some gaps in supply and distribution management system and rational use of health products which need to be addressed.

Regionally, the Pharmacy Desk has started to collaborate in the process to harmonize standards and regulations in the East African Community (EAC) regarding medical products and technology.

Medical procurement and production Division, MPPD/RBC, one of the 14 entities that were merged to form the RBC, is the primary supplier of pharmaceutical commodities, including generic essential medicines, medical supplies, and laboratory reagents.

2.4.3 Human Resources for Health (HRH)

In 2013, there were 678 doctors, 400 pharmacist and 9,448 nurses/midwives working in Rwanda. This corresponds to a ratio of one doctor per 16,046 inhabitants, one pharmacist per 20,000 inhabitants, one midwife per 18,790 inhabitants and one nurse per 1,227 inhabitants (11). This low ratio of health care workers to the general population also applies to the allied health professionals and to health managers.

Specialized physicians represent a small portion (24%) of the total physicians in clinical practice in the country. Additionally, specialized physicians are mainly located in and around Kigali City whereas 76% of general practitioners are distributed in district hospitals in the rural areas.

The process for continuous learning of the graduates to have specialization at all levels of health professional cadres is still low (A0/A1 nurses represent 31% of all nurses, and specialized physicians 24% of all physicians). The objective is to have human resources with Masters degree level for different competencies in the health system. The HRH quality improvement targets both health care providers and health managers and is conducted in close collaboration with the Ministry of Education, in charge of overseeing the content of curricula.

Decentralization, Performance Based Financing (PBF) and new initiatives in the HRH area have all positively impacted health services and outcomes. However, there is still work to be done to increase the quantity, quality, and overall management/coordination of HRH. There is a general shortage of health professionals, particularly amongst more highly skilled groups. As geographic distribution favours urban areas, there are still health facilities that are under-staffed. Four types of challenges can be identified: insufficient number of qualified staff, insufficient capacities of existing staff, inadequate deployment of existing staff and high turnover of health workers due to a lack of clear retention policy. Capacity building of CHWs is needed to improve cost-effective health care services delivery at community level. Their increased role should be supported by proportional incentive mechanisms in support of CHW's cooperatives.

2.4.4 Health Financing.

Over the last few years, Rwanda has developed a comprehensive financing framework with two main channels for financing, one from the supply side, transfers from the treasury to districts and health facilities and one from the demand side, the insurance system. These mechanisms have permitted to attain important achievements such as reduction of unmet needs, increased consumption of health care, decreased incidence (risk) of catastrophic expenditures and decreased inequality in consumption of health

care. This was facilitated by political commitment and the issuance of a legal framework which makes health insurance compulsory for all Rwandans. However, bottlenecks remain such as constraints for the use of locally generated funds by health facilities and high operational costs for some health insurance mechanisms leading to inefficiency.

Largely due to the funds flowing from global disease initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the President's Emergency Plan for AIDS Relief (PEPFAR), and the President's Malaria Initiative, donor expenditures are responsible for a large share of the total health expenditure (THE), U\$ 303 million in 2011/12 which represent 59% of total Government and donors expenditures. Government spending on health has surpassed the 15% required under the Abuja Declaration showing high commitment and support to the development of the sector financing within our limited resources. In 2011/2012 FY, it was 16.05% of the total government spending (MOH Report 2011/2012) (12).

Government agencies such as the Ministry of Health and RBC manage 53% of health funds. Other major financing agents are NGOs and other implementing agencies (31%), followed by referral hospitals (7%). Coordination of health financing interventions is ensured by MOH Health Financing Unit (HFU) at central level, with decentralized mechanisms in place for some programs (CBHI, PBF). A growing part of the budget is transferred to district level. The expenditures for FY 2010/11 and FY 2011/12 indicate an increase in funding allocated to district level from 36% to 45% respectively and a consequent decrease in funding allocated at the national level, confirming the tendency to decentralize funding (HRT REPORT 2011/12) (13).

Risk pooling has been greatly improved as a result of the extension of community-based health insurance schemes which allow the majority of the population access to healthcare services and drugs. Social and private health insurances now cover approximately 92% of the population. Other pooling mechanisms are important for efficient management of drug procurement, performance-based financing (PBF) and CHW cooperatives.

Financial accessibility to health care services remains a major challenge for some vulnerable households who are not classified in the lower Ubudehe categories but are unable to pay for Mutuelles insurance. Stronger social protection mechanisms need to be put in place to manage catastrophic health expenditures. Health insurance mechanisms need to be diversified. Currently, Community-Based Health Insurance (CBHI) relies only on fee for service mechanisms. There is a need to explore other purchasing mechanisms such as capitation, Diagnosis Related Groups (DRG) and PBF/accreditation.

An important challenge to address in the mid-term is the risk of decreasing external resources supporting the health sector. The private sector, which is identified as a growing source of investment for health, has not been sufficiently involved until now. Other options to increase mobilization of domestic resources also need to be developed.

2.4.5 Service delivery

The Rwanda health system is comprised of a network of five referral hospitals, 42 district hospitals, 30 district pharmacies, 5 blood transfusion centres, 466 health centers, 16 prison dispensaries, 60 health posts, 45,000 Community health workers at household level, 60 private sector health facilities including clinics, 114 dispensaries, laboratories and pharmacies (14). The initiation and implementation of community health services has increased outreach and brought health services closer to the people they serve. The referral system from community to health centers and from health centers to hospitals has greatly improved with PBF coupled with other health facility and community initiatives.

In addition, the Pre Hospital Emergency Care Service (PHECS/SAMU) is now fully operational in all districts with 213 ambulances (a minimum of five ambulances in each district is the standard requirement fitted with tracking system) and a call center managing the flow. Emergency Departments have been constructed in 24 health facilities. However, there is need for more capacity (Human resources, equipment, infrastructure and management). Adequate capacity of the emergency medical assistance service is an integral part of the effort to ensure provision of high quality health care services, from primary to tertiary care.

Similarly, for laboratory services, there is a sound and well established laboratory network coordinated by the National Reference Laboratory Division of RBC but there is a gap in qualified human resources and maintenance of laboratory equipment and supply chain in health facilities.

Rwanda has adopted healthcare facility quality assurance approaches/standards towards accreditation as a priority strategy to improve health care quality and safety. Accrediting hospitals in Rwanda was first initiated in the three teaching hospitals namely King Faisal Hospital (KFH), the University Teaching Hospital-Kigali (CHU-K) and the University Teaching Hospital of Butare (CHU,B), and the accreditation process is ongoing in other health facilities.

