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R

WHO COUNTRY COOPERATION STRATEGY

2009-2013

RWANDA

WHO Country Cooperation Strategy, 2009-2013 Rwanda

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SUMMARY

ABBREVIATIONS

ANSP+	:	*Association nationale de soutien aux séropositifs*
ARV	:	Antiretrovirals
ATM	:	AIDS, Tuberculosis and Malaria
CCA	:	Common Country Assessment
CCM	:	Country Coordination Mechanism
CDC	:	Centre for Disease Control
TTC	:	Treatment and Testing Centre
NACC	:	National AIDS Control Commission
NBTC	:	National Blood Transfusion Centre
COD	:	Common Operational Document
COMESA	:	Common Market for Eastern and Southern Africa
DMTF	:	Disaster Management Task Force
DPCG	:	Development Partner's Coordination Group
EAC	:	East African Community
EB	:	Extra Budget
EDPRS	:	Economic and Development Poverty Reduction Strategy
DHS	:	Demographic and Health Survey
DHSRIII	:	3rd Demographic and Health Survey in Rwanda
ISHLC	:	Integral Survey on Household Living Conditions
EIDHS	:	Intermediate Survey on Demographic and Health Indicators (2007-2008)
EPI	:	Expanded Programme on Immunization
FHP	:	Family Health Programme
GAVI	:	Global Alliance for Vaccines and Immunization
GFATM	:	Global Fund to Fight AIDS, Tuberculosis and Malaria
GLIA	:	Great Lakes Initiative on AIDS
GSM	:	Global Management System
GoR	:	Government of Rwanda
HAMS	:	*Hygiène et Assainissement en Milieu scolaire*

HBM	:	Home-Based Management
HIV	:	Human Immunodeficiency Virus
HQ	:	Headquarters (WHO)
HSSP I	:	Health Sector Strategic Plan I (2005 - 2009)
HSSP II	:	Health Sector Strategic Plan II (July 2009 - June 2012)
HSP	:	Health System and Policies
ICT	:	Information and Communication Technology
IDHS	:	Interim Demographic and Health Survey (2007-2008)
OI	:	Opportunistic Infections
STIs	:	Sexually-Transmitted Infections
ICT	:	Intercountry Support Team (WHO Subregional Office)
KHI	:	Kigali Health Institute
NRL	:	National Reference Laboratory
M&E	:	Monitoring and Evaluation
MAP	:	Multi-country HIV/AIDS Programme for Africa.
MINISANTE	:	Ministry of Health
MIP	:	Malaria in Pregnancy
Mini DHS	:	Mini-Demographic and Health Survey
MOU	:	Memorandum of Understanding
NTD	:	Neglected Tropical Diseases
MTR	:	Mid-Term Review
NEPAD	:	New Partnership for Africa's Development
NISR News Bulletin	:	The Rwandan Statistician, Bulletin of the National Statistics Institute in Rwanda
MDGs	:	Millennium Development Goals
WHO	:	World Health Organization
ONG	:	Nongovernmental Organization
IMCI	:	Integrated Management of Childhood Illnesses
PEPFAR	:	President's Emergency Plan for AIDS Relief
AFP	:	Acute Flask Paralysis
PHAST	:	Participatory Hygiene and Sanitation Transformation

PNILT	:	Integrated National Leprosy and Tuberculosis Control Programme
PRSP	:	Poverty Reduction Strategic Paper
MTSP	:	Medium-Term Strategic Plan
PMTCT	:	Prevention of Mother-to-Child Transmission
PLWH	:	Persons Living with HIV
RB	:	Regular Budget
CCS	:	Country Cooperation Strategy
AIDS	:	Acquired Immunodeficeincy Syndrome
ISDR	:	Integrated Surveillance of Disease and Response
HIS	:	Health Information System
SO	:	Strategic Objective
SWAP	:	Sector Wide Approach
TRAC	:	Treatment and Research AIDS Centre
TRACNET	:	Electronic Health Information System of TRAC
TRAC PLUS	:	Treatment and Research AIDS Centre Plus Tuberculosis and Malaria.
TSP	:	Technical Support Programme
UN	:	United Nations
UNAIDS	:	United Nations Joint Programme on AIDS
UNDAF	:	United Nations Development Assistance Framework
UNDP	:	United Nations Development Programme
USAID	:	United States Agency for International Development
USG	:	United States Government
VCT	:	Voluntary Counselling and Testing
HIV	:	Human Immunodeficiency Virus
WPC	:	WHO Presence in Country
WR	:	WHO Representative

FOREWORD

The WHO Country Cooperation Strategy (CCS) crystallizes the essential element of the reforms adopted by the World Health Organization with a view to enhancing its action in the countries. It has given a decisive qualitative orientation to our Institution's modalities of intervention, coordination and advocacy in the African Region. Presently well established as a medium-term planning tool of the WHO at country level, the cooperation strategy aims at promoting greater relevance and focalization in determination of priorities, greater effectiveness in the achievement of objectives and greater efficiency in the use of resources allocated for WHO action in the countries.

The first generation of CCS was developed through a participative process, which mobilized the three levels of the organization, the countries and their partners. For the majority of countries, the 2004-2005 biennial period constituted the crucial point of refocusing WHO action. It enabled the countries to better plan their interventions, according to a results-based approach and improved management process, which made it possible for the three levels of the Organization to address their actual needs.

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

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

I commend the effective and efficient leadership role played by the countries in the conduct of this important exercise of formulating the WHO Country Cooperation Strategy documents and request the entire WHO staff, particularly the Country Representatives and division directors, to redouble their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy with a view to achieving better health outcomes for the benefit of the African populations.

Dr Luis G. Sambo
WHO Regional Director for Africa

SUMMARY

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

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

i) Improving the performance of the health system;

ii) Disease control;

iii) Health promotion as well as health and environment.

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

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

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

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

Health financing is mainly external but contributions from Government and especially the populations, through mutual health schemes, are on significant increase. External funding facilities now follow the national aid policy, which advocates budget support and the sector approach. Several partners have adopted this approach, including UN agencies, by signing the memorandum of understanding of the SWAP health in 2007, and through their active participation in its operationalization.

To better apprehend these health problems facing the population, Rwanda has carried out administrative reforms of the health system, in response to the national policy on decentralization. It recently adopted the second Strategic Plan of the sector as the tool for operationalizing the EDPRS and Vision 2020.

