HEALTH SECTOR STRATEGIC PLAN
2005 - 2009

Government of Rwanda

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ACRONYMS

ACT	Artesunate Combination Therapy
AIDS	Acquired Immuno-Deficiency Syndrome
ARV	Anti Retro-Viral (Drugs)
BUFMAR	Office for the Not-for-Profit Medical Facilities in Rwanda
CAMERWA	Central Drug Purchasing Agency for Rwanda
CBO	Community Based Organisation
CEPEX	Central Public Investments and External Finance Bureau
CHUB	Butare University Hospital
CHUK	Kigali University Hospital
CHW	Community Health Workers
CNLS	National AIDS Commission
CNTS	National Blood Transfusion Centre
CPLS	Province AIDS Commission
CWIQ	Core Welfare Indicator Questionnaire
DEHP	Department of Epidemiology and Public Hygiene
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short Course
DSS	Department of Health Care
EPI	Expanded Programme for Immunisation
FBO	Faith Based Organisation
FOSA	Health Facility
FSP	Financial Sustainability Plan
GDP	Gross Domestic Product
GESPER	Government Human Resources Management System
GOR	Government of Rwanda
HIV	Human Immuno-Deficiency Virus
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
ICT	Information, Communication, Technology
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide Treated Net
KAP	Knowledge, Attitude and Practices
KHI	Kigali Health Institute
LNR	National Referral Laboratory
MDG	Millennium Development Goal
MDR	Multi-Drug Resistant (TB)
MICS	Multiple Indicator Cluster Survey

MIFOTRA	Ministry of Public Service, Skills Development, and Labour
MIGEPROFE	Ministry of Gender and Women Promotion
MIJESPOC	Ministry of Youth, Sport and Culture
MINAFRA	Ministry of Infrastructure
MINALOC	Ministry of Local Administration, Community Development & Social Affairs
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education, Science, Technology, and Research
MINISANTE	Ministry of Health
MINITERE	Ministry of Land, Resettlement and Environment
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NGO	Non-Governmental Organisation
NHA	National Health Accounts
ORT	Oral Rehydration Therapy
OVI	Objectively Verifiable Indicator
PETS	Public Expenditure Tracking Survey
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother-To-Child Transmission (of HIV)
PNILP	National Malaria Control Programme
PNILT	National Tuberculosis Control Programme
PRSP	Poverty Reduction Strategy Paper
RAMA	Rwanda's Medical Insurance Agency
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TB	Tuberculosis
TBA	Traditional Birth Attendant
TRAC	AIDS Treatment and Research Centre
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

I. INTRODUCTION

The value attached to health in its own right cannot be overemphasized. It is one of the basic capabilities that gives value to human life and is valued by poor people around the world as the most important human asset. In a material sense, health is the basis for individual productivity and, more generally, it is a critical input into the long-term development of a country. Ill health is not simply a consequence of poverty; it is an aspect of it. A large body evidence now supports the hypothesis that health is a crucial determining factor of economic development. As is the case in Rwanda, too often a negative outcome of this relationship presents itself in a vicious cycle of poverty and ill health: an individual falls ill, then cannot work, cannot afford to provide adequately for himself, and so falls further into illness and poverty.

The Government of Rwanda is committed to tackling illnesses related to poverty and ignorance and improving the health status of the population over the long term through a sector strategy process, whereby all resources are progressively channelled over time towards the support of the sector strategic plan. It is intended that the sector strategic planning process will provide the impetus for appropriate and necessary health sector reform and encourage a greater investment in Rwanda's health system.

The development of the Health Sector Strategic Plan is one of the steps following on from the Government of Rwanda's decision to pursue a sector strategy process in the implementation of its Poverty Reduction Strategy Paper. It provides an overarching framework for health sector support over the next five years with the principal aim of reducing poverty and improving the health status of the population. It comes at a time when the Government of Rwanda has shifted its focus towards sustainable development through the implementation of its PRSP and is embarking on the policy of decentralisation.

The HSSP is an instrument to make both the Health Sector Policy and PRSP operational and has been developed in close consultation with all partners under the umbrella of a sector wide approach. As such, the HSSP is designed to guide the direction of the *entire* sector over the medium-term. The plan will be updated following annual joint sector review missions to ensure the planning process is flexible and responsive to changing circumstances.

The Sector Wide Approach in developing the HSSP is based on a bottom-up method, including all relevant stakeholders. From the health system, members from the central, provincial and district level participated in workshops defining objectives, targets and implementation arrangements. Development organisations, both bilateral and multilateral, helped define focus areas and provided crucial input and feedback in the drafting process, and NGOs and other health care providers were consulted. International best practise from other countries and the literature was used to determine benchmarks and to verify targets.

Broadly speaking, the plan defines prioritised objectives and strategic interventions across all areas of the health system. The HSSP will be implemented through the Medium Term Expenditure Framework (MTEF), which links sector objectives and activities to a budget under a single comprehensive framework that can be monitored. It will prove an indispensable tool in integrating the activities of all stakeholders in the sector and ensuring there is less duplication between different actors.

The plan consists of six main chapters. Chapter 1 gives an introduction to the HSPP. Chapter 2 provides a brief overview of the health sector, giving a review of recent progress made in the sector and the national and international policies that underpin this document. Chapter 3 presents national targets, the strategic framework and specific implementation arrangements for each area of service delivery and support to the health sector. Chapter 4 discusses the implementation mechanisms of the HSSP at both the national and district level. Chapter 5 provides a broad indicative cost framework and a projection of expected resources to finance the HSSP over the duration of its five years. And finally, Chapter 6 provides a monitoring and evaluation framework to measure progress in the implementation of the HSSP at both the national and district level.

In summary, the purpose of this strategic plan is to:

- Define the strategic direction of the health sector towards the achievement of the Millennium Development Goals in 2015.
- Guide the participation of all stakeholders in health sector development.
- Provide a logical framework of prioritised objectives, outputs and activities for the sector.
- Make an estimate of the implementation cost of the HSSP vis-à-vis the projected financial resources available to the sector.
- Put in place a monitoring and evaluation framework that will form the basis for national and district monitoring of the sector.

II. OVERVIEW OF THE HEALTH SECTOR

II.1 Health Sector Definition

The health sector comprises of a public, private and traditional health system, which are supported by Government, development partners, non-governmental organisations and civil society.

The Ministry of Health has been designated as the principal Government agency responsible for health sector development. More specifically, it is in charge of defining policy, setting standards, regulating, resource mobilisation and monitoring activities in the sector. However, support is also channelled through or in partnership with a number of other line ministries who each have different responsibilities in the delivery of services and support to the health sector.

1. *Ministry of Education, Science, Technology, and Research is responsible for the education and basic training of health professionals.*

2. *Ministry of Land, Resettlement and Environment is responsible for the protection of the environment and overseeing the delivery of water and sanitation services.*

3. *Ministry of Gender and Women Promotion is responsible for gender mainstreaming in health, especially reproductive health.*

4. *Ministry of Youth, Sport and Culture is responsible for the mobilisation and sensitisation of the youth.*

5. *Ministry of Local Administration, Community Development and Social Affairs is responsible for the decentralisation of the health system and oversees the development of community based health initiatives.*

6. *Ministry of Public Service, Skills Development, Vocational Training and Labour is responsible for professional training and administering the salaries of all public health workers.*

7. *Ministry of Finance and Economic Planning is responsible for national policy development, the Poverty Reduction Strategy and overseeing the MTEF.*

8. *Ministry of Defence is responsible for the delivery of health services to military personnel and their dependents.*

II.2 Policy Context

II.2.1 National Policies

The global vision of the Government of Rwanda is to guarantee the well being of the population by increasing production and reducing poverty within an environment of good governance. Within this context, the mission statement for the health sector is to ensure and

promote the health status of the Rwandese population by providing quality preventative, curative and rehabilitative services within a well performing health system.