Implementation of the integrated community health services package which was initiated in 2005 has been one of the successful innovations in integrated decentralization of health services. The Rwandan health system has greatly benefited from task shifting in which CHWs are delivering primary health services at the community level. This has relieved the workload at health centers and has reduced patients' travel costs to reach health centers. It is estimated that the community level sustains around 80% of disease burden and has to be appropriately strengthened. Practice of traditional medicine exists but is not well regulated.

Beside of the classical health services and facilities, there are Rwanda Traditional Medicine, Complementary and Alternative Medicine which invading the health sector. This sector is not yet well known and regulated; so many malpractices are assumed to be frequent and obvious.

The traditional medicine in Rwanda is practiced by recognized and registered traditional Healers which have been confirmed by the community, where they are practicing. However, there is still some tradi- practitioners who are not registered what is justifying the need for better organize and regulate Traditional medicine practices at the same time protect the Rwanda culture and intellectual property. Regarding the Complementary and Alternative Medicine, currently the following practices are identified in Rwanda: Therapeutic Reflexology, Traditional Chinese Medicine and Acupuncture, Naturopathy and Homeopathy or Homeopathic Medicine among others.

The Rwanda Health System is facing the following challenges in area of traditional medicine and Complementary and Alternative medicine: (i) Lack of harmony of research policies and legal framework, (ii) Lack of coordination of the actors involved in research on traditional medicine (iii) Lack of Rwanda Pharmacopeia which census all Rwanda traditional medicine (iv) Lack of clear legal framework to regulate Rwanda Traditional Medicine practitioners.

Based on the above challenges, there is need for concrete national strategies to implement research initiatives for improved access to medicines and protection of the public health, a clear definition and regulation of CAM practitioners and a clear orientation of development of Rwanda Traditional Medicine.

2.4.6 Health Information System

From 2005, Rwanda has made many gains in the area of Information management. These have included achievements in the automation of systems that are operational at different levels of the health system (HMIS, SISCom, RapidSMS, LMIS, IHRIS, etc.) and incorporate an innovative mix of paper-based and technological solutions. The sector has improved reporting compliance for the HMIS and addressed issues of data quality by introducing a standardized data quality assessment methodology at national and district levels.

PBF has facilitated the environment for better reporting by introducing not only incentives for performance and its reporting but also putting penalties for late or incorrect reporting. Recent efforts to harmonize quality improvement initiatives by combining health facility accreditation assessments with the routine PBF quality assessments is another important development that enables the Ministry and its partners to assess and improve quality of care at the service delivery level.

Rwanda has also developed a Health Sector Data Sharing Policy that is designed to enhance access to data and engages approved data users in the process of continuous data quality improvement. This is an important mechanism for ensuring transparency broader stakeholder involvement in sector performance assessment.

Apart from the above achievements, Health Information System are still facing challenges: gaps in the area of data use and further harmonization of data collection in certain areas, multiplicity of software platforms established with partners support, delays in the implementation of the nationwide fiber optic network and absence of an affordable national data center.

2.4.7 Knowledge Management and Research.

The health research in Rwanda is benefiting from strong political commitment within the MOH and in the country at large. There are several high-level research institutions with wide international networks, such as the Institute of HIV/AIDS, Disease Prevention and Control (IHDP) and Division of Medical Research within the Rwanda Biomedical Center (RBC); the School of Public Health; and the two academic hospitals (CHUK and CHUB). Among the health sector stakeholders, there is also increasing interest in the development of evidence-based policy-related research,. The main challenges in health research area are: (i) limited research capacity and limited numbers of qualified and experienced researchers; (ii) insufficient research infrastructure, including limited effective coordination mechanisms; (iii) insufficient funding to carry out all necessary and desirable research.

3. POLICY ORIENTATION.

3.1 Vision

The vision of the Government of Rwanda set out in Vision 2020 is to guarantee the well being of the population by increasing production and reducing poverty within an environment of good governance. As part of this vision, the Rwandan Health Sector seeks to continually improve the health of the people of Rwanda, through coordinated interventions by all stakeholders at all levels, thereby enhancing the general well-being of the population and contributing to the reduction of poverty. Article 41 of the Rwandan Constitution, as amended to date clearly declares that health is a Human Right: “All citizens have rights and duties relating to health. The State has the duty of mobilizing the population for activities aimed at promoting good health and to assist in the implementation of these activities. All citizens have the right of equal access to public service in accordance with their competence and abilities.”

3.2 Mission statement

The Rwanda Health Sector mission is to provide and continually improve affordable promotive, preventive, curative and rehabilitative health care services of the highest quality, thereby contributing to the reduction of poverty and enhancing the general well-being of the population.

3.3 Values and guiding principles

The fulfilment of this mission is based on values and guiding principles that orient and underlie the provision of health services. These guiding principles are classified under three key orientations:

- 1) People-centered services
- 2) Integrated services
- 3) Sustainable services

3.3.1 People-centered services.

- The first principle is that the health system ensures **universal demand and access to affordable quality services**;
- The health system encourages and **values community inputs** to identify health priorities and needs expressed by the population;
- It is focused on the **well-being of individuals and communities**, and more specifically of **women and children**;
- It fosters **equity and inclusion** and **integrates marginalized groups**.

3.3.2. Integrated services

- The health system is **aligned with national goals**, among which Vision 2020 and EDPRS overarching goal of poverty alleviation;
- It **leverages and builds on existing assets** in terms of infrastructures and human resources, but also on cultural values and institutional bodies;
- It develops and **strengthens decentralized services** whenever possible while **remaining coordinated**;
- **All sectors of the Rwandan population are actively involved**, including the private sector and civil society.

3.3.3 Sustainable services

- To ensure the quality of services, the health system **builds the capacity of people, communities and institutions**;
- It prioritizes **value for investment**, seeks **cost effectiveness**, uses **appropriate technology** and adopts **creative innovations** to maintain the achievement of outcomes in a context of scarce resources; among cost effective interventions, **health promotion, communication and prevention** are prioritized;
- It promotes **rigor and transparency** of outcomes and ensures the collection and dissemination of **quality information** so that decisions and choices are **based on evidence**;
- In the context of decreasing external support, the health system **develops self-reliance of organizations and individuals** by mobilizing **domestic resources**, advocating for **greater financial ownership** by the **public sector** and promoting investment and involvement by the **private sector and civil society**.

3.4. General Policy Objectives

The overall objective of the health sector is to ensure universal accessibility (in geographical and financial terms) of **equitable and affordable quality health services** (preventative, curative, rehabilitative and promotional services) for all Rwandans.