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

Hence, jointly with the Ministry of Health, 13 areas of work have been identified and are all aligned with the country priorities defined in the framework documents, notably the second Health Sector Strategic Plan, itself inspired by the Poverty Reduction and Economic Development Strategy, Vision 2020 and UNDAF in the context of "Delivering as One".

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

They are:

i) Reduction of maternal and child mortality;

ii) Control of communicable and noncommunicable diseases;

iii) Health promotion, food safety and nutrition, health and environment;

iv) Improvement of health system performance.

To honour its commitments to the Government of Rwanda, represented by the Ministry of Health, the WHO Country Office supported by the Regional Office and headquarters, will enhance its management and financial capacities in terms of human, technical and material resources to address the challenges expressed in the document on WHO strategy for cooperation with Rwanda.

SECTION 1

INTRODUCTION

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

i) The poverty reduction strategies developed by developing countries and on which all the cooperation programmes must be aligned;

ii) The initiatives of the rich countries to reduce or cancel the debt of certain poor countries;

iii) The establishment of new global initiatives for financing of health, including the creation of the Global fund to Fight HIV/AIDS, Malaria and Tuberculosis (GFAMT) , the Global Action on Vaccination Initiative (GAVI), etc.

To adapt to this new order, Rwanda, like many countries in the African region, has made some changes, especially in the management and coordination of external aid. One of the first changes is the establishment by Rwanda of a Sector-wide approach (SWAP), through which the Government has enhanced its leadership and coordination role in the mechanisms for joint programming and management of development aid. The initiative of reform of the United Nations system, “One UN” was reflected by the establishment of the Common United Nations Programme (COD), as operationalization tool of the United Nations Development Assistance Framework (UNDAF).

The second generation of Strategy for cooperation with Rwanda (2009-2013), is based on the WHO Medium-term strategic plan (2008-2013), the WHO 11th General Programme 2006-2015 and the strategic orientations of WHO action in the African Region 2005-2009.

Like the previous CCS, it is also based on the National Health Policy of Rwanda, adopted in 2005, and also the second National Health Sector Strategic Plan (HSSPII 2009-2012). The HSSP II is for Rwanda the operationalization tool, in the health sector in the medium- term, of the Economic Developmeny and Poverty Reduction Strategy of Rwanda (EDPRS 2008-2012), Vision 2020

of the Government, the Millennium Development Goals, the Common Country Assessment (CCA, 2000), and the United Nations Development Assistance Framework (UNDAF). For the period 2009-2013, the WHO will support the Ministry of Health to implement its biennial action plans and will focus its intervention on 4 priority areas:

i) Reduction of maternal and child mortality;

ii) Control of communicable and noncommuicable diseases;

iii) Health promotion, food safety and nutrition, health and environment;

iv) Improvement of health system performance.

SECTION 2

HEALTH CHALLENGES AND DEVELOPMENT

2.1 COUNTRY PROFILE

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

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

Rwanda has carried out administrative reforms to enhance the decentralization and participation of the population in decision-making. Hence, the administrative division has been reviewed and, presently the country is subdivided into 4 administrative provinces, with the city of Kigali subdivided into 30 administrative districts, and then into 416 sectors, and again into 2148 units and 14,980 villages/imidugudu[5]. The administrative district is the basic politico-administrative unit.

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

[1] IDHS in Rwanda (RDHS 2007).
[2] The Population was estimated at 9.3 million inhabitants in 2007 (based on projections of the 2002 Census).
[3] Population projections, Gisenyi Meeting, hosted by NISR, February 2009.
[4] *MINISANTE, MINECOFIN*: Demographic and Health Survey, 2005.
[5] Site of the Ministry of Local Administration (MINALOC).

The country's socio-economic situation has been greatly influenced by the consequences of the genocide up to the years 2000, and presently, the situation keeps improving.

The impact of the genocide was most visible in the social sector. Hence, in 2006, after 12 years of efforts, the Ministry of Gender and Family Promotion provided the following estimates: number of children in host families, 22,535; number of street children, 7000; number of children in centres for unaccompanied children (CENA), 3751; and number of children living in households managed by children[6], 100,956.

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

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

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

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

2.2 HEALTH PROFILE

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

6 National conference on care, treatment and assistance to children infected and affected by HIV/AIDS, 2006.

7 NISR News Bulletin, August 2007, Page 6. The Rwandan Statistician, Bulletin of the National Institute of Statistics, Rwanda.

8 ISHLC 2006.

9 NISR; ISHLC2, 2005-2006.

10 U.N.

11 EDPRS, 2008-2012.

12 Ministry of Health, 2007 Annual Report.

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

However, Rwanda is also experiencing an emergence of noncommunicable diseases associated with the development of high-risk behaviours and urbanization. As the other countries in the sub-region, it is threatened by natural or man-made disasters and emerging and re-emerging diseases (SRAS, avian flu, A flu (H1N1), etc.).

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

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

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

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

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

Despite this progress, there are still a few challenges in the following areas:

- Intensification of the prevention efforts in the face of the number of new infections, the low rate of condom use, insufficient interventions targeting high-risk population groups (sex workers and their clients, MSM, sero-discordant couples), the extension of priority prevention activities like circumcision, PITC, promotion of condom use and sensitization of the communities;
- Antiretroviral treatment, where the coverage rate remains low (43%) as compared to that of VCT and PMTCT services, including the intensification of the support;
- Strengthening of the health system, with adequate human resources, the delegation of tasks for extension of antiretroviral treatment, perpetuation of the funding mechanisms, production of quality strategic information;
- Monitoring of drug resistance.

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

The annual incidence of tuberculosis is estimated at 2.6% in Rwanda, according to WHO. The most recent epidemiological data show a net increase in the prevalence of this pathology. According to the reports of the Ministry of Health, the number of tuberculosis cases detected and treated increased from 3205 in 1995 to 8014 in 2007. More than 50% are microscopic-positive tuberculosis cases. This increase can be explained, among others, by the AIDS epidemic and capacities for detection, care and treatment.