In order to best carry out this mission, the Ministry of Health has laid down seven major goals:

1) To ensure the availability of human resources
2) To ensure the availability of quality drugs, vaccines and consumables
3) To expand geographical accessibility to health services
4) To improve the financial accessibility to health services
5) To improve the quality of and demand for services in the control of disease
6) To improve national referral hospitals and research and treatment institutions
7) To reinforce institutional capacity

These seven goals form the basis of the HSSP and, to ensure consistency, correspond to the seven programmes of the MTEF through which the HSSP will be implemented. They act as an umbrella under which objectives and outputs have been derived and they ensure that all the key dimensions of health sector performance are addressed.

II.2.2 International Policies and Goals

The Government of Rwanda is committed to the United Nations Millennium Development Goals and the strategies contained within this document are orientated towards achieving the target(s) for each of the health-related goals. Furthermore, the indicators and targets specified in the plan are consistent with the attainment of the MDGs in 2015. Box 1 shows the targets for each health related MDG.

Box 1. Goals and targets for the Millennium Development Goals in Health

Goal 1: Eradicate extreme poverty and hunger - Target 1: reduce the proportion of people living on less than US$ 1 a day to half the 1990 level by 2015. Target 2: reduce the proportion of people who suffer from hunger by half the 1990 level by 2015.

Goal 4: Reduce child mortality - Target 5: reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

Goal 5: Improve maternal health - Target 6: reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.

Goal 6: Combat HIV/AIDS, malaria and other diseases - Target 7: have halted by 2015 and begun to reverse the spread of HIV/AIDS. Target 8: have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

The attainment of these goals, however, is not the sole preserve of the health sector as many non-health factors affect health outcomes. For example, the level of education and/or literacy of females is a particularly strong determining factor of health. Thus the responsibility falls on not only the health sector but also others to do their part in working towards the attainment of these targets above.

The New Partnership for African Development initiative has developed a strategy for health development, which has guided the Ministry of Health in the development of Rwanda's HSSP. The strategic axes of the NEPAD health strategy are shown in box 2.

Box 2. New Partnership for African Development Health Strategy

The NEPAD health strategy rests upon six strategic axes:

1. Reinforce the role of Governments in the mobilisation of efforts and resources for health development.
2. Strengthen health services so as to provide health care that is efficient and equitable, including traditional medicine.
3. Promote transmittable and non-transmittable disease control programmes with a special focus on fighting HIV/AIDS, tuberculosis, malaria, diarrhoea, child pneumonia, and malnutrition.
4. Strengthen reproductive health programmes.
5. Reinforce community based IEC / BCC activities.
6. Mobilise sustainable and sufficient resources for the functioning of health systems and disease control programmes so as to achieve health objectives.

The International Conference on Primary Health Care at Alma Ata in 1978 called for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation. Rwanda adopted the policy soon after the Alma Ata declaration and has since been committed to developing a health system based on the delivery of primary health care, which is orientated according to the demand of the population.

Following the 35th session of the African Regional Committee of the World Health Organization held at Lusaka in 1985, Rwanda adopted a health development strategy based on decentralized management and district-level care (see box 3). The decentralization process began with the development of provincial-level health offices for health system management. Progress has been made towards decentralizing management to the province and, ultimately, to the district level.

Box 3. Lusaka Declaration on Decentralisation and District Health Systems

The Lusaka declaration promotes three strategies to improve the quality and accessibility of health services:

1. The decentralisation of the health system using the health district as the basic operational unit of the system;
2. The development of the primary health care system through its eight core components; and
3. The reinforcement of community participation in the management and financing of services.

The case for investing in health has been further strengthened by a growing body of evidence showing that better health contributes to greater economic security and growth. These findings have formed the basis of the WHO's Commission on Macroeconomics and Health recommendations, which Rwanda is actively pursuing.

II.3 Sector Performance Review

II.3.1 Historic Background

Rwanda's health sector has undergone a number of dramatic changes in the last 150 years. Prior to colonial rule, traditional African healing formed the basis of health care in the country. The transition to more widely used modern medicine started at the time of German colonial rule and continued in the first half of the 20th century; faith based institutions, such as the Catholic Church played an important part in this process.

In the second half of the 20th century, before the war and genocide, Rwanda's health system was characterised by a high degree of centralisation and was free of charge. Faith based institutions continued to play an important role.

In the genocide, much of sector's infrastructure was destroyed and human resource loss was enormous. The first years after the war were spent with the reestablishment of basic health care and the rebuilding of human resources in the sector. Now, as health indicators begin to recover, Rwanda's health care system is ready to enter the next phase of development.

II.3.2 Demographic and Socio-economic Background

The country of Rwanda covers an area 26,338 km^2 and currently has a population of 8.59 million, of which 45 percent are under fifteen years of age[1]. Even though the population density is 329 inhabitants per km^2, one of the highest in the world, most people (85 percent) live in rural areas. The ratio of women to men is 1.1 and one third of all households are female headed. The annual population growth rate is 2.8 percent and the fertility rate is 5.8[2]. Life expectancy at birth is currently estimated at 41.9 years for men, 46.8 for women and 44.4 years for the entire population[3].

The economy has recovered strongly since the war. There has been steady economic growth of over 10 percent on average annually between 1996 and 2002 and inflation has been kept to a low level. However, with a real GDP per capita of $230[4], Rwanda remains one the poorest countries in the world. Poverty is more firmly established in rural areas and has a larger impact on female-headed households than on others. In 2001, 66 percent of the rural population, where the majority of Rwandans live, and 60 percent of the total population were below the poverty line. Furthermore, 42 percent of the population was living in extreme poverty[5].

The Government budget allocation to health has increased substantially over the past number of years, showing almost a twofold nominal increase (185 percent) between 2002 and 2004[6]. The proportion of the Government recurrent budget allocated to health in 2004 is 6.1 percent. The budget allocation to the health sector still remains relatively low in view of both the importance attached to health in terms of development and the 15 percent target agreed by the Government of Rwanda in Abuja in 2001.

Rwanda is in the process of implementing its strategy for poverty reduction and economic growth over the medium term. The PRSP forms our foundation for sector strategic planning and provides a framework to guide Government expenditures into priority areas of

action. Continued security, economic growth and stability are assumed to be necessary conditions for the successful implementation of the PRSP and HSSP.

II.3.3 Health Sector Performance

The health care system has demonstrated remarkable resilience following the war and genocide, which resulted in a massive loss of health professionals, a destruction of the health infrastructure and general impoverishment of the population. Current health indicators quantify the considerable progress made by the health sector over the last decade but equally highlight the enormous challenges that remain if the Millennium Development Goals in health are to be reached in 2015.

Health Indicators – Poverty and Health

In Rwanda, there is a clear link between health outcomes, accessibility to modern health services and poverty. Many of the key indicators shown in table II.1 illustrate vividly the inequity in health between rich and poor. The gaps between the poor and non-poor in terms of coverage and health outcomes are large, underscoring the importance of targeting those in greatest need in order to reduce poverty levels.

Table II.1 Key health sector indicators by poorest and richest quintile in 2000

INDICATOR	Poorest Quintile	Richest Quintile	Total
A. Mortality Rates			
Under five mortality rate (per 1,000)	225	120	196
Maternal mortality ratio (per 100,000)	n/a	n/a	1071
Infant mortality rate (per 1,000)	121	70	107
B. Reproductive Health			
Proportion of pregnant women who receive at least two antenatal visits	66.1	77.3	68.4
Proportion of assisted deliveries by qualified staff	12.1	57.7	31.3
Proportion of deliveries taken place in health facility	20.0	65.2	26.5
Modern contraception prevalence rate (amongst women)	1.2	8.1	4.3
C. Child Health			
Proportion of children (12-23 months) immunised against measles	73.2	79.0	77.7
Proportion of children under five sleeping under an impregnated mosquito net	0.5	17.9	6.0
Prevalence of underweight children (malnutrition)	31.5	13.7	24.3
Utilisation of health services by children under five (fever or cough in last two weeks)	6.6	26.6	13.4
D. Utilisation of Health Services			
% Utilisation of modern health services in the event of illness	10.7	31.1	17.5
% Utilisation of traditional healers	4.2	2.5	3.9

E. Access to Drinking Water			
Proportion of households with access to drinking water from a water fountain	37.7	43.7	39.6
Proportion of households within 30 minutes of water source	37.2	50.9	39.9
Proportion of households who have a latrine	56.5	86.7	64.4

Source: Using data from Demographic and Health Survey and Household Living Conditions Survey

As in many post-conflict countries, Rwanda is considerably off track in its progress towards meeting the child and maternal mortality MDGs. Infant and under five mortality have gradually dropped since the mid 1990s but have not yet reached pre-genocide levels. The rate of decline of under-five mortality was relatively slow, highlighting the precarious socio-economic and nutrition conditions of Rwandan households.