This overall objective will be attained through the full implementation of (1) the various **programs**, while strengthening (2) the various **systems** that will support them at (3) all levels of **service delivery** together with (4) the **governance** of the sector.

General Objective 1: Key Health Programs

Improve demand, access and quality of essential health services: Maternal, Neonatal and Child Health; Family Planning and Reproductive Health; Nutrition Services; Communicable Diseases, Infectious Diseases Surveillance and Research (IDSR) and Disaster Preparedness and Response (DP&R); Non communicable Diseases; Health Promotion.

This objective is centered on the reduction of burden of disease of the most important health problems in Rwanda, i.e. maternal and child health problems, infectious diseases and non communicable diseases through access to primary health care. Both prevention and treatment and care services are included in these programs, as well as interventions aiming at improving important health determining factors, such as behavior change communication, promotion of adequate nutrition, environmental health and sanitation and access to safe water.

General Objective 2: Health support systems

Strengthen policies, resources and management mechanisms of health support systems to ensure optimal performance of the health programs.

Health system strengthening is centered around six building blocks to ensure availability of necessary resources and management mechanisms for an appropriate functioning of the key health programs described under objective 1. These building blocks are Human resources for Health, Health products management and regulation, Health service delivery (Infrastructures and equipment), Health Financing, Leadership and Governance and Health information system.

General Objective 3: Health service delivery

Strengthen policies, resources and management mechanisms of health services delivery systems to ensure optimal performance of the health programs.

This objective aims at the effective organization and management at the different levels of the health service delivery system, from the community to health centers and district

hospitals and to referral hospitals, and also including the emergency medicine and pre-hospitalization services.

General Objective 4: Governance

Strengthen the Health Sector Governance mechanisms (decentralization, partnership, aid effectiveness, and financial management) to ensure optimal performance of the health sub-programs.

Governance mechanisms are essential to ensure that all actors involved in the management and provision of health services have clear roles and responsibilities and that the appropriate structures and regulations are in place to give all health sector stakeholders a conducive environment to fulfill their roles. This includes management and accountability mechanisms, stewardship and coordination structures and partnership relationships.

3.5. Policy Directions

3.5.1. Objective 1: Improve demand, access and quality of essential health services

3.5.1.1 Maternal and child health services contribute positively to the health status of the family, by reducing maternal and child mortality and morbidity. The six priority areas for the Maternal and Child Health program are the following: (i) safe motherhood and infant health; (ii) family planning; (iii) prevention and care of genital infections and HIV/AIDS/STI; (iv) adolescent reproductive health; (v) prevention and care of sexual violence; and (vi) social change for the empowerment of women.

Integration of MCH and disease specific health services is already effective but has to be strengthened through strong leadership at central level, support and advocacy by district authorities and health facility managers.

As a foundation for quality of services, healthcare providers are sensitized to improve customer care (availability, continuity and quality, choice, confidentiality) in all health facilities. Monitoring and Evaluation of MCH interventions must be strengthened to generate reliable data for decision-making.

3.5.1.2 To reduce mortality and morbidity linked to **malnutrition**, a multi-sector approach is implemented under the coordination of the Social cluster ministries. Public health and in particular, nutrition has to be mainstreamed in “non-health sector” programs. The policy emphasises the importance of food and nutrition during pregnancy and the first two years of a child’s life (1,000 days window of opportunity) in order to prevent illness, assisting in recovery from infection and to increase the efficacy of medications including antiretroviral drugs. Growth monitoring of children at the community level will be expanded gradually across the whole country to achieve universal coverage. Other population groups made vulnerable by various pathologies and needing nutritional support are also targeted: patients in convalescence, HIV infected

patients and other groups of patients with chronic diseases like diabetes, hypertension and malignancies. Prevention, behaviour change communication and community-based interventions are essential to effect change in nutritional habits of the population.

3.5.1.3. There is a strong political and institutional orientation towards integration of planning and implementation of **Infectious diseases** programs with the following objectives:(i)Increase the knowledge, behaviours and practices towards specific infectious diseases prevention methods for general and key populations, (ii) Increase the demand and use of health services for infectious diseases, (iii) Provide and improve early detection, diagnosis, confirmation, care and treatment of infectious diseases in the general and targeted populations, (iv) Regulate emerging and re-emerging infectious diseases control measures.

Service delivery for infectious diseases is already integrated but management, supervision and mentorship need to be better coordinated. Instead of separate mentors for each vertical program, a district supervisors/mentors team will be established and integrated in the district health team. Collaboration between central level (MOH), decentralized local government and health infrastructures, civil society and communities, private sector and other non health sectors must be strengthened for integrated interventions.

Continuing capacity development of health care providers, epidemiologists and public health specialists for improved infectious diseases services at all levels of the health care system is a priority as this type of pathologies still represents the main causes of morbidity and mortality. Capacities need to be strengthened for prevention, diagnosis and management of infectious diseases.

To develop adapted services to priority target groups (youth friendly services, key populations), capacities of health care providers and institutions have to be strengthened and the general population and key populations need to be sensitized on human rights promotion and community participation.

Regulations and procedures will be revised to enhance involvement of private sector in training, service provision and management of health services (including supervision and mentorship).

3.5.1.4 To reduce **mental health** morbidity and other psychosocial conditions, quality mental health care services are provided in a manner appropriate to the national context and accessible to the community. These mental health services are integrated into all health facilities of the national system and mental health problems are managed at the community level. The legislation regarding mental health will be issued and the Government will develop standards and guidelines for the integration of mental health into primary health care. Inter-sectoral collaboration between social ministries and between Government and NGO sectors needs to be strengthened. Priority intervention

areas include psycho-active substance abuse, issues related to psycho-trauma, care for epilepsy and psychosocial problems in children and adolescents.

3.5.1.5 To address the growing burden of disease related to **non-communicable diseases (NCDs)**, among which the most common are cancers, diabetes and arterial hypertension, new efforts have to be developed for the prevention, diagnosis and management of these diseases. The general population has to be informed and mobilized about risk factors such as tobacco consumption, alcohol abuse, unhealthy diet, inactive life style and environmental pollution. Essential NCD services will be available, accessible and affordable at community level (screening, follow up, palliative care) and more specialized services will be offered at different levels of health facilities depending on the facility service package. Financial access will be ensured by expansion of Community-based health insurance coverage to include selected NCD services.

To improve the quality of NCD services, capacities of health care services, including private services will be strengthened in terms of human resources knowledge and skills and of adequate infrastructures and equipment.