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

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

Rwanda officially eliminated maternal and neonatal tetanus in 2004. The Expanded Programme on Immunization has already initiated the process of integrating other interventions in favour of child survival into its regular immunization programme, such as the distribution of an insecticide-treated bed net to a 9-month old baby who has just received his anti-measles vaccine and the integration of vitamin A supplement during regular vaccination activities. Since 2002, the year Rwanda introduced the new vaccines (HepB and Hib), the vaccination coverage increased from 82% in 2002 to 97% in

2007, according to administrative data from the EPI. The report of the Intermediate Survey on Demographic and Health Indicators (2007-2008) shows an improvement in the vaccination coverage of children since 2000, with the rate increasing from 76% to 80%. In April 2009, Rwanda became the first developing country to introduce vaccination against pneumococcal infections in its national programme.

In the framework of vaccine independence, the Government fully finances traditional vaccines and injection materials, and has been doing so since 2000. Hence, co- financing for new vaccines started in 2006.

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

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

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

The country is also exposed to natural disasters like volcanic eruption, floods and especially man-made disasters such as conflicts and wars, leading to massive population displacements. Indeed, in 2006, there was a repatriation of 19,000 Rwandans who had taken refuge in Burundi and 65,000 Rwandans from Tanzania. An earthquake occurred in Rwanda in February 2008, causing the death of 37 people and injuring 600 others in the South-Western part of the country.

These emergency problems are quite important in the sub-region, hence the need to put in place mechanisms for their prevention and management at the national and sub-regional levels.

According to the DHSR-III, 45% of children under 5 suffer from chronic malnutrition, 19% of whom in the severe form. At the national level, 33% of women suffer from anaemia. Micronutrient deficiency in children under 5 and pregnant women concern mainly iodine, iron and vitamin A. The basic reasons for this situation are insufficiency of food ration, high prevalence of infectious and parasite diseases, high level of poverty, affecting particularly women and children family heads, poor dietary habits and very low level of education.

Mental health remains a public priority in Rwanda. The national policy and mechanism of care should target and ensure not only basic mental healthcare but should also deal with the consequences of the genocide, which remain a key factor in the major causes of morbidity and invalidity, in the area of mental health. Moreover, it is important to note the share of epilepsy in the general morbidity in Rwanda, as well as inadequate knowledge of the share of neurological disorders in the general morbidity.

The most frequent pathologies are, by order of importance, epilepsy (46.9%), psychiatric disorders (21%), psychosomatic disorders (15%), neurological disorders (7.4%), and psychotraumatic disorders (3.6%). To deal with this situation, several strategies have been adopted and put in place:

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

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

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

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

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

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

The rate of potable water supply was 69% at the national level in 2007. The rate of coverage in latrines was 85% at the national level in 2007, 38% of which meet the required standards. Poor management of wastes and dangerous and toxic chemical products constitute threats to the environment and public health. The main challenge is, therefore, improving the quality of potable water supply systems and their accessibility for the population and promoting a safe, sustainable and enabling environment for health.

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

The improvement of the capacities of the communities, the creation of an enabling environment for health and advocacy constitute the pillars of health promotion. Health promotion in general and

management of care by the communities in particular do not occupy a place of choice in health improvement, whereas 70% of the most common diseases are avoidable through prevention. Community health is presently built on a binomial of community health agents (one woman and one man) per village/Umudugudu, representing one binomial for 600 inhabitants.

To improve its health system, Rwanda has adopted a health policy based on decentralization and community participation.[13]

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

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

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

i) Primary health care through its eight main components;

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

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

iv) Development of human resources;

v) Supply of essential drugs;

vi) Strengthening of the health information system;

vii) Intersectoral collaboration.

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

- The central level is constituted by central departments of the Ministry of Health as well as the national reference hospitals. It is responsible for the formulation of health policies, strategic planning, high-level technical supervision, monitoring and evaluation of the health situation as well as the coordination of resources at the national level.[14]

[13] Health sector policy in Rwanda, 2005.
[14] Strategic plan for Development of Human Resources in Health, 2006-2010.

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

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

The authorized or confessional sector plays an appreciable role in the health system. In 2007, out of the entire primary and secondary health facilities, 38.4% of them were authorized structures (44% of functional hospitals and 35% of first level health facilities).

The authorized structures pledge to follow the policy of the Ministry of Health to which they are linked by an agreement.[15]

The profit-making private sector is especially oriented towards curative activities. It is preponderant in urban areas. Its installation does not always take into account the needs of the population in the health sector, but rather the capacity of the latter to pay for the care provided. This sector is not organized, not controlled and its relationships with the public sector are still poorly defined.

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

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

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

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

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

[15] Data from the Ministry of Health, December 2007.
[16] Ministry of Health (1999), Public Expenditure Review - Health Sector.
[17] Ministry of Health, 2006 Annual Report, March 2007.
[18] Rwanda 2007, Joint Health Sector Review.
[19] 545 Rwandan francs are worth US$ 1, according to the average official rate of the National Bank of Rwanda, in January 2008 .

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

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

To finance the priority interventions of the EDPRS 2008-2012, the most probable scenario, which privileges interventions that have a deeper and long term impact provides for a cost of US$ 12.80 per person. This scenario takes into consideration the funding available in 2007. On the other hand, the health sector plan, more optimistic than the EDPRS, provides for an increase in health expenditures per inhabitant, from US$13.6 in 2005 to US$ 15.3 in 2009.

Human resources constitute a major challenge but have been improving. Indeed, at the end of the year 2006, Rwanda had 1 doctor for 50,000 inhabitants and the needs covered in human resources for health were as follows: 13% of positions set aside for specialized doctors were filled as against 32% of posts for general practitioners and 4% for midwives.

A strategy document on development of human resources in health for 2006-2010 has been produced. Its implementation has produced several results, including the direct or indirect increase in salaries, through the contractual approach, development of capacities through the 3rd cycle in medicine and the training of Ao and A1 nurses at the Kigali Health Institute and A1 nurses in several nursing schools.