Although maternal mortality has also declined since the 1994 genocide, the level is still almost twice as high compared to the late eighties, remaining one of the highest in the world. Between 1995 and 2000, approximately 1,071 women died per 100,000 live births[7], compared to 611 during 1985-1990. This high MMR is largely a reflection of the inadequate access to obstetric care and of the poorly functioning health care system.

Immunization coverage has returned to an acceptable level of over 85 percent (for DPT3), reflecting the strengths of the vaccination programme, which is considered amongst the strongest in sub-Saharan Africa. The modest gains in improving access to family planning services during the 1980s have been severely eroded in the post-genocide period with the contraceptive prevalence rate (modern methods only) dropping to a meagre 4 percent by 2000 in comparison to 9 percent in 1992 with the use of traditional methods also declining from about 10 percent in the early 1980s to 5 percent most recently[8].

Burden of Disease

Rwandans are most likely die from poverty related preventable diseases. The principal causes of death and consultations in health facilities are transmittable diseases, which can largely be avoided through improved hygiene and behavioural change. Two diseases in particular, malaria and HIV/AIDS, place the greatest health and economic burden on households, the population and the health system. Figures II.1 and II.2 show the leading causes of under-five mortality and morbidity for both children under five and the total population.

Figure II.1 Causes of under-five mortality in Rwanda[9]

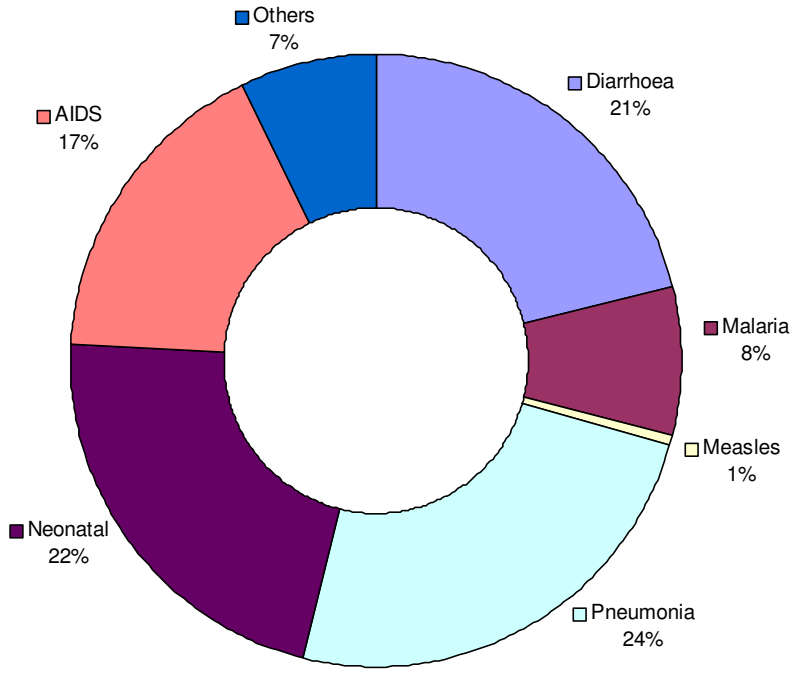
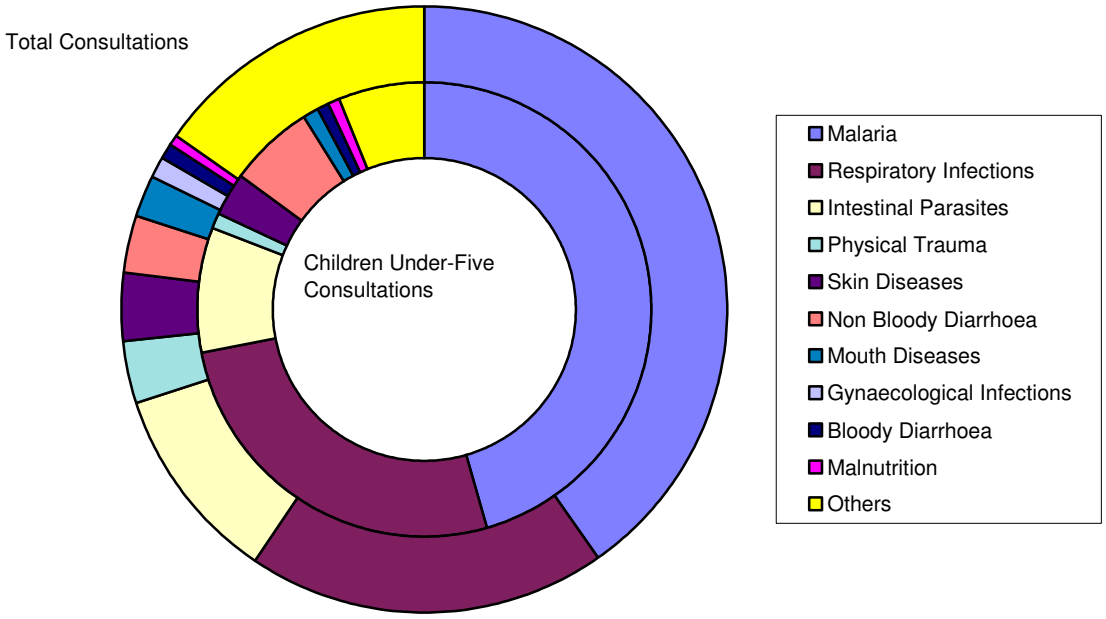

Others
7%
Diarrhoea
21%
AIDS
17%
Malaria
8%
Measles
1%
Neonatal
22%
Pneumonia
24%

Figure II.2 Causes of morbidity in health facilities in 2003[10]



Malaria is clearly the leading cause of morbidity in Rwanda, accounting for forty-one percent of all consultations in health facilities. Malaria has in recent times surfaced amongst populations living in mountainous regions who have little or no immunity to the disease.

The proportional morbidity attributed to HIV/AIDS is likely to be underestimated due to difficulties involved in the diagnosis to establish a link between opportunistic infections and HIV/AIDS. The prevalence rate amongst the adult population is estimated at 5.1 percent at end of 2003[11] (13.2 percent in Kigali town, 6.3 percent in other urban areas and 3.1 percent in rural zones[12]). The political and social turmoil of the mid 1990's altered and exacerbated the course of the epidemic and narrowed the gaps between rural and urban infection rates. The genocide triggered massive population movements, resulted in the rape of thousands of young women, and fostered high-risk sexual behaviour in refugee camps.

Other significant causes of morbidity include acute respiratory infections, intestinal parasites and diarrhoeal ailments. Also, the number of cases of tuberculosis has risen in recent times to 220 cases per 100,000 as a result of the spread of HIV but also due to an expansion in testing facilities[13].

Health Infrastructure

Health infrastructure is broadly satisfactory after considerable construction and rehabilitation efforts since 1994. In the public and Government assisted not-for-profit sectors there are 385 health centres, 34 district hospitals and four national referral hospitals. In recent years, the health sector has seen an expansion in the private sector, which now consists of around 325 private dispensaries and clinics, 52 percent of which are found in Kigali City[14].