3.5.1.6 To reduce mortality and morbidity due to events causing **disabilities**, preventive and promotive interventions must be strengthened, such as protective legislation against traffic accidents (use of seat belts, policing,...) and guidelines disseminated on handling of trauma, disabilities, and rehabilitation. Access to health services for people with disabilities is progressively being improved (physical accessibility, adapted services depending on the type of disability). Protocols for disability-friendly services will be established in all hospitals and consultation services will be available at health center level for this vulnerable group.

3.5.1.7 Health promotion is one of the priority areas for the prevention of diseases. To strengthen this field of intervention, the Rwanda Health Communication Center (RHCC) is established to lead the planning and implementation of all related activities. Its mission is to create public awareness, facilitate community participation promoting and maintaining access to health services and healthy behaviour; to advocate for an environment that enables individuals, families and communities to translate health information into desired action to promote health.

Environmental health interventions will be strengthened from the national to the village level. Hygiene inspections will be decentralized to empower districts and sectors and the Community-Based Environmental Health Promotion Program is scaled up to be implemented country wide. Inter-sectoral collaboration between Non-health Departments and the Ministry of Health is essential for interventions targeting **health determinants**: water distribution and sanitation systems to meet essential health needs, public hygiene activities (domestic and health care waste management, health inspections), traffic safety, prevention of road accidents, workplace safety; prevention of work-related injuries and illnesses, activities providing supplemental food to people who need it and medico-social activities for vulnerable groups.

For **Occupational Safety and Health (OSH)** specifically, different interventions will be established in collaboration with the Ministry having Labour under its responsibilities including prevention programs to ensure Safety and Health at Workplaces.

Priority areas of intervention include strengthening the culture of conducting Occupational Safety and Health related risks assessment and come up with appropriate preventive measures, qualifying Occupational diseases, raising awareness on OSH among Health Sector Workers, conducting medical check-ups for Workers, promoting more extensive reporting on OSH, integrating OSH into different Health Sector legislations and develop OSH specific regulations for Health Sector.

3.5.2 Objective 2: Strengthen policies, resources and management mechanisms of health support systems to ensure optimal performance of the health programs

3.5.2.1 Human resources. The policy objective of this programme is to improve the availability of well-qualified health professionals throughout the country, particularly in rural and other poorly served areas.

HRH management is in process of decentralization, improving district health governance and enhancing local recruitment and district services operationality.

Quality of services is improved by organizing service delivery based on client needs and established norms and standards. Community participation and linkages between health sector and communities must be strengthened.

Human resource management and development are focused on delivering quality and cost-effective services to meet health needs of the population according to established guidelines. The capacity of teaching institutions (TI) is being strengthened to augment HRH production and identify specialized training needs which cannot be offered locally to be considered abroad. In parallel the collaboration of various US top universities who provide every year professors to teach and train Rwandan doctors at specialization level have been initiated in order to augment the qualified and specialized doctors. The HRH management will be improved to ensure rational deployment, adequate and equitable distribution, retention and continuing professional development of HR staff. An enabling environment has to be put in place to encourage health workers to work in remote areas, as they are often reluctant to do so. The MOH, together with district authorities, shall establish clear staff motivation and retention strategies and clear mechanisms determining the actors' respective responsibilities and accountability to ensure continuity and the increase of quality of service delivery. Civil services classifications and pay scales shall be confined in a way that the training and skills of all categories of public health professionals are in accordance with market-driven rates, with consideration of regional

and national market rates across the sector, and budgetary factors. Performance -based Financing (PBF)/Accreditation mechanisms will be strengthened, with emphasis on compensation for work in remote areas and challenging work environments and delivery of quality care and management following accreditation criteria.

The remuneration for doctors undergoing specialization training and after , will be reviewed and implemented according to the Prime Minister's Order No. 92/03 of 01/03/2013 modifying and complementing the Prime Minister's Order no 53/03 of 14/07/2012 establishing salaries and fringe benefits for public servants of the Central Government.

CHWs incentive mechanism must be reviewed to maintain their involvement and recognize their increasing workload.

The role and empowerment of the private health service providers will be enhanced so that the private sector can play an increasing role in health care delivery.

3.5.2.2 Health products (medicines, vaccines, lab commodities, derived blood products and consumables)

The aim of this programme is to ensure universal accessibility and availability (in geographical and financial terms) of quality health products for all Rwandans. To achieve this, the following strategies will be implemented :

- Strengthening the organizational and managerial capacities of Pharmacy Desk for the systematic coordination of health products related institutions and of District pharmacies at decentralized level.
- Strengthening the health product regulatory and monitoring systems to ensure the safety, efficacy, quality and affordability of health products for all people in Rwanda.
- Strengthening the capacities of supply chain system to ensure the availability and accessibility of essential health products to the public in adequate quantities at service delivery points in Rwanda. This will be implemented through the following sub strategies:
 - Put in place an effective and efficient distribution system of health products
 - Ensure that private sector is part of national supply chain system to provide health product of assured quality and within price control framework
 - Encourage the private sector to avail essential health products in country
 - All health product supply establishments in the private sector shall have to comply with all the rules and prescribed requirements of registration, licensing, import, transport, storage and distribution.
 - Ensure adequate capacity in health products management in order to improve stock management and prevent losses through expiries and pilferage
 - To establish an exceptional health procurement requirement which is adapted to health system needs and particularity

- Promoting the rational use of all health products at all levels of the health system and by the public.
- Strengthening the institutionalization of traditional medicine (Policy making and regulations).
- Establishing a Rwanda Food and Medicine Regulatory Authority which will ensure the regulatory part of health products so to ensure availability and accessibility and product with quality and efficacy which are rationally and safe used in order to ensure patient safety.

3.5.2.3 Geographical accessibility of health services. The policy objective of this programme is to improve geographical accessibility to health services in accordance with the health infrastructure development plan. This plan provides mid and long term vision and milestones for new health infrastructures to be developed at central and decentralized level and for the package of activities to be provided at each level of health facilities. An important aspect for improvement of accessibility is the increased role of the private sector for investment and provision of health services to complement government effort.

The geographic distribution of health facilities is planned according to comparative needs of rural and urban communities, with the target of ensuring that all people living in Rwanda have access to a health facility within 5 km distance from their home. Medical equipment will be procured to address the evolving burden of diseases and regularly maintained to maximize its utilization. With the rapid progress of Rwanda's socio-economic status towards becoming a mid-income country by 2020, the burden of NCDs in the epidemiologic situation of the country is increasing, causing the emergence of new needs in terms of health services and requirement for adapted infrastructures and equipment. Diagnostic capacity and monitoring of diseases must be improved through the strengthening of the national laboratory network and promotion of research for new diagnostic tools and methods. Medical (including laboratory) equipment is regularly maintained to ensure its optimal use and durability.