According to the results of the EIDHS[20] (2007-2008), targets for the 2005-2009 Health Sector Strategic Plan, concerning availability of human resources in health had been exceeded, for the doctor/population ratio was 1/33,000 (target: 1/37,000), nursing staff/population ratio, 1/1700 (target: 1/3900). However, only 46 midwives are working in the public sector and 75% of doctors were in the city of Kigali, where nearly 15%-20% of the entire population lives. [21]

The analysis of the situation of the pharmaceutical sector of Rwanda shows significant progress. The country has a substantial legislative and regulatory arsenal and other tests are being developed. The implementation bodies, though they are still not quite operational, are in place, notably an Inspection of Pharmaceutical Services, pharmaceutical information, registration services. The country has an autonomous drug purchasing pool (CAMERWA). In order to maximize the capacity of the above-mentioned bodies, the National Drug Agency is being put in place. The country has a local production of drugs, but of a low capacity.

Concerning the accessibility, use and quality of services, the public health system is based on the primary health care strategy, with 433 health facilities.

[20] Mini DHS (April 2008).
[21] MTR HSSP I, Final Report.

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

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

2.3 ASSESSMENT OF IMPLEMENATION OF THE PREVIOUS CCS 2004-2007

The major challenges of the previous CCS to be identified in the sector consisted in:

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

To meet these challenges, WHO proposed the following strategic orientations:

i) improving health system performance;
ii) combating diseases;
iii) promoting health as well as health and environment.

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

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

The strengthening of the capacities of the Ministry of Health in the management of the sector, coordination of the interventions of partners and advocacy, allocation of resources and their rational use, marked by the pursuit of the decentralization process that was instituted at the level of the National Public Administration in early 2006.

Technical support was provided to highlight the place of health in the country's development. Indeed, the assessment of the PRSP I (Poverty Reduction Strategy Paper), specific to the health sector, was done and the results guided the ongoing process of development of the EDPRS (Economic Development Poverty Reduction Strategy), which was validated in September 2007.

WHO also contributed to the production of the 2006 report on the National Health Accounts, the improvement of the production and management of human resources in terms of both quality and quantity, the improvement of access to quality health care, notably with the establishment of mutual health and financing schemes based on performance, the improvement of the quality of the water supply system, the preparation and response to the persistence of high-prevalence communicable diseases.

WHO contributed to the strengthening of the capacities of the health system for the health financing component, the improvement of the integrated management of mutual health schemes (MH), with a view to ensuring the performance of MHs, the strengthening of the capacities of analysis, monitoring and evaluation of financial resources invested in health. It also contributed to the integration of the "Health Metrics Network" (HMN) approach for strengthening the Health Information System (HIS), the improvement of access to quality drugs and institutionalization of traditional medicine.

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

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

2.4 WEAKNESSES IN IMPLEMENTATION OF THE STRATEGIC AGENDA

The different strategic orientations have been developed. However, the health system of Rwanda is still confronted with major problems:

- Low accessibility to quality health care, notably for the poorest population groups;
- Persistent insufficiency of human resources in terms of quality and quantity, due to lack of mastery of the system of managing these resources (production, utilisation, etc.);
- Extreme poverty of a major section of the population;
- Inadequate funding of the sector and strong reliance on external contributions.

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

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2.5 CURRENT CHALLENGES

Despite the major achievements of CCS 2004-2007, through the biennial plans it covered, the health development is still facing challenges.

Hence, in the framework of its CCS 2009-2013, WHO will concentrate its efforts on the aid to be provided for meeting the following challenges:

- strengthening the managerial and technical capacities at the different levels as well as the health system performance;
- supporting the restructuring of the Health Information System in order to improve timely production of reliable and usable data to guide adequate decision-making in health;
- improving the production and management of human resources for health, with a view to making good the present shortage of human resources in both quantity and quality;
- strengthening the health system with a view to improving access to quality health care, especially for the most disadvantaged population groups;
- improving the quality of sanitation and potable water supply systems to ensure better accessibility for the populations and, thereby, promoting an enabling environment for health;
- tackling the persistence of communicable and noncommunicable diseases, epidemics and disasters, particularly HIV/AIDS, malaria, tuberculosis, childhood diseases and problems associated with pregnancy and delivery;
- strengthening the mechanisms of community participation in care and treatment and health promotion;
- strengthening the system of supply of quality essential products and technologies and mechanisms for monitoring their uses.

SECTION 3

DEVELOPMENT ASSISTANCE AND PARTNERSHIP

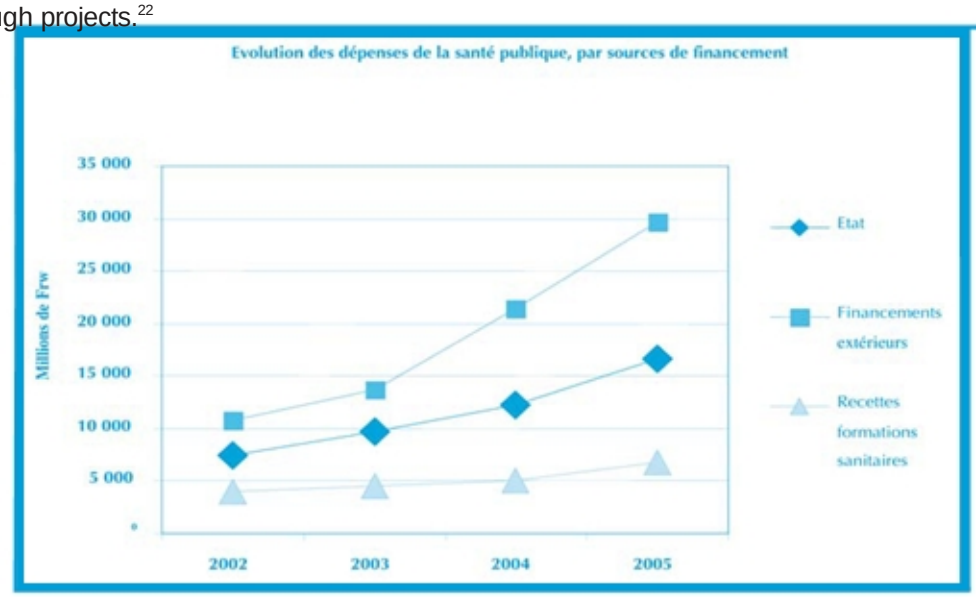
3.1 GENERAL TREND OF DEVELOPMENT ASSISTANCE

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

Since the end of the year 1999, the trend has been reversed and as the country is coming out of emergency and has acquired political and economic stability, assistance from donor countries and international organizations went directly to the Government, represented by the Minister of Finance and Economic Planning.