Geographic access to health facilities is similar to other countries in the region, with almost 60 percent of the population living within 5 km of a health centre, and 85 percent of the population within 10 km[15]. Disparity in geographical access does however exist between provinces and there is a pressing need to improve access in particular health districts.

Health Personnel

The lack of health professionals remains one of the greatest challenges for the health sector. The number of qualified doctors and nurses across the country is insufficient, and the problem is particularly acute in rural areas. In the public health system, personnel are poorly motivated, which can explain in the past an increasing shift of physicians to the private sector. In 2003, there were 168 physicians and 2157 nurses working in the public sector, representing an increase of 10 percent and 7 percent respectively on the previous year[16].

The number of inhabitants per nurse is 3900 and the number of inhabitants per doctor is 50,000. The nurse to population ratio is within the WHO norm of 5000, however the doctor to population ratio is almost five times the WHO norm of 10,000. Furthermore, these figures hide the large disparity between provinces and between rural and urban areas, a phenomenon that can be explained by low basic salaries and the lack of an effective incentive structure to favour rural areas.

III. THE STRATEGIC FRAMEWORK 2005 – 2009

III.1 Areas of Focus

The strategic framework is guided by the Government of Rwanda's commitment to the Millennium Development Goals and the implementation of the Rwanda Poverty Reduction Strategy. The strategic framework provides a road map for the health sector in the next five years in order to keep the country on tract to meet the MDGS. It builds on the PRSP identification of malaria and HIV/AIDS prevention, and support to mutuelles and community health workers among the core programmes to be given high priority. In addition, priority actions in the decentralisation of primary health care, quality, access, and prevention in the health sector, and cross-cutting issues of HIV/AIDS, gender, technology, and capacity building identified in the PRSP are mainstreamed in the HSSP through the elaboration of its seven programmes. Gender specific implementation, for example, can be found in the malaria, HIV/AIDS, reproductive health and IEC programmes.

The seven programmes are aligned to meet the Health Sector Policy major objectives. These seven programmes determine the broad priority areas of focus within the HSSP. The programmes can be broken down into more specific components of health service delivery and support, as shown in table III.1. Each programme consists of one or more component areas of service delivery and support which when considered together work towards achieving the programme objective.

Table III.1 Programme Objectives and Areas of Service Delivery and Support (Programme Components)

Health Sector Programmes Objectives	Programme Components
1. To improve the availability of human resources	1.1 Human Resource Development
2. To improve the availability of quality drugs, vaccines, and consumables	2.1 Drugs, Vaccines and Consumables
3. To expand geographical access to health services	3.1 Infrastructure, Equipment & Laboratory Network
4. To improve financial access to health services	4.1 Health Sector Financing
5. To improve the quality of and demand for services in the control of disease	5.1 IMCI
	5.2 Reproductive Health
	5.3 Expanded Programme on Immunisation
	5.4 Nutrition
	5.5 Malaria
	5.6 HIV/AIDS/STI
	5.7 Tuberculosis
	5.8 Epidemics and Disaster Response
	5.9 Mental Health
	5.10 Blindness & Physical Handicap
	5.12 Environmental Health
	5.13 IEC / BCC
6. To strengthen National Referral Hospitals and Treatment and Research Centres	6.1 National Referral Hospitals
	6.2 Treatment and Research Centres (included in HIV/AIDS component)
7. To strengthen the sector's institutional capacity	7.1 Institutional Capacity

III.2 Logical Framework Approach

The strategic framework has been developed using a logical framework approach. The logframe matrix establishes a logical hierarchy of means by which objectives will be reached, identifies the potential risks to achieving the objectives, and establishes how outputs and outcomes will be monitored. In short, it presents a summary of the sector strategy in a standard format. The matrices that follow adhere to the vertical and horizontal logic of the approach. The vertical logic defines what the sector strategy intends to do, how it will do it and what are the important assumptions outside of the control of those implementing the plan. The horizontal logic specifies how the sector objectives will be measured and by what means.

This chapter lies at the heart of the HSSP as it establishes the link between health sector policy goals, targets, outputs and activities that will provide the basis for health sector reform and development over the next five years. It is important to note that the logframe matrices defined prior to implementation provide simply a starting point, and will need to be reassessed, refined and updated through a regular and dynamic process of review and planning after implementation has begun. It is also envisaged that the HSSP will be subject to mid-term review and re-appraisal.

III.3 Overall Logical Framework for Health Sector Strategic Plan

Figure III.1 presents the overall logical framework for the sector strategic plan. More detailed outputs and activities along with objectively verifiable indicators, means of verification and assumptions are specified for each programme component in later sections.

Figure III.1 Overall Logical Framework of Health Sector Strategic Plan

Hierarchy of Objectives	Key Performance Indicators	Critical Assumptions
Goal		
To guarantee the well being of the population by increasing production and reducing poverty within an environment of good governance	- Average GDP growth rate - Growth of national investment, agricultural sector, industrial sector and service sector - % of population under national poverty line - Indicators of good governance: democratisation, anti-corruption, decentralisation, civil society participation	
Purpose	***Impact indicators***	***From Purpose to Goal***
To ensure and promote the health status of the population of Rwanda, by providing quality preventative, curative, promotional and rehabilitative services	- Reduce maternal mortality rate from 1071 to 600 per 100,00 live births - Reduce child mortality rate from 196 to 110 per 1,000 children - Reduce infant mortality from 107 to 61 per 1,000 live births - Reduce child malnutrition from 24.3% to 18% - Reduce adult HIV prevalence rate to under 5.1%	- Rwanda maintains internal security and at peace with neighbours - Economy grows at 8 % per annum and equitably within stable macro environment - Implementation of PRSP in other sectors contributes to poverty reduction - Political commitment to poverty reduction and good governance maintained

Programme Outputs	*Key Performance Indicators*	*From Output to Purpose*
1. Availability of human resources improved	- Increase % of health facilities meeting minimum staffing norms to 50% - Reduce doctor to population ratio to 1/37,000 - Maintain nurse to population ratio at 1/3,900 - Increase % of midwives assigned to rural areas to 55%	- Behavioural change is not impeded by cultural factors - Effective legislation to regulate sector is put in place - Population is responsive to improved quality and availability of services - Private sector expands - Government and donor commitment to equity in provision of health care is maintained as expected - Donors at least maintain or increase level of health sector financing in a predictable manner - Government expenditure on health increases progressively towards the target of 15 % - Activities of other sectors improve water and sanitation services as expected - Malaria drug resistance is effectively managed - Implementation of PRSP in other sectors impact positively on health outcomes - National decentralisation implementation increases human capacity and financial resources at district level - Government policy to use generic drugs not impeded
2. Availability of drugs, vaccines and consumables improved	- Reduce average number of out-of-stock days of essential drugs in health centres to 0.5 days per month - Increase % of health facilities with all vaccines available to 95% - Increase % of health facilities with condoms available to 90% - Drug pricing policy developed and published, including subsidies for the poor	
3. Geographical access to health services expanded	- Increase % of population within 5km of a functioning health centre to 70% - Increase % of health centres with means of transport for emergency referral services to 60%	
4. Financial access to health services improved	- Increase % of Government budget allocated to health to 12% - Increase per capita annual expenditure on health to $16 - Increase % of population covered under community based health insurance schemes (mutuelles) to 50% - Pricing policy on high impact health services receiving public subsidies developed and published	
5. Quality of and demand for services improved in the control of disease	- Increase % of children under five and pregnant women sleeping under ITN to 70% - Increase % of pregnant women receiving IPT for malaria to 65% - Reduce rate of mother-to-child transmission of HIV to x% - Increase condom utilisation rate amongst youth 15-19 in most recent act of premarital sex to 10% - Increase number of integrated VCT centres to 130 - Increase treatment success rate of TB cases registered under DOTS to 85% - Maintain DPT3 coverage rate above 85% - Increase % of deliveries attended by skilled health workers to 60% - Increase % of pregnant women who receive at least 3 antenatal (ANC) visits to 65% - Increase Vitamin A coverage rate to 85% - Increase % of households with access to clean drinking water to 75% - IEC campaigns implemented covering entire population, focused at community level	
6. National referral hospitals and treatment and research centres strengthened		
7. Sector's institutional capacity strengthened	- Results orientated MTEF developed and linked with annual budget and monitoring tools - MTEF monitoring of outputs and expenditures carried out quarterly - HMIS fully operational, integrating national referral hospitals and private sector. - Block grants to districts introduced throughout the country	