The initiative of communities is recognised as a crucial component in successful delivery of health services. The government is facilitating this by supporting community lead initiatives, such as the creation of community demanded health posts through Public-Private-Community Partnership (PPCP).

3.5.2.4 Financial accessibility of health services. The goal of the Health Financing program is to ensure universal financial access to quality health services in an equitable, efficient, and sustainable manner.

Coordination of health financing activities has to be strengthened both at national and decentralized levels.

In order to ensure evidence-based decision-making, the health information system has to collect and avail precise data on the management of financial resources.

In keeping with the prioritization of cost effective interventions, primary health care, preventive and high impact interventions will be preferentially implemented.

Sustainability of health financing will be ensured by increased mobilization of domestic resources and an increased role of the private sector and civil society. For external resources, budget support is the preferred option and other mechanisms for the health sector financing have to be explored to mitigate the effects of external financing reduction.

Among income generating strategies for increased self-reliance, cooperatives of community health workers, income generated by health posts and hospitals and revenues generated by Rwanda Biomedical Center (RBC) are being encouraged. The capacity of cooperatives in business plans, financial management will be strengthened to make them financially self sustained. The studies will be conducted to explore how and when there will be a shift from old PBF subsidies to the PBF financing using revenue generated by cooperatives. A Public-Private-Community Partnership (PPCP) model for creation of health post will be strengthened as per a Public-Private-Community Partnership between the Ministry of Health, Districts, private operators and local community. Some District hospitals situated in corners of country will be upgraded into referral in order to attract patients from neighboring countries and improve the accessibility to health services. District hospitals will be also supported to put in place “paying VIP wings” providing the same health care services but improved non-clinical services (rooms, catering services etc).

Rwanda will explore the Innovative International Financing for Health Systems included increasing taxes on air tickets, foreign exchange transactions and tobacco, alcohol, processed food levies on products like mobile phone and identify what should be applied in Rwanda to increase domestic health resources.

The private sector will be encouraged to be involved in both supply of health services (including development hospital, clinics, diagnostic centers, education institutions, medical tourism etc.) and demand for health services, essentially through the health insurance system. The supply of health services and the access (demand) to these will be developed hand in hand. The partnership with private sector for the maintenance of medical equipment and management of health facilities will be explored and the corporate social health responsibility of private companies will be promoted.

Special attention will be given to ensure that this diversification of resources does not hamper accessibility, particularly for the vulnerable populations. Financial and social protection mechanisms (through pre-payment whenever possible) are needed in order to avoid household catastrophic expenditures and out-of-pocket expenditures as barrier when seeking health services. The desired outcome is that all essential services be equitably covered by Community-Based Health Insurance (CBHI).

Health insurance mechanisms need to be diversified. Apart from the current fee for service mechanism, other purchasing mechanisms such as capitation and

PBF/accreditation, Disease-Related Group (DRG) will be explored and implemented. The establishment of private insurance companies will be encouraged to diversify the offer of health insurance services to the population. MOH will continue to hold responsibility for development of policy and regulations, while management of health insurance schemes will be under the responsibility of RSSB or private companies.

3.5.2.5 Health Information system and Research:

To strengthen the health information system, the access and use of Rwanda Health Information Management (RHMIS) and its related systems will be improved. A web-based system should improve access to data at all levels of the health system and will serve as a sustainable platform for integrating additional modules. The catchment area populations and vital registration (MOH, Justice, MINALOC and NISR) will be enhanced and the e-learning as well as the implementation of telemedicine software in selected hospitals will be promoted in order to provide a platform for remote access to specialized clinical services.

To improve the health research, the Health Sector will operate under four objectives: (i) To promote a culture of research, (ii) to ensure the facilitation of health research, (iii) to reflect on the guiding principles for health research and (iv) to coordinate the research in health sector and protect the population.

The health sector will continue to support the implementation of health research agenda which is identifying the priorities based on research needs to improve the health in Rwanda.

3.5.3 Objective 3: Strengthen policies, resources and management mechanisms of health services delivery systems.

3.5.3.1 Community Health Program

Community health interventions are implemented by Community Health Workers and by Community-based organizations. **Collaboration and coordination** between these two key groups is important to strengthen linkages between the health care delivery system and the community.

To ensure quality interventions at community level, continuous **capacity-building** of implementers (CHWs and CBO agents) and of the health staff involved in the community health program at central, district, and decentralized levels is necessary.

CHWs are not salaried health workers and their compensation is channeled through support to their cooperatives. To ensure the sustainability of the Community Health Program, CHW cooperatives are progressively strengthened to become self-sufficient.

3.5.3.2 District Health Care System

Each administrative district has one or two district hospitals supervising all health facilities in their catchment area. Infrastructures are progressively upgraded to improve accessibility and quality of health care services. Now that all administrative sectors have at least one health center, the focus will be on the improvement of existing health facilities as well as development of the next level of health facilities to improve access of the general population to essential health services. Health posts are now being installed with the final objective of having one in each cell (administrative unit below the sector) through Public/ Private/ Community Partnership (PPCP) to provide primary health care services to the community and strengthen the linkage between community and health care facilities. Private investors and community initiatives will join with public leadership and resources to scale up this new level of health facility.

In district hospitals, private corners will be developed to give more affluent patients the opportunity to access more comfortable non-medical services (room and accommodation), while medical services will be of equal quality for all patients.

3.5.3.3 Referral Hospitals (Tertiary care)

In each province, one district hospital will be upgraded to become a Provincial hospital to diminish the burden placed on referral hospitals by the high demand from district hospitals. The main aspects of hospital capacity strengthening cover hospital management (including financial and medical products management), infrastructure and equipment, quality of services and customer care, HRH training and research.

Specialized medical centers will be established to meet the growing need for diagnosis and treatment of complex pathologies (i.e. oncology, cardiology,...) for people living in Rwanda and for foreigners seeking care in settings where quality specialized medical can be obtained at that level of quality in their country of origin (medical tourism). Two other elements contribute to the current need for high quality specialized health services: the rapidly increasing flow of tourists from highly developed countries who require first class, specialized services in case of need during their stay in Rwanda and the need to provide in-country specialized medical services to decrease the number of Rwandan residents who need to be evacuated to other countries for medical treatment.