This was facilitated by the new aid policy developed by the Ministry of Finance and Economic Planning and adopted by the Government. It reflects the desire of the Government of Rwanda to see partners directly supporting the Government instead of directing their support through projects or NGOs.

In 2006, 26% of external assistance was in the form of budget support and this rate increased to 30%, in 2007. Indeed, as the emphasis was placed on budget support, an increasing number of bilateral and multilateral donors joined the group of donors. The United Nations remain the greatest donor of Rwanda, but their support is 100% provided through projects.[22]



Trend of public health expenditures by source of funding

In the health sector, the development was the same as in the other sectors, and between 2002 and 2005, the three sources of public health funding increased significantly (see graph). The annual growth rates over the period were largely higher than the GDP deflator rate[23] (+8.9% per annum) and the population growth rate (+2.75% per annum), which represents a significant improvement of the resources and expenditures per capita.

The participation of donors represents nearly two-thirds of the total resources of the sector for the two years 2004 and 2005. The State and donors seem to mutually encourage and accompany each other in their contribution efforts. Incomes of health facilities have also registered sustained growth although at a less rapid pace. It is probable that the contractual approach and subscription to mutual health schemes were at the origin of the increase in visits to health facilities. [24]

3.2 MODALITIES OF DEVELOPMENT ASSISTANCE

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

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

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

There are also clusters and sector working groups, which are forums, put in place to facilitate dialogue between the Government and its development partners. In this regard, the publication of an annual review of the health sector will help to assess the progress made and sector performance.

[22] Strengthening partnerships, Annual report of the Government of Rwanda and developmentt partners, 2006

3.3 MAIN PARTNERS AND AREAS OF INTERVENTION

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

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

3.4 COORDINATION MECHANISMS OF THE INTERVENTIONS

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

Intersectoral coordination**: in the** public sector, three orientations were selected, namely exchange of information, establishment of confidence and enhancement of "liability". Information exchange is done through the national planning forum, which regroups all the directors of planning in the ministries and meets twice a year. To establish confidence, the stakeholders are requested to respect the deadlines, more particularly for activities involving several actors.

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

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

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

Coordination within the Ministry of Health:

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

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

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[23] Rate by which the GDP is adjusted to obtain real GDP.
[24] Public health expenditure review, 2002-2005.

The HIV/AIDS Treatment and Research Centre (TRAC PLUS) ensures the coordination in the fight against HIV and AIDS, malaria, tuberculosis and other epidemics, at the level of the health sector.

Interagency coordination:

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

The interagency coordination is conducted through the United Nations group in Rwanda (UN Country Team/UNCT), a coordination forum, where representatives of all the agencies meet to discuss their common action in Rwanda. This forum is supported by six thematic groups, two of which concern respectively HIV/AIDS and Health/Population/Nutrition.

In the framework of the implementation of its new reform (“One UN”), the United Nations system has conceived a programming document called Common Operational Document (COD), which explains how its Development Assistance Framework (UNDAF) in the country is coordinated and operationalized.

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

[25] The equivalent of this concept in Kinyarwanda is “Imihigo” or commitment, a concept, which is of capital importance in the Rwandan culture since you have to honour your commitments at the risk of being excluded from the group of honest men.

SECTION 4

WHO INSTITUTIONAL POLICY FRAMEWORK: GLOBAL AND REGIONAL ORIENTATIONS

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

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

4.1 GOAL AND MISSION

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

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

4.2 CORE FUNCTIONS

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

1. providing leadership in matters critical to healthand engaging in partnership where joint action is needed;
2. shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;
3. setting norms and standards, and promoting and monitoring their implementation;

4. articulating ethical and evidence-based policy options;
5. providing technical support, catalyzing changes, and building sustainable institutional capacity;
6. monitoring the health situation and assessing health trends.

4.3 GLOBAL HEALTH AGENDA

In order to address-related policy gaps in social justice, responsibility, implementation and knowledge, the global health agenda identifies seven priority areas, namely:

1. investing in health to reduce poverty;
2. building individual and global health security;
3. promoting universal coverage, gender equality and health-related human rights;
4. tracking the deterlminants of health;
5. strengthening health systems and equitable access;
6. harnessing knowledge, science and technology; and
7. strengthening governance, leadership and accountability.

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

4.4 GLOBAL PRIORITY AREAS

The Global Priority Areas have been outlined in the 11th General Programme of Work. They iinclude:

- providing support to countries in moving to universal coverage with effective public health interventions;
- strengthening global health security;
- generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
- increasing institutional capacities to deliver public health functions, under the strengthened governance of ministries of health; and
- strengthening WHO's leadership at the global and regional levels and supporting the work of governments at country level.

4.5 REGIONAL PRIORITY AREAS

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

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

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

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

In collaboration with the other agencies concerned, the problem of how to assist countries source financing for their goals will be addressed under the leadership of the countries.

To meet these added challenges, one of the important priorities of the region is the decentralization and installation of intercountry support teams to further support countries in their own decentralization process, so that communities may derive maximum benefit from the technical support available to them.

To effectively address these priorities, the Region is guided by the following strategic orientations:

- strengthening WHO Country Offices;
- improving and expanding partnerships for health;
- supporting the planning and management of district health systems;
- promoting the scaling-up of essential health interventions related to priority health problems; and
- enhancing awareness and response to key determinants of health.