III.4 Human Resources

Background and Problem Analysis

The lack of well-trained, highly motivated health professionals in the health system has been identified as one of the core problems for the sector. Table III.2 shows the number of various health professionals working within the different health facilities of the public health system. There is a concentration of health professionals within the richest region of the country Kigali City, where 75 percent of all doctors and over fifty percent of nurses can be found. This means that some provinces, particularly Gikongoro, Byumba, Gisenyi and Gitarama, have serious shortfalls in health professionals with respect to the WHO recommended norms. Furthermore, the capacity to train health professionals both in universities and in-services is insufficient to meet requirements. Finally, poor management of human resources is cited as a key cause for the low availability of health professionals. A critical underlying cause is the salary and incentive structure, which has been recognised as a key area to address over the next five years.

Table III.2 Current number of health professionals in the public health system by health facility type[17]

	CHUK	CHUB	District Hospitals	Health Centres	Total
General Doctor	31	22	63	0	116
Specialist Doctor	22	19	2	1	44
Nurse (A1/A2/A3)	378	115	676	815	1984
Medical / Social Assistant	15	6	60	122	203
Mid-Wife (Registered / Associated)	22	11	8	1	42
Lab Technician	23	22	52	37	134
Auxiliary Health Worker	13	8	154	348	523

The Ministry of Health has defined minimum staffing norms at the health centre and district hospital level, as shown in table III.3. At present, only 30 percent of health facilities are able to attain these minimum standards.

Table III.3 Ministry of Health staffing norms at health centre and district hospital level

	Health Centre Norms	District Hospital Norms
Doctor A0	N/A	4
Nurse A1	N/A	4
Nurse A2 / A3	4	15-20
Other (Nutritionist, Lab Tech, Social Assist, Admin) A2	4	8

Objective(s)

The overall objective is to improve the availability of human resources. Within this objective, the human resource development strategy will focus on:

- Investing in teaching and training institutions to ensure the supply of quality health professionals.

- Reforming the salary and incentive structure to improve distribution and number of health professionals in rural areas.
- Progressively transfer the management of health professionals and their salary supplements to more decentralised levels of the health system.
- Putting in place a meritocratic system of career advancement, built upon transparency and clear job descriptions.

Activities under these focus areas contribute to mainstreaming capacity building and strengthening decentralization in the health sector according to the poverty reduction strategy directions. Basic and in-service training will be overhauled to increase the capacities and skills of health workers, while management and incentive structures will be aligned to increase the motivation of health personnel and to encourage more qualified personnel to serve in poor rural areas.

National Targets by End of 2009:

- Increase from 30% to 50% the proportion of health facilities that meet the minimum staffing norms.
- Decrease the doctor to population ratio from 1/50,000 to 1/37,000.
- Maintain the nurse to population ratio at 1/3900.
- Increase the percentage of midwives assigned to rural areas from 17% to 55%.

Implementation Arrangements

Human resources are currently jointly managed by the Department for Human Resources and Support Services and the Department of Health Care, which collaborate closely with MIFOTRA and MINEDUC. The nursing profession is overseen by the Division of Nursing, which is responsible for policy guidance, supervision, and registration.

The human resource strategy sees an increasing role for provinces, health districts and health facilities in the management of health professionals as performance based contracting is expanded and the responsibility for management of salary supplements is transferred to a lower level. Basic training is carried out under the responsibility of MINEDUC, and will be supported by MINISANTE in areas of curriculum development.

Implementation of the human resources strategy will be closely coordinated with the construction of health facilities to ensure that the objective of increasing the proportion of health facilities meeting minimum staffing norms is achieved.

Logical Framework

HSSP LOGFRAME: HUMAN RESOURCE DEVELOPMENT			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Basic training and in-service training expanded	% of health care providers who have received in-service training in last six months by type of training	Health district supervision reports; Service provision assessment survey	Brain drain to foreign countries is taken account of
	Number of newly graduated doctors annually	University hospitals annual report	
	Availability of human resource development plan	HR development plan	
2. Equitable geographical distribution of health professionals established	% of health professionals working in rural areas	GESPER system; Health district supervision reports	
	% of health facilities with minimum staffing norms	GESPER system; Health district supervision reports	
	Health professional to population ratio by province	GESPER system; Ministry of Health Annual Report	
	% of registered mid-wives in rural areas	GESPER system; Health district supervision reports; Nursing division human resources report	
	Incentive structure in place for rural health workers, managed by province	HR department supervision report	
3. Management of human resources strengthened	Availability of clear, well defined job descriptions at all levels	Job descriptions	
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Develop and implement a human resource development plan for health professionals 1.2 Develop in-service training modules and an operational plan to integrate the in-service training needs of all programmes (malaria, IMCI etc.) 1.3 Review and revise the teaching programmes of health professionals 1.4 Provide internship training for newly graduated doctors 2.1 Carry out a health worker labour market study to cover both private and public sector 2.2 Develop criteria for recruitment, allocation and distribution of personnel 2.3 Determine the material needs of health professionals 2.4 Put in place an incentive structure of salaries and allowances in rural areas 2.5 Transfer responsibility for management of salary supplements for people working in remote areas to provinces 2.6 Establish a scheme requiring minimum service for new graduates in public sector 3.1 Define job descriptions for each position at all levels 3.2 Put in place a transparent system of career advancement based on meritocracy 3.3 Put in place an integrated system of supervision, defining the role of national referral hospitals 3.4 Establish boards and councils for all categories of health professionals 3.5 Develop a computerised personnel information system	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans

III.5 Drugs, Vaccines and Consumables

Background and Problem Analysis

The provision and distribution of drugs, vaccines and consumables constitutes one of the essential support systems for delivering health services in Rwanda. In light of the strategic importance that drugs play in the provision and financing of basic health services, the availability of drugs and consumables is one of the key dimensions in accessing health services for population. Not only are drugs a key way for health facilities to mobilise their own resources, they also constitute a large proportion of a household's expenditure on health (60 per cent), making their cost of one of largest barriers to accessing modern health care. The central purchaser of drugs, CAMERWA, imports and services largely the public national hospitals and health district pharmacies, which play an intermediary role in the distribution chain between CAMERWA and health facilities. Similarly, BUFMAR purchases and imports drugs for the Government assisted not-for-profit health facilities. The private sector relies on five main importers, who together account for over 70 percent of private drugs imports.

At the level of the district pharmacy and health centre, stock shortages of essential drugs are common across the whole country. For example, the average number of out-of-stock days per month is 2.6 for Amoxycillin, and 0.6 for Quinine[18]. The poor availability and accessibility to pharmaceutical products is caused by a weak procurement system and an absence of standardised procurement procedures, the failure to develop and enforce a clear drugs pricing policy, and a low number of district pharmacies maintaining drugs stocks rationally. The setting of high drugs prices and margins by health centres is caused largely by the severe financial resource constraints that they face and this is detrimental to the financial accessibility of households to drugs.

Objective(s)

The overall objective of this programme is to improve the availability of quality drugs, vaccines and consumables. To achieve this, the programme will:

- Put in place an efficient procurement and distribution system to ensure the availability of vaccine antigens (BCG, measles, DTP, hepatitis B, haemophilus influenza), essential drugs, and condoms for high risk groups at all level of the health system.
- Develop and publish a drug pricing policy, including subsidies for some essential drugs and consumables to improve access for the poor and ensure price transparency.
- Strengthen the quality assurance and registration system of drugs in both the public and private sectors.
- Improve the rational use of drugs.