3.5.3.4 Pre-hospital care services

The quality of pre-hospital care services is another area that needs to be strengthened through increasing the number of competent staff (pre-service and in-service training) and improving infrastructures and equipment, with adequate ambulance vehicles for rapid transportation of patients needing emergency specialized care.

3.5.3.5. Traditional, Complementary and Alternative medicine(CAM)

Traditional health care sector: The Government recognises that a large number of the population is using the traditional medical services. The MoH is developing Legal and Logical framework to determine how traditional medical services can operate alongside health services within the district. The MoH is collaborating with international, regional and the national institute in charge of health research to regulate and ensures the rational development of traditional health care in the country.

The establishment of safety standards of traditional medicines and set up all quality assurance mechanisms including quality control, registration and inspection of traditional medicines as well as the guidelines and protocols for local production of traditional medicines and promotion of their proper will be prioritized.

Complementary and Alternative Medicine: the Country is facing an abnormal increasing of CAM and Rwanda Citizens are adhering to it. To mitigate any malpractice and threat to Public health, the MoH in collaboration with the existing Health professionals councils will develop a regulatory framework which define component of CAM, the scope of their practices and code of conduct as well as requirement for practicing. While waiting for the definitive regulatory authority of CAM, all existing four health professional councils (Allied Health Professional; Pharmacy Council, Nurse & Midwives Council and the Council Medical & Dental Council) shall identify members to constitute a steering committee to regulate the CAM.

3.5.4 Objective 4: Strengthen the Health Sector Governance mechanisms

3.5.4.1 Organization and management of sector

The Government of Rwanda has adopted a **sector-wide approach** in the management and coordination of internal and external interventions in the health sector. The Medium Term Expenditure Framework (MTEF) is used as a tool for planning and management of the health sector. The Government has adopted a system of planning and management that is decentralised with the close involvement of the community and which takes account of Ministry of Health programme priorities, resource availability and capacity absorption in the sector. Managerial and administrative capacities are being developed at all levels within the context of decentralisation, with mechanisms to supervise, monitor and evaluate the implementation of the Health Sector Policy with a focus on specified input and process indicators (human and financial resources, utilisation of services etc): evaluation will be conducted both internally and externally in collaboration with the Ministry of Health's partners.

The implementation of the Health Sector Policy is based on a health sector strategic plan and the associated medium term expenditure framework. Every year, operational action plans are elaborated at all levels of the health system in order to coordinate activities of all actors and to reach the objectives of the Health Sector Policy.

3.5.4.2 Decentralization.

The district health system is structured around new coordination structures, the District Health Unit (DHU) providing the local government with adequate information and technical expertise for evidence-based decision-making, and the District Health Committees (DHC) are responsible for supervising and overseeing health services provided in the decentralized public health facilities. The DHC were placed under the guidance of the District i.e. the Vice Mayor for Social Affairs, in line with Article 134 of the Law N° 87/2013 of 11/09/2013 determining the organisation and functioning of decentralized administrative entities.

Members of the DHC particularly report and monitor on services provided by the District hospitals and Health Centers, health posts, pharmacies, PBF,). However, the District Hospitals, CBHI district offices (Mutuelles) and District Pharmacies are managed under the authority of their respective Boards of Directors. To enhance the health system coordination at decentralized level, a relevant and strong capacity-building program for all district managers in planning and financial management will be developed. This includes team-building measures and on-the-job trainings, integrated Supportive Supervision and Mentorship and productive collaboration with private sector services.

In the framework of enforcing the decentralization policy, on 23 March 2013, the Cabinet approved the Draft Law determining the mission, organization and functioning of health care facilities in Rwanda. The draft Law, once approved, will endow health facilities, that meet the set criteria, with financial and administrative autonomy. The key targeted health facilities are Provincial and District Hospitals. Health Centers and Health Posts shall be supervised under their respective District Hospitals.

3.5.4.3 Intersectoral activities

Intersectoral activities are an essential part of the health of individuals and communities because the determinants of health are defined in a much broader context than the health sector itself. The structural determinants and the conditions of daily life constitute the social determinants of health where unequal distribution of power, income, goods, and services causes inequity in their access to health care, schools, and education and consequently in health status.

MOH and its health partners must play an increasing role in public policies and strategies of other sectors, such as education, water and sanitation, agriculture, and transport. It is within this broad collaboration that important gains can be made in reducing morbidity and mortality of the Rwandan population. More specifically, the MOH is already involved in several intersectoral activities: Fight against malnutrition, Promotion of early child development, adolescent health and family hygiene, Fight against Gender-based violence, Social integration of people living with disabilities.

4. GOVERNANCE FRAMEWORK

4.1 Organization of Health care delivery system

The first aspect of the implementation framework is the description of the health delivery system, with the different levels of facilities and programs providing health services.

4.1.1 The health system has a pyramidal structure, consisting of three levels: central, intermediary and peripheral. The central level includes the Ministry of Health, Rwanda Biomedical Center (RBC) and the national referral hospitals. The central level elaborates policies and strategies, ensure monitoring and evaluation, capacity building and resource mobilization. It organises and coordinates the intermediary and peripheral levels of the health system, and provides them with administrative, technical and logistical support.

4.1.2. Relative to health care delivery, the central level has five national referral hospitals whose mission is to provide tertiary care to the population: King Faisal Hospital (KFH), Rwanda Military Hospital, Kigali University Hospital (CHUK), Butare University Hospital (CHUB) and Ndera Hospital for psychiatric care. The King Faysal hospital was created to provide a higher level of technical expertise than that available in the national referral hospitals to both the private and public sector; its role is also to ensure that there is a reduction in the number of transfers abroad.

4.1.3. A network of specialized health services providing high level of quality tertiary care will be promoted and strengthened with the aim to offer attractive services targeting medical tourism for patients coming from foreign countries and looking for high quality specialized services. This network will be developed in collaboration and with financial involvement of private investors.

4.1.4 An intermediary level of health facility will be established with one provincial hospital in each province, with the objective of creating an intermediate level of referral hospitals to decrease the demand of services in the national referral hospitals.

4.1.5. The peripheral level is represented by the health district and consists of an administrative office, a district hospital and a network of health centres that are either public, government assisted faith based, or private. An intermediate level of health post between the community and health center is promoted by the Ministry of Health in a model of Public-Private-Community Partnership to bridge the gap of geographic accessibility. The health district deals with the health problems of its target population. The functions of the health district include: (i) the organisation of health services in health centres and the district hospital in terms of the minimum and complementary package of activities, (ii) administrative functioning and logistics, including the

management of health resources and supplies, under the responsibility of the district management team, and (iii) the supervision of community health workers.