4.6 MAKING WHO MORE EFFECTIVE AT COUNTRY LEVEL

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

SECTION 5

CURRENT WHO COOPERATION WITH RWANDA

5.1 COUNTRY OFFICE

5.1.1. Background

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

5.1.2. WHO areas of work for the 2008-2009 biennial period

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

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

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

	Strategic Objectives	Amounts allocated in US$ RB	FV	TOTAL
SO1	Reducing the health, social and economic burdens due to communicable diseases	335,000	2,032,685	2,367,685
SO2	Combating HIV/AIDS, tuberculosis and malaria.	133,000	1,695,000	1,828,000
SO3	Preventing and reducing the burden of morbidity, invalidity and premature mortality associated with noncommunicable chronic illnesses, mental disorders and violence.	140,000	75,000	215,000
SO4	Reducing morbidity and mortality and improving health in the main stages of life (pregnancy, delivery, neonatal period, childhood, including adolescence), while improving sexual and reproductive health and helping all individuals to grow old while remaining active .	287,000	583,000	870,000

SO5	Reducing the effects on health, emergency situations, disasters, crises and conflicts, as well as their social and economic impacts .	53,000	553,000	606,000
SO6	Promoting health and development, and preventing or reducing the risk factors for health, associated with tobacco, alcohol, drogues and use of other psychoactive substances, imbalanced feeding, sedentarity and high-risk sexual behaviours.	147,000	83,000	230,000
SO7	Dealing with the social and economic determinants of health, through policies and programmes that promote equity in health and integrate approaches that are favourable to the poor, respectful of gender differences and human rights.	84,000	18,000	102,000
SO8	Promoting a healthier environment, developing primary prevention and reorienting public policies in all sectors, so as to tackle the underlying causes of environment-related threats to health .	93,000	67,000	160,000
SO9	Improving nutrition, food safety, supply of healthy food throughout life; supporting public health and sustainable development .	72,000	183,000	255,000
SO10	Improving health services by improving the governance, funding, recruitment and management, relying on factual data and reliable and accessible research .	311,000	869,000	1,180,000
SO11	Extending access to medical technologies and products, while improving the quality and use .	80,000	121,000	201,000
SO12	WHO's presence in the country.	742,000	79,000	821,000
SO13	WHO's presence in the country.	794,000	120,000	914,000
TOTAL BUDGET		**3 ,271,000**	**6,478,685**	**9,749,685**

5.1.3. Human resource development

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

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

5.1.4. Development of financial resources

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

5.2 SUPPORT FROM HEADQUARTERS AND REGIONAL OFFICE

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

5.3 STRENGTHS, WEAKNESSES, CHALLENGES, OPPORTUNITIES AND THREATS OF COUNTRY COOPERATION

Strengths:

- Excellent collaboration with the Ministry of Health;
- Technical support reflected by the existence of focal points from the Country Office and international consultants from the ICSTs, Regional Office and headquarters;
- Availability of quality technical documentation;
- Joint programming and evaluation with the Ministry of Health;
- Financial support for implementation of activities.

Weaknesses:

- Non-availability of staff, voluntary funds for certain programmes;
- Inadequate monitoring of the implementation of the work plan by the two parties (WHO and Ministry of Health);

- Sluggishness of the administrative and financial procedures.

Threats/challenges:

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

Opportunities:

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

SECTION 6

STRATEGIC AGENDA: CHOICE OF PRIORITIES FOR WHO COUNTRY COOPERATION

The strategic agenda of WHO cooperation with Rwanda for the period 2009-2013 is in line with the context of several reforms for the development of the country, in general and the health sector in particular. The cooperation between WHO and Rwanda during this period is in line with the framework of the 11th General Programme of Work (2006-2015), of the Global Health Action Programme and also the operationalization of the WHO Medium-Term Strategic Plan.

The WHO strategy for cooperation with Rwanda for the period 2009-2013 aims at guiding the support interventions of WHO for implementation of the second Health Sector Strategic Plan (HSSP II), a tool for operationalization of the EDPRS and Vision 2020. It is also in harmony with the common programme of the United Nations (COD), which, in the framework of the "One UN", operationalizes the United Nations Development Assistance Framework (UNDAF).

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

I. reduction of maternal and child mortality;
II. the fight against communicable and noncommunicable diseases;
III. health promotion, food security, health and environment;
IV. improvement of health system performance.

6.1 REDUCTION OF MATERNAL AND CHILD MORTALITY

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

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

WHO will support:

- the finalization and implementation of the strategic plan for accelerating the reduction of maternal and neonatal mortality;
- the development of operationalization plans for the strategic plan at district level;
- the scaling-up of emergency obstetrical and neonatal care;

- the implementation and monitoring of the audit of maternal and neonatal deaths;
- the strengthening of the capacities of the communities in the area of safe motherhood and child survival.

6.1.2. Implementation of the reproductive health policy

WHO will intervene in the following support areas:

- review of the reproductive health policy, development and implementation of the reproductive health strategic plan, including reproductive health of adolescents;
- establishment of mechanisms and initiatives for improving accessibility, demand and quality of family planning services;
- strengthening of the application of the family planning policy;
- improvement of the accessibility and quality of FP services, more specifically long-term contraceptive methods;
- development of a minimum package of reproductive health services of adolescents;
- strengthening of the capacities of health staff and health workers.

6.1.3. Implementation of child survival interventions

WHO will provide support for:

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

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

6.2 CONTROL OF COMMUNICABLE AND NONCOMMUNICABLE DISEASES

The control of communicable and noncommunicable diseases features is one of the priorities of the second Health Sector Strategic Plan (HSSP II, 2009-2012). In that regard, WHO will provide expertise and support in the following areas:

6.2.1 Integrated Disease Management and Response (IDMR)

The emphasis will be placed on:

- strengthening of the implementation of the integrated disease surveillance strategy;
- implementation of the new international health regulation;
- strengthening of capacities of response teams and laboratories at the different levels of the health system;
- preparation and response to other major epidemics and pandemics (cholera, meningitis, haemorrhagic fever, pandemic flu);
- promotion and integration of the surveillance of noncommunicable chronic diseases and their risk factors;
- advocacy among the other partners for mobilizing the necessary resources for implementing the SIMR strategy.

6.2.2 Combating HIV/AIDS, malaria and tuberculosis

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

WHO will pursue its support for the consolidation, extension, strengthening of the scaling-up of interventions aimed at promoting universal access STIs/ HIV/AIDS, malaria and tuberculosis prevention treatment, care and support services. WHO contribution will focus on the following actions:

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

more in prevention, care and treatment activites and intensifying joint development and review of the plans for controlling the 3 diseases.

6.2.3 Control of Neglected Tropical Diseases (NTDs):

WHO will provide support for:

- updating the cartography of NTDs;
- developing and implementing the integrated strategy for combating Neglected Tropical Diseases;
- mobilizing partners for support to the national NTD control strategy.