These focus areas are aligned with the poverty reduction strategy priority on malaria and HIV/AIDS prevention, achievement of universal coverage under the immunization programme, and the improvement of the quality, affordability and access to essential drugs. To reinforce capacity building in the health sector, activities under this programme will be focused on strengthening drug procurement systems, decentralization of distribution systems, and strengthening regulatory capacities in the pharmaceutical sector, and alignment of drug pricing policies with the poverty reduction strategy.

National Targets by End of 2009:

- Reduce the average number of out-of-stock days of essential drugs in health centres from 1 day to 0.5 of a day per month.
- At least 40,000 units of screened blood are distributed to district and national referral hospitals annually.
- Increase the proportion of health facilities that have all vaccines available from 83% to 95%.
- Increase the proportion of health facilities that have condoms available from 64% to 90%.

Implementation Arrangements

The Department of Pharmacy is responsible for national policy development, regulation, standards and the coordination of supervision activities in both public and private pharmacies. It will also develop drug procurement procedures and ensure that they are adhered to.

The inspection system will be decentralised for reasons of efficiency. Provincial pharmacy inspectors will be in charge of supervising pharmacies in terms of whether they adhere to the national laws and regulations set by the Government.

CAMERWA and BUFMAR, as the central purchasing agencies for the public and not-for-profit sectors, will provide drugs, vaccines and consumables through the supply chain to the district pharmacies and ultimately to the district hospitals and health centres.

Logical Framework

HSSP LOGFRAME: DRUGS, VACCINES AND CONSUMABLES			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Procurement and distribution system of pharmaceutical products, consumables and blood strengthened	Average number of out-of-stock days of essential drugs for primary and secondary health facilities	HMIS; DPHARM study	Exonerations on essential drugs maintained over period of strategic plan
	Number of units of safe blood distributed to health facilities annually	CNTS report	
	Availability of drug procurement plan	Procurement policy	
	% of health districts operating a decentralised distribution system of drugs and consumables	DPHARM supervision report	
2. Access to and quality of essential pharmaceutical products improved	Publication of essential drug price list annually	National newspapers; Audit	
	Development of pharmaceutical pricing policy	Policy document	
	% of pharmacies respecting price regulations on drugs (margins)	DPHARM inspection report	
3. Rational use of pharmaceuticals ensured	% of health facilities maintaining drug stock rationally	HMIS; Health district supervision reports	
	Availability of national drug formula	National drug formula	
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Define, adopt and disseminate laws and decrees regarding the pharmaceutical sector 1.2 Determine the national needs for drugs and consumables	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans

1.3 Develop and implement drug procurement plan integrating needs of all programmes and levels of the health system 1.4 Decentralise the distribution of pharmaceutical products and consumables 1.5 Make a mapping of pharmacies 1.6 Carry out inspections of pharmacies in public and private sectors to enforce standards 1.7 Screen and distribute units of safe blood to district and national referral hospitals 2.1 Develop pharmaceutical pricing policy, including subsidies of key essential drugs and consumables 2.2 Supervise implementation of pricing policy through supervision of price margins in public sector pharmacies 2.3 Publish annually list of prices of essential drugs in newspaper and/or radio 2.4 Draft a plan and national policy for the pricing of pharmaceuticals in collaboration with CAMERWA and implement 2.5 Revise and distribute list of essential drugs as governed by national policy to promote generic drugs 2.6 Put in place a registration system for drugs 2.7 Elaborate national directive regarding donations of drugs 2.8 Monitor the manufacture of drugs to ensure compliance with standards 3.1 Develop and distribute a national drug formula to health professionals 3.2 Set up a national pharmaceutical board 3.3 Establish a monitoring system of psychotropic and addictive drugs and the side effects of newly introduced drugs 3.4 Develop national treatment standards with regard to drugs 3.5 Carry out operational research			

III.6 Geographical Access to Health Services

Background and Problem Analysis

The number of health centres has increased from 333 in 1997 to 385 in 2003; meanwhile the number of functioning district hospitals has risen from 30 to 34 over the same period. Despite these efforts, large disparities remain in geographical accessibility between provinces and these disparities are often strongly related to poverty. For example, in the poorest province, Gikongoro, only 30 percent of population lives within 5 km of a health centre, well below the national average. Access to *functioning* health facilities, which are sufficiently staffed and equipped and have working laboratories is another closely related problem. A comprehensive assessment of the inventories of district hospitals revealed an acute shortage of medical equipment throughout the country. Finally health districts too often lack the means of transport to supervise health facilities, provide outreach services and refer patients from health centres to the district hospital. This last problem is particularly relevant if maternal mortality is to be reduced through improved access to emergency obstetrical care.

Objective(s)

The overall objective is to expand geographical access of the population to functioning health services. Over the five-year period of the HSSP, this programme will expect:

- To construct and rehabilitate health centres and district hospitals in health districts with the worse geographical access in accordance with the health infrastructure development plan.
- To establish an efficient equipment procurement system.
- To provide health districts with adequate transportation for emergency referral to district hospitals.
- To ensure there is a functioning laboratory network in place.
- To ensure the functioning and regular inspection of health facilities.
- To promote the use of private sector health facilities to complement public health facilities

Activities under this programme focus on strengthening decentralization and capacity building in the health sector in accordance with the poverty reduction strategy. At the operational level, they will contribute to strengthening the decentralization of the health system and the structural quality of the health district delivery and referral systems, and extending the reach of health services in underserved areas. Not only will these activities contribute to increase the geographical accessibility of health services and the logistical capabilities to support community-based activities, but they will reinforce the motivation of health personnel working in the rural areas as they overhaul their material working conditions. At the strategic and central level, they will contribute to strengthening regulatory capacities in health infrastructure development, equipment procurement and maintenance, and laboratory policy.
In addition to improving public health facilities, existing private health care facilities should be leveraged to improve access to health care in the population. To achieve this aim, private health facilities will be encouraged to increase the quantity and quality of services provided to all citizens.

National Targets by End of 2009:

- Increase the proportion of the population within 5km of a health facility from 58% to 70%.
- Increase the proportion of health centres with means of transport for emergency referral services from 32% to 60%.

- Increase the proportion cases treated by private sector health care providers from x% to y% through the implementation of volume incentives.

Implementation Arrangements

The Ministry of Health's infrastructure development plan, which provides a detailed mapping of health facilities and optimal construction and rehabilitation scenarios over the medium term, will guide the implementation of the strategic plan. Owing to the regional disparities, improvement in geographical disparity will be focused in Gikongoro, Butare, Kibungo, Umutara and Kigali Ngali. It is fully recognised that construction and rehabilitation is hugely costly and that because of financial constraints, the health infrastructure development plan will only be partially implemented over the period of this strategic plan.

Incentive schemes to promote the use of private health care will be developed by the Department of Health Care in cooperation with provinces and health districts and will be guided by the principle of broadening geographical and financial access to health care. Incentive schemes will be adapted to local needs due to regional differences.

Construction and rehabilitation of health facilities will be under the responsibility of the Ministry of Infrastructure who will liase closely with the Directorate of Planning in the Ministry of Health. The central maintenance workshop will coordinate and manage routine maintenance of both health facilities and central ministry buildings.

The supervision and maintenance of the nationwide laboratory network is under the responsibility of the National Laboratory of Rwanda. It will coordinate activities to ensure all health facilities are supported by a functioning laboratory.