4.1.6. Packages of activities: Different packages of activities have been defined according to each of the levels in the health pyramid in order to provide equitable and quality care across the country, to ensure that there are procedural standards for operation and management, to allow for better planning and management of resources, to provide the basis for establishing and evaluating the quality of health services and particularly to ensure provision of adapted services to key populations.

4.1.7. The minimum package of activities is a common list of priority activities for all health centres and health posts, intended to cover basic health problems in an equitable, effective and efficient manner. The package takes into account the health needs and demands of the population, and competences of health providers at the primary level but equally recognises the financial constraints of the Ministry of Health and the population.

4.1.8. The complementary package of activities is a common list of priority activities for all district hospitals, intended to provide curative health care in an equitable, effective and efficient way using techniques unavailable at the primary level. The demands of the population as well as the financial resources of the Ministry of Health and the population determine the package.

4.1.9. Community health services are integrated into the community development services and administrative structures. Integrating community health services at every level is very important as it improves the quality of services for the clients by reducing missed opportunities that often result from vertical programs.

Community participation in planning, implementing, monitoring, and evaluating services for the community is essential to building sustainability and self-reliance. All sectors of the community, including people living with HIV and AIDS, young people, traditional healers, traditional birth attendants (TBAs), women, men, and community associations, should be mobilized to participate in health care delivery.

Critical to the effective engagement of communities is the direction, support, and direct field supervision of communities by health workers. Transfer of skills and knowledge to communities fosters ownership and enhances sustainability.

A new field of intervention for community health workers is the provision of end-of-life care to promote for all the right to die in dignity. This will require innovative mechanisms to ensure increased availability of this body of volunteer workers already playing an important role for access and use of health services by the general population.

4.1.10. Pre-hospitalization care services aim at ensuring emergency care and rapid transportation to appropriate level of health facility depending on the complexity of pathology. The priority orientations of this program are the following:

- Access to better health care services at all levels,

- Availability of adapted infrastructures and equipment for emergency medicine including pre-hospital care,
- Availability of qualified emergency care providers at all levels.
- Improved coordination of referral system by networking the referral facilities for efficient management of emergencies.

Currently, Ministry of Health is financing the Emergency Medicine and Pre-hospitalization care programme in Rwanda in collaboration with few stakeholders. Health insurers and Special Guarantee Fund should be more involved and boost the management of all kind of emergencies.

4.2. Governance

4.2.1 Governance and accountability mechanisms

At all levels of the health district, decisions are made collectively through various committees, which serve as vehicles of **community participation** in the health sector. Community participation is a key element in the implementation of the primary health care strategy: it plays a role in the planning, execution and monitoring of primary health care activities, including the provision of certain services at the grass roots level (nutrition, mental health, family planning) and the search for appropriate solutions to local health problems and the mobilisation of resources.

The Government of Rwanda (GOR) adopted in 2001 **its decentralisation policy** which provides guidelines for the development of local government. In 2011, GOR approved a revised Financial and Fiscal Decentralization Policy. In line with this national policy, the Ministry of Health (MOH), together with the Ministry of Economy and Finance (MINECOFIN) and under the leadership of the Ministry of Local Government (MINALOC), is updating its guidelines and include resource allocation, planning, budgeting, budget execution, financial reporting, and fiduciary issues.

The main characteristics of the decentralized health system are the following:

- District health unit (DHU) under the leadership of the Mayor/Vice Mayor; is the coordination and M&E mechanism of health services implemented by health entities (District hospitals, Health centers, district pharmacies and CBHI district offices), holding accountable these health entities and being responsible for all their operations.
- Health personnel, infrastructure, equipment, and financial resources are decentralized to the district level, although MOH still recruits and affects medical staff (doctors and nurses) to ensure equitable distribution of human resources. The MOH remains responsible for policy development, technical guidance (protocols, tools) and supervision, while district councils (DHUs) control the program implementation process in the 30 districts.

- Progressively, more funds are channeled directly to the districts for the management of health interventions.
- A relevant and strong capacity-building program for all district health managers (and also for committee members in HC and DH in planning and financial management).
- A health commission will be established under the Joint Action Development Forum (JADF) at district and sector levels to promote the implementation of SWAp and advance the aid effectiveness (harmonization and alignment) and accountability agenda at district level.

4.2.2. Management and Stewardship structures

The Ministry of Health holds responsibility for central functions such as policy and priority setting, financial management, budget execution, and audits. The Rwanda Biomedical Center (RBC) is the implementing arm under the MoH for most of the health programs, most importantly (1) the Institute of HIV/AIDS, Disease Prevention and Control, (2) the Medical Production and Procurement Division, (3) the Biomedical Services Division, (4) Rwanda Health Communication Center, (5) the Medical Research Center and (6) the Planning, M&E and Business Strategy Division.

Within the Rwandan system of decentralized governance, elements of devolution, delegation, and deconcentration are combined as a means of establishing and empowering decentralized administration. To improve accountability and transparency, local leaders are directly accountable to the communities they serve, as well as to the President, through the *Imihigo* performance contracts, which include also the health priorities. The system aims to increase the responsiveness of public administration by transferring planning, financing, and control of services to the point closest to where they are delivered.

4.2.3. Partnership and Coordination structures

Sector-wide approach. Building on the national poverty reduction strategy, actions in the health sector have a more sustainable impact if they are integrated and fundamentally incorporated into the national development programmes. Inter-sectoral consultation and collaboration with ministerial/development partners is essential in the implementation of major health strategies. An institutional framework is in place to strengthen intersectoral collaboration at the central, intermediary and peripheral levels of the health system.

The Joint Action Development Forum (JADF) coordinates local development interventions, and specifically for health interventions, ensures that all stakeholders fulfill their responsibilities and are accountable within the Sector wide approach (SWAp) at decentralized level and facilitates involvement of private health care providers.

Coordination with other stakeholders

The following structures ensure the involvement of all health stakeholders:

The Health Sector Working Group (HSWG) comprises representatives of the MOH, development partners, and civil society. Its goals are to improve coordination of activities and harmonization of procedures of both GoR and DPs, in order to increase effectiveness and efficiency of aid in the health sector and to ensure better alignment of DPs behind the Health Sector Strategic Plan (HSSP), with an enshrined principle of mutual accountability.

Technical working groups (TWGs) are operational entities where technical and policy issues are discussed by staff of the MOH with representatives of development partners, NGOs, FBOs, and CSOs. TWGs operate under the authority of the HSWG. The objective of the TWGs is to support and advise the MOH in the implementation of subsector strategies and policies and develop relevant guidelines and tools to be used by the implementing agencies.