6.2.4 Prevention, care and treatment of noncommunicable diseases

WHO will provide counselling and support for:

- adaptation and implementation of WHO's framework for surveillance of noncommunicable chronic diseases and their risk factors;
- implementation of the strategies for prevention and integrated control of common risk factors of the main noncommunicable chronic diseases;
- development of a policy for prevention of violence and traumas and management of disabilities;
- review of the national mental health policy and strategies for prevention and management of mental health, drug and tobacco abuse problems;
- intensification of the integration and decentralization of services for management of mental health problems (including at the community level) in the primary health care strategy. WHO will provide support in the development of a plan for strengthening capacities in the area of mental health.

6.2.5 Management of health consequences of emergencies and disasters

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

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

Health promotion, food safety and nutrition, health and environment form part of the second strategic objective of the Health Sector Strategic Plan (2009-2012), on the consolidation, extension and improvement of disease prevention and health promotion services.

WHO will continue to play a leadership role in the support for development of norms and standards in the area of water quality, hygiene and sanitation and food safety and nutrition. This support will also concern the following different areas:

6.3.1 Promotion of healthy lifestyles

WHO will intervene in:

- the implementation and monitoring of the school health policy as well as the development of the school health guide;
- the technical support for strengthening the school health programme and in advocacy actions with the other partners;
- the support for the development of a health policy and promotion plan, with the emphasis on family planning, adolescent health, noncommunicable diseases, HIV and AIDS, malaria and tuberculosis, and coordination of health promotion activities.

6.3.2 Promotion of the management of the health of communities

The action of WHO will concern:

- technical and financial support, and advocacy for strengthening the capacities of community health workers within a partnership;
- support for dissemination of good community health practices.

6.3.3 Promotion of an enabling physical health environment

WHO will focus its efforts on:

- support for implementation of health policies and strategic plans on the environment and management of biomedical wastes;
- support for improvement of health and environment conditions, hygiene and sanitation in favour of the population;
- support for promotion of health and the environment at community level;
- support for improvement of the management of data on health and the environment;
- strengthening of the capacities of health and environment professionals;
- advocacy with the partners for resource mobilization.

6.3.4 Food safety and nutrition

WHO will intervene in:

- the support for capacity building, at the level of the districts, for the inspection food safety and nutrition;
- the support for implementation of the strategic policy and plan on food safety and nutrition.

6.4 ENHANCING HEALTH SYSTEM PERFORMANCE

With a view to improving the health system, WHO will provide support in the following areas:

6.4.1 Health system policies and offer of services

WHO will provide support for:

- strengthening of managerial and technical capacities at the different levels;
- the process of developing and reviewing the strategic policies and plans of the different health sectors;
- intensification of the coordination of the health sector in the framework of the sector approach;
- implementation of global and African recommendations, notably those of Ouagadougou on Primary Health Care, Alger on Health Research and Libreville on the Environment.

6.4.2 Financing health and social protection

WHO will provide support for:

- development and implementation of the sustainable health financing policy;
- intensification of the integrated management and performance of mutual health schemes (MHS);
- performance of the contractual approach “Performance-Based Financing” (PBF);
- analysis, monitoring and evaluation of financial resources invested in health, notably, through development of reports on national health accounts.

6.4.3 Production and management of human resources

WHO will provide technical and financial support for:

- monitoring, evaluation and review of the policy and strategic plan for developing human resources in health;
- strengthening of capacities for implementing the Human Resources for Health Strategic Plan;

- integration of the teaching of national programmes into the curricula of initial training schools. WHO will pursue its support for strengthening the skills of teachers of schools for training health professionals;
- development and implementation of a task transfer plan.

6.4.4 Capacity building in the integrated management of the Health Information System (HIS)

WHO support will concern:

- development and implementation of a national policy on the Health Information System;
- promotion of operational research in the priority health areas;
- strengthening of the national Health Information System, epidemiological surveillance and capacities in management of knowledge.

6.4.5 Strengthening of the policy on access to medical technologies and products

WHO support will concern:

- development and review of national policies and regulatory texts in the pharmaceutical, traditional medicine, blood transfusion and laboratory areas;
- adaptation and implementation of international norms, guidelines and standards for the quality, innocuousness, efficiency and effectiveness of pharmaceutical and health products and technologies;
- promotion of traditional medicine and strengthening of the national pharmacovigilance system;
- promotion of the use of factual and scientific data to render more efficient and effective health and pharmaceutical technologies and products, by care providers and consumers;
- development and review of basic documents for ensuring rational use of health products and technologies.

SECTION 7

IMPLICATIONS OF IMPLEMENTATION OF THE STRATEGIC AGENDA

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

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

The WHO Country Office will be the key pin of WHO cooperation with Rwanda, by coordinating the support from the different programmes and components of the Organization, while ensuring effective control of all the resources intended for the country. As has been the case since the establishment of the WHO Office in Rwanda, the Ministry of Health will continue to be the privileged interlocutor, but the action framework will be adapted to the strategies and orientations of Vision 2020, the EDPRS, 2008-2012, the HSSP II, 2009-2012.

The WHO Office in Rwanda will continue to play a reference role in the area of information and norms, while supporting the coordination of the health sector partners. In this perspective, the Office will ensure the strengthening of its own capacities in order to address more efficiently the needs of the country and its partners. This will entail notably the strengthening of the technical and managerial capacities of the Country Office team in the following areas:

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

Improvement of the administration and management of the Country Office in the planning of activities:

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

***Human resources*:**

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

The attributions of the staff will be reviewed to enhance its availability and, where necessary, the services of national and regional consultants will be required, notably, for the monitoring and evaluation of activities.

***Technical and material resources*:**

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

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

Financial support

The Ministry of Health is quite hopeful that WHO will honour its financial commitments especially, for activities requiring vertical funds. This point constitutes one of the weaknesses of WHO, although the Country Office cannot overcome this difficulty without the support of the Regional Office and headquarters.

WHO's financial support, which currently targets planned activities, should be transformed into direct budget support to the Ministry of Health. A common strategy for mobilization of funds within the United Nations should provide part of the response.

7.2 INTERCOUNTRY SUPPORTTEAMS, REGIONAL OFFICE AND HEADQUARTERS

The recommendations made in the previous version of the CCS are still valid:

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

SECTION 8: MONITORING AND EVALUATION

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

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

The monitoring and evaluation of the Country Cooperation Strategy will be done through the monitoring and evaluation of work plans of the biennial periods. The present 2009 - 2013 CCS covers the 3 plans of the 2008-2009, 2010-2011 and 2012-2013 biennial periods.