Logical Framework

HSSP LOGFRAME: INFRASTRUCTURE, EQUIPMENT AND LABORATORY NETWORK			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Health infrastructure development plan implemented	% of population within 5km of health centre	Household Living Standards Survey	Resources are available to finance planned construction
	Number of health facilities newly constructed and fully equipped each year	Ministry of Health Annual Report; Site visit reports	There are sufficient health care workers to fill vacancies in new health facilities
	Number of health facilities rehabilitated	Ministry of Health Annual Report; Site visit report	Health infrastructure construction remains priority for government
	District hospital / population ratio	Health Information System	
	Health centre / population ratio	Health Information System	
2. Laboratory support system functioning at all levels	% of laboratories meeting minimum standards	LNR supervision inspection report	Availability of trained laboratory technicians is sufficient to staff laboratories
	% of health facilities with functioning laboratory	Health district supervision reports	
	Number of laboratory technicians trained	Training records	
3. Health facilities at district level are fully functioning	% of health facilities fully equipped	Health district supervision reports	
	% of health centres with means of emergency transport for referral		

Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Construct 20 health centres and 6 district hospitals in accordance with health infrastructure mapping plan 1.2 Rehabilitate x health centres and y district hospitals 1.3 Provide ambulances, motorbikes and bicycles for district hospitals, health centres and community health workers 1.4 Establish standards and norms for construction and rehabilitation of health infrastructures 1.5 Develop guidelines for monitoring and control of construction and rehabilitation	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans
1.6 Develop and adopt regulation for the maintenance of biomedical equipment 2.1 Develop a national laboratory policy 2.2 Develop and adopt laboratory norms and standards 2.3 Provide equipment, consumables and reagents 2.4 Construct and rehabilitate laboratory services 2.5 Train laboratory technicians 2.6 Develop a protocol for procurement of materials 2.7 Supervise laboratory activities at all levels 2.8 Carry out quality control of laboratories 2.9 Affiliate the national laboratory network to the international laboratory accreditation 2.10 Train personnel in quality assurance and control 2.11 Put in place an accreditation system for private laboratories 3.1 Develop and put in place a procurement procedure for equipment 3.2 Establish a programme of regular inspection and maintenance of health infrastructures 3.3 Support the functioning costs of district hospitals and health centres			

III.7 Financial Access to Health Services

Background and Problem Analysis

In interviews with households, the cost of services is cited by the population as the greatest barrier to accessing health care in Rwanda, which given the level and depth of poverty is to be expected. Improving financial access of the population and especially the poor to cost effective proven health and nutrition interventions will be one the main challenges in reducing mortality and reaching the MDGs. Great efforts have been put into risk pooling mechanisms through the design and implementation of pilot mutuelle health insurance schemes and important lessons have been learnt for expansion of such initiatives into other health districts. The piloting and extension of performance based payment schemes, whilst found in programme five, also has important implications for efficiency in the use of financial resources.

The first immediate cause of the poor financial access to health care is the insufficient amount of resources in the sector from the four sources of funds, that is donors, the government, households and private businesses. The second cause is the inequity in health care financing. The rich contribute proportionately less to health care than the poor, yet use health services proportionately more. The final cause of the low financial access concerns inefficient resource allocation, such as ineffective targeting of the poor where the greatest marginal benefits can be sought, and leakages as money travels through the system.

Objective(s)

The objective is to improve financial access of the population to health services. Within this overall objective, the programme is expected to:

- Increase total financial resources to the health sector in line with requirements to meet the HSSP targets.
- Improve efficiency, allocation, and utilisation of financial resources in the health sector in line with the objectives of the PRSP and HSSP.
- Reduce cost and affordability barriers in accessing essential health care through the expansion of mutuelles across the country based on a thorough analysis of best practice and financial sustainability.
- Contract mutuelles to cover membership of the poorest through block grant transfers to administrative districts.
- Develop a pricing policy on high impact health services receiving public subsidies.

Activities under this programme establish in the health sector a financing framework aligned with strategic directions of the PRSP, the targeting required to meet the MDGs, and empowerment of communities. The identification of health as a priority in the PRSP will be translated by maintaining the growth of government expenditures allocated to health and strengthening the institutional capacity to coordinate and to monitor financial resources of the health sector. The extension of community-based health insurance schemes (mutuelles) will be supported not only to provide mechanisms for expanding financial protection and financial accessibility in the health sector, but also to serve as intermediary organizations for targeting demand-based subsidies to the poorest. Pricing policies in the health sector will be aligned to improve access to high impact health services and to reduce the financial burden on households.

National Targets by End of 2009:

- Increase proportion of government budget allocated to health from 6.1% to at least 12%.
- Per capita annual expenditure on health increases from $8.25 to $16.
- Increase proportion of the population covered under community based health insurance schemes from 12% to 50%.

Implementation Arrangements

Implementation of health care financing activities will fall under the responsibility of many of the Ministry of Health's departments, as well as other agencies. The Department of Planning will take the lead in increasing resources to the health sector by working with MINECOFIN and external partners and will ensure allocations reflect the priorities of the Government outlined within the HSSP. Expansion of health insurance to the formal labour market will be implemented through RAMA.

A national mutuelle coordination unit will guide the expansion of community based health insurance schemes in close collaboration with MINALOC. It will be responsible for promotional, training and monitoring activities in the support of mutuelle schemes and where necessary provide technical capacity to ensure that they adhere to the regulatory and legal framework in place. The Department of Health Care in conjunction with the Department of Pharmacy will determine pricing policies (including subsidies) of essential health services and drugs to improve access of the poor in a sustainable manner.

Financial management at the national level is the responsibility of the Department for Human Resources and Support Services. It will ensure that all Government funds are executed in strict adherence of Government regulations, through regular monitoring of the MTEF (both financial and output) and carry out periodic surveys, such as National Health Accounts, Public Expenditure Reviews and Public Expenditure Tracking Surveys, to assess the allocation of resources vis-à-vis declared Government policy.

Logical Framework

HSSP LOGFRAME: HEALTH CARE FINANCING			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Financial resources to health sector increased	% of total public expenditure spent on health	Public Expenditure Review; Budget execution report	Economic growth continues as projected
	% of total government budget allocated to health	Annual Finance Law; Public expenditure review	Donor commitment to health sector is maintained
	Per capita expenditure on health (including government, donor and private contributions to health)	Public expenditure review; National health accounts	Government maintains commitment to increase health sector budget as forecast
	Ratio of budget support / total aid in health sector	CEPEX report	Donor coordination mechanisms are effective
2. Equity in the financing and utilisation of health services improved	% of government health expenditure on primary health care	Public Expenditure Review	Government commitment to transparency and accountability maintained
	Proportion of the poor receiving subsidised essential health services	DSS annual report	
	% of indigent, as identified by community, subsidised for mutuelle membership	Administrative district purchase of mutuelle card records	
	% of population covered by mutuelles schemes	Mutuelle coordination unit report	
	% of mutuelles schemes with a coverage rate of their target population of at least 30%	Mutuelle coordination unit report	

3. Allocation and management of financial resources optimised	Availability of Public Expenditure Tracking Survey Availability of quarterly MTEF financial and output monitoring report % of Government health budget executed	PETS report DP quarterly MTEF monitoring reports Ministry of Finance annual execution report; Audit	
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Re-establish health sector cluster to coordinate stakeholders, manage external resources and expand budgetary support to sector 1.2 Carry out an actuarial analysis to determine sustainability of RAMA including (i) actuarial estimate of contributors, (ii) cost of entitlement, and (iii) adequacy of reserves 1.3 Assess feasibility of expanding RAMA to include formal labour market (private sector) 1.4 Lobby MINECOFIN to increase government expenditures in health in accordance with Abuja agreement 2.1 Expand financial protection against health risks in a sustainable manner through the implementation of the mutuelle support programme 2.2 Establish a national coordination unit for mutuelles with appropriate legal framework 2.3 Develop a best practice study on mutuelles and adopt legal and regulatory framework 2.4 Contract mutuelles for the poorest through direct transfers of block grants to administrative districts from central level 2.5 Study user fees and unit costs of basic health services in a representative sample of health facilities and hospitals 2.6 Dissemination of policy on price of high impact health services benefiting from public subsidy, including pricing policy and exemptions on drugs and services to fight major diseases 2.7 Put in place incentive mechanisms to improve utilisation of health services amongst women 3.1 Implement MTEF financial and output monitoring at central and province level on a quarterly basis and disseminate reports 3.2 Carry out a Public Expenditure Tracking Survey periodically 3.3 Conduct National Health Accounts and Public Expenditure Review bi-annually 3.4 Set up a database of donor funded activities and publish the mapping of their interventions	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans

III.8 Quality of and Demand for Health Services in the Control of Disease

The components of this programme attend to the major diseases and risks that contribute to the heavy burden of morbidity and mortality and lower productivity in Rwanda, building on the knowledge and evidence available on the effectiveness and affordability of key health interventions. They act synergistically with the programmes defined above to improve the availability of human and material resources, geographic and financial accessibility in the health sector to increase the impact of health services on morbidity and mortality in the country, and to put the country on track to meet the health-related MDGs.