The Single Project Implementation Unit (SPIU) aims at reducing the number of separate projects and the administrative burden of the MOH in managing and reporting on the various projects with off-budget resources.

National and international cooperation. National, regional and international cooperation is in line with the activities of the health sector strategic plan set out by the Ministry of Health for implementation of the Health Sector Policy. Multilateral, bilateral and non-governmental cooperation is founded on the basis of mutual agreement between the Government and the donor country or organisation. Mechanisms for the joint management and evaluation of resources to support the functioning of health services are to be strengthened.

Regional integration. GOR has adopted an active policy of orienting its various socioeconomic activities towards the integration of the countries in the East African Community (EAC). For the health sector, important integration issues are the procurement of medicines and medical / laboratory equipment, active sharing of information and training opportunities, health sector management and medical education.

International Health Regulations. MOH puts in place all regulations and public health mechanisms to align with International health regulations (IHR) designed under the authority of WHO for the following public health issues:

- National legislation, policy and financing;
- Coordination, communication and advocacy related to IHR;
- Surveillance for early detection, rapid response capacity and preparedness and response plan for public health emergencies;
- Risk communication to inform the population during public health emergencies;
- Human resources capacity to implement IHR;
- Laboratory capacity to test, diagnose and confirm public health threats;

- Specific mechanisms to detect and respond to different public health events: points of entry, zoonotic events, food safety, chemical events and radiation emergencies.

4.2.4. Roles and responsibilities of stakeholders

Professional councils. The existence of professional health associations helps the Ministry of Health to better organise the medical, dental, pharmaceutical, nursing and paramedical professions. The reinforcement of their structures will allow them to better understand their role, most notably in: the recognition of qualifications, the registration of diplomas, the management of problems relating to professional ethics, and the elaboration and revision of professional classifications according to qualification and specialisation. Equally, they must support the Ministry of Health in the accreditation of services and the certification of professionals.

Private and not-for-profit sectors. The Ministry of Health is strengthening its relationship with the private and not-for-profit sectors. Collaboration is based on (1) elaboration and implementation of regulations to enhance private medical practice and private sector investment for improved health services, (2) encouragement of private sector investment in medical services for promotion of medical tourism, (3) a greater participation of the private sector in the provision of services to the entire population, (4) improved accessibility of the private sector to facilities offered by the Ministry of Health and establishment of multidisciplinary medical centers for private practitioners providing comprehensive medical services to the population, (5) improved participation of private health care providers in planning and organization of training and supervision activities, and (6) a reinforcement of the Professional bodies coordinating private health care providers for better collaboration with the Ministry. The role of the private sector is not only in service provision, but also in the production, promotion, management of health facilities and social marketing of different medical products and of generic drugs. A formal agreement detailing the nature of cooperation between the Ministry of Health and the private sector has been established.

Government assisted health facilities fulfil all the functions of publicly owned facilities (as defined by the Ministry of Health) and have official management structures. They are fully integrated into the structure of the health district. The not-for-profit sector adheres to a convention, and this formal agreement determines the respective obligations and rights of those working in the sector. Local partnership between NGOs, churches, private providers of health and the public sector are encouraged to ensure coordinated and integrated planning.

4.3. Monitoring & Evaluation Mechanism

The Health sector Monitoring and Evaluation (M&E) system regularly measures the sector's performance and how it contributes to achievement of EDPRS goals. It oversees the establishment and effective functioning of the following mechanisms:

1. Ensuring an unified, sector-led platform and procedures for collecting, analyzing and sharing data;
2. Routinely assessing the performance of the health system at achieving its objectives through routine data collection and population-based surveys;
3. Establishing formal mechanisms for periodically sharing performance results and revising targets and interventions, both at central (Health Sector Working Group, Joint Health Sector Review, Planning and M&E Technical Working Group) and at district level (Joint Action Development Forum, District Health Committees).

4.3.1 Indicators, data sources and review

The national health sector performance indicators are identified and thoroughly described in the M&E plan that is part of the Health Sector Strategic Plan. Most of the data sources and mechanisms to collect data necessary to measure progress of these national indicators are already well established in Rwanda.

The **RHMIS (Rwanda Health Management Information System)** is the primary source of routine data on health services provided through health centers, district hospitals, and referral services. The RHMIS was substantially revised in 2012 and it has been built on a new web-based platform that enhances data sharing and use. In addition, reporting formats have been introduced for all referral hospitals and private facilities, so coverage of reports should continue to improve.

A limited number of others health information system are in place to track the progress of health sector in different area such as: (i) The **SISCom (CHW Information System)** which supplies important data on the increasing contributions of CHWs to the provision of health services; (ii) The **IHRIS (Integrated Human Resource Information System)** a data base for Human Resource for Health management both for central and decentralized health sector; (iii) The **Resource Tracking Tool (RTT)** which provides important data related to financial resources committed to and disbursed to districts by donors and GOR; (iv) the **Mutuelle Indicator Database** that tracks key performance indicators from Mutuelle section offices and helps to manage Mutuelle memberships and renewals; (v) **Performance-based financing database (PBF)** that tracks the progress of indicators for which performance incentives are provided and records the evolution of quarterly service quality assessment conducted each quarter; (vi) **TracNet** that has historically been used for collecting data on HIV program implementation and is currently being integrated into the RHMIS.

A **national data warehouse and dashboard portal** has been configured to draw the data from the HMIS, SISCom, DHS and other sources. This will become the one-stop shop for indicator data related to health sector.

In addition to these primary routine data collection systems, the national survey such as the Demographic and Health Survey (DHS), the Integrated Household Living Conditions Survey (EICV), Rwanda National Census among others are used to monitor the health sector performance

4.3.2 Reporting, monitoring, and evaluation

The mechanisms for effective reporting, monitoring and evaluation including reporting templates used at all levels, periodicity data quality assessment and review of the different components of the health system are described in the Health sector monitoring and evaluation plan and are documented in the HMIS data recording and reporting guideline document.

4.3.3. Mechanisms for sector performance assessment

The selection of indicators and establishment of efficient systems for data collection are only part of the M&E system. It is crucial to continue to strengthen mechanisms for the routine review of sector performance and the adjustment of implementation strategies if required. Key mechanisms are the JADF (Joint Action Development Forum), semi-annual Joint Health Sector Reviews (JHSR) and various TWGs. The M&E/Planning Technical Working Group meets regularly for improving coordination, reviewing progress, and mobilizing resources in this area.

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