The lessons learnt from the evaluation of the previous CCS 2004-2007 are presented in Section 2.4 on assessment of its implementation.

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

A mid-term evaluation is conducted in December of the first year, and a final evaluation at the end of the second year, of each biennial period.

The mid-term evaluation will help to review the status of implementation of the plan of action and, where necessary, it will result in a re-planning of activities, in consultation with the Ministry of Health.

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

WHO contribution to the reform of the United Nations in Rwanda, and notably, its active participation in the pilot initiative, "One UN", are subjected to periodical monitoring and evaluation, in accordance with the framework of the monitoring and evaluation defined in the COD. The "value added" attributable to WHO, within the United Nations system and with other development partners, is evaluated every 6 months.

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ANNEX 1

Table 2: Development, Assistance and Partnership

Name of part.	Type of partnership	Main areas of intervention	Venue of intervention	Amount
United States (USAID, CDC PEPFAR, USG, Foundations)	Bilateral	HIV/AIDS (prevention, care and treatment, ARV); research; malaria and tuberculosis; strengthening of the health systems and community health; reproductive health and FP;	Countrywide	US$ 150,000,000 in 2007
Swiss Cooperation Agency	Bilateral	Community participation; improvement of the health system (access and quality of services, Management capacities, coordination);	Districts of Karongi and Rutsiro	CHF 4,050,000 in 2007-2008
Luxembourg Coop. Agency	Bilateral	HIV/AIDS: drug supply, improvement of the diagnosis and biological monitoring of HIV and OIs, optimization of clinical care, research, support;	Kigali and Rwamagana	4,800,000 for 2007- 2009
German Coop. Agency	Bilateral	Capacity building; reproductive health, blindness control: support for primary health care HIV/AIDS;	Huye, Nyaruguru, Nyamagabe, Gicumbi	3,500,000 in 2006
Belgian Coop. Agency	Bilateral	Institutional building; strengthening of the health system; (CHUK, health services of the town. LNR, capacity building); malaria, mental health; nursing schools;	Central level Kigali, 6 districts	About 21,000, 000 for all support projects for 2003 - 2009
United-Kingdom	Bilateral	SWAP; HIV/AIDS (community-based care, including ARVs, comprehensive care); access to care;	Countrywide	9,250,000
World Bank	Multilateral	HIV/AIDS (MAP)	Countrywide	US$ 30,500,000 in 2002 - 2006
FMSTP	Multilateral	HIV/AIDS (integrated VCT, decentralization of care; access to quality care, going on scale of services); malaria; tuberculosis;	Countrywide	US$ 230 million for implementation of 7 projects (HIV, MAL, TB) covering 2002-2007
European Union	Multilateral	Strengthening of health systems; reproductive health and FP; promotion of HIV/AIDS control;	Countrywide	748,800
United Nations	Multilateral	Capacity building; strengthening of health systems; prevention and control of communicable and noncommunicable diseases; response to epidemics and disasters; HIV/AIDS, tuberculosis, malaria; reproductive health and FP, nutrition, health promotion; nutrition, hygiene and sanitation.	Countrywide	120,440 2008-2012 for "One UN"

ANNEX 2

Table 3: Indicators of monitoring of the biennial action plan WHO/Ministry of Health, 2010 - 2011

Description of indicators of the 2010 – 2011 biennial action plan	Base (2008)	Target 2011
Percentage of execution of the budget of the action plan:	80%	90%
All districts will have put in place the strategy “Reaching Each District” (RED) and attained at least 90% of vaccination coverage in pentavalent 3.	60%	100%
Number of districts having maintained the indicators of surveillance of poliomyelitis at the level of certification:	27	30
Proportion of health districts (HD) preparing regular reports in real time, on communicable diseases (common WHO/UNICEF declaration form) :	50%	80%
National action plan document for implementation of the IRS available:	0	1
Number of epidemics managed according to standardized operating modes:	60%	80%
Proportion of epidemics and/or health emergencies having benefited from WHO support at the international level:	100%	100%
National coverage for ARV treatment:	77%	90%
National coverage of PMTCT for pregnant women:	75%	90%
National coverage in MII:	57%	85%
Tuberculosis testing and treatment rates:	27%	70%
Proportion of health districts integrating at least TB-HIV interventions:	100%	100%
Proportion of HDs preparing regular reports in real time, on insecticide and drug resistance, trend and resources:	0	100%
Proportion of HDs preparing regular reports in real time of the trend of the interventions and finical resources:	0	100%
Number of meetings of CCMs for control of HIV/AIDS, tuberculosis and malaria (STP):	0	24
Number of tools and strategies conceived and/or improved for implementation of HIV/AIDS, tuberculosis and malaria control activities:	0	6
Multisectoral programme documents for promoting mental and behavioural health available:	0	1
Strategic documents available for universal access to care for the mother and newborn baby, to reproductive and sexual health, and health of the elderly:	2	4
Number of studies finalized on the health of children, young people, adolescents and the mother:	1	3

Proportion of health districts carrying out quality SONU:	30%	60%
Proportion of health districts carrying out quality IMCI:	50%	70%
Proportion of health districts covered by IMCI:	99%	100%
Proportion of administrative districts with a document on contingency plan (ORSEC) to deal with emergency and humanitarian disaster situations;	0	50%
Proportion of health regions having activated the early warning and response system in emergency and disaster situation	0	50%
Health promotion strategic document available:	0	1
Number of districts equipped with materials for sensitization on anti-tobacco products and trained in smoking cessation:	0	30
Number of members of school health committees trained:	0	800
Number of information bulletins and thematic days having received support:	0	20
Number of income-generating projects having received financial support:	0	10
Environmental policy documents and implementation strategic plans :	0	2
Policy and strategy documents on food and nutrition (including the fight against nutritional deficiency) available	1	2
Proportion of health regions and districts carrying out quality activities, in the area of nutrition in infant and the young child:	10%	50%
Number of annual coordination meetings of SWAP organized:	0	2
Number of managers of district mutual health schemes sensitized and trained in auditing:	0	30
Number of policy documents and legislative texts developed/revised, in the pharmaceutical sector:	0	7
Percentage of activities carried out, of which the technical and financial reports are available within the set time-frames.	0%	80%