Priority actions in health and cross-cutting issues identified in the PRSP are mainstreamed in all the components of the programme. Decentralization is reinforced through the strengthening of the content of district health services and the elaboration of community-based interventions building on community health workers in most of the components of the programme. All components build on training of health workers to improve the quality of health services in specific technical areas, and include IEC activities to support prevention and positive behaviour changes in targeted population groups. Gender is specifically mainstreamed in the malaria, HIV/AIDS, reproductive health and IEC components of the programme. Finally, all components include activities to strengthen the health sector capacities in respective technical areas.

III.8.1 Transmittable Diseases

A. Malaria

Background and Problem Analysis

Malaria is the primary cause of morbidity in Rwanda. Uncomplicated malaria has accounted for over half of all consultations in health facilities between 1995 and 2003[19]. With respect to severe malaria, 8% of mortality amongst children under five can be attributed to the disease. The impact of malaria has expanded as environmental factors and population movements have spread the disease and increased its drug resistance to new regions. The immediate causes of the high rates of morbidity and mortality are: (i) the poor quality of treatment in health facilities, in terms of non-compliance with national treatment protocols, (ii) the late and inadequate care of malaria cases in the community, (iii) inadequate measures of prevention, as indicated by the low utilisation of insecticide treated nets, absence of intermittent presumptive treatment for pregnant women, and inadequate environmental control (iv) lack of an early warning epidemic prevention system and (v) weaknesses in the overall health system, such as low capacity of health personnel and lack of resources at district level.

Objective(s)

To reduce the mortality and morbidity attributed to malaria.

National Targets by End of 2009:

- Increase the proportion of children under five sleeping under an insecticide treated net from 3% to 70%.
- Increase the proportion of pregnant women sleeping under an insecticide treated net from 13% to 70%.

- Reduce the malaria case fatality rate from 1% to 0.3%.
- At least 65% of pregnant women receive intermittent presumptive treatment or chemoprophylaxis.
- Increase the proportion of severe malaria cases in health facilities treated in accordance with national policy from 44.3% to 70%.

Implementation Arrangements

Whilst people of all ages and both sexes are at risk, malaria represents the most serious health problem for children under five and pregnant women. The strategy is designed to target these two groups in particular. At the national level, a national multisectoral committee will be put in place to validate policy, mobilise funds and play an advocacy role. Within the malaria control programme (PNILP), there are a number of sub-units responsible for the coordination of IEC activities, treatment at health facility and community level, prevention activities, epidemiological surveillance, monitoring and evaluation, operational research and documentation. The main prevention strategy, the distribution of impregnated mosquito nets, will be reinforced by vigorous IEC campaigns.

At the provincial and health district level, malaria control coordination will be integrated into the HIV/AIDS control committees (CPLS), which are already functional. Implementation of the malaria strategy at the community level will be through the community health workers and community leaders.

Logical Framework

HSSP LOGFRAME: MALARIA			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Prevention measures strengthened	% children under five sleeping under insecticide impregnated mosquito net	Household surveys (DHS, MICS); Sentinel site survey	Malaria prevention is integrated effectively into IMCI activities
	% pregnant women sleeping under insecticide impregnated mosquito net	Household surveys (DHS, MICS); Sentinel site survey	Drug resistance of malaria is effectively monitored and managed as expected
	% of pregnant women receiving intermittent preventive treatment or malaria prophylaxis, according to national policy	Household surveys (DHS, MICS); Health facility maternity ward patient records	
2. Treatment of malaria cases improved	% of children under five with fever who receive correct treatment within 24 hours of onset of symptoms	Household surveys (DHS, MICS)	
	Malaria case fatality rate	HMIS; Sentinel site surveys	
	% of severe malaria cases in health facilities treated in accordance with national policy	HMIS	
	% of health care providers trained in malaria case management	PNILP annual report; Training reports	
3. Epidemics detected and controlled	% of malaria epidemics detected and controlled within two weeks of outbreak	PNILP annual report	
	% of districts with an early warning prevention system in place	District supervision reports	
4. Institutional capacity strengthened	Availability of plans for prevention and control of malaria at district level	PNILP annual report; Minutes of planning workshops	
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Introduce progressively intermittent presumptive treatment for pregnant women	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans

1.2 Promote the use of subsidised long-lasting impregnated mosquito nets, targeting children under five and pregnant women 1.3 Create awareness and behavioural change through IEC activities 1.4 Initiate a multisectoral environmental response to vectors 1.5 Implement community based distribution programme of ITNs and re-impregnation kits 2.1 Provide subsidised anti-malarial drugs and equip laboratories 2.2 Introduce community based care for fever cases in conjunction with IMCI strategy 2.3 Train health workers in malaria treatment at health facility level 2.4 Establish a referral and patient feedback system 2.5 Develop a mechanism of collaboration with private sector 2.6 Carry out regular integrated supervision 2.7 Revise anti-malaria drug policy based on results of operational research 2.8 Develop and implement home based treatment of fever cases 2.9 Publish policy on anti-malarial drug (ACT) pricing and subsidy scheme 3.1 Make an epidemiological mapping of malaria 3.2 Develop and put in place a malaria epidemic early warning and control system 3.3 Expand epidemiological surveillance to private sector 4.1 Finance health district planning in malaria 4.2 Integrate malaria reporting and analysis into health information system (HMIS) 4.3 Provide means of transport and communication at district level 4.4 Carry out operational research on drug resistance and resistance of insecticides for malaria vector control			

B. HIV/AIDS/STI

Background and Problem Analysis

The HIV prevalence rate in Rwanda is 5.1 percent according to the UNAIDS 2004 Report on the Global AIDS Epidemics. The prevalence rate is 13.2 percent in Kigali Town, 6.3 percent in other towns and 3.1 percent in rural areas[20]. AIDS is estimated to account for 17 percent of under five mortality[21]. The HIV/AIDS epidemic affects all segments of the population, in particular young women, sex workers, orphans, prisoners and commercial drivers. Young women and older men have the highest rates of infection. HIV in Rwanda is spread primarily through heterosexual contact (75 percent) and mother-to-child transmission (20 percent). The Government adopted its National HIV/AIDS Multi-Sector Strategic Plan in 2002, and this document forms the basis for the HIV/AIDS/STI component of the HSSP.

The high prevalence rate and the large number of people living with HIV/AIDS is caused primarily by: (i) insufficient measures of prevention, reflected in part by the extremely low condom utilisation rate, the inadequate availability of HIV and STI testing in health facilities, the poor availability of PMTCT services, and ignorance amongst the population; (ii) low access to and availability of treatment and care at the facility level, in the community and at home; (iii) poor availability and quality of information regarding HIV/AIDS; and (iv) a lack of coordination amongst partners in what is a complex sector.

Objective(s)

To reduce the transmission of HIV/AIDS and STIs and mitigate the personal effects of AIDS

National Targets by End of 2009:

- Reduce the HIV sero-positive prevalence rate in general population to less than 5.2%
- Increase percentage of youth 15-19 reporting condom use in most recent act of premarital sex from 0.3% to 10%.
- Reduce the sero-positive prevalence rate 15-19 years from 5.2% to y%.
- Increase the number of integrated VCT centres from 40 to 80% of all health centres.
- Reduce mother to child transmission of HIV from x% to y%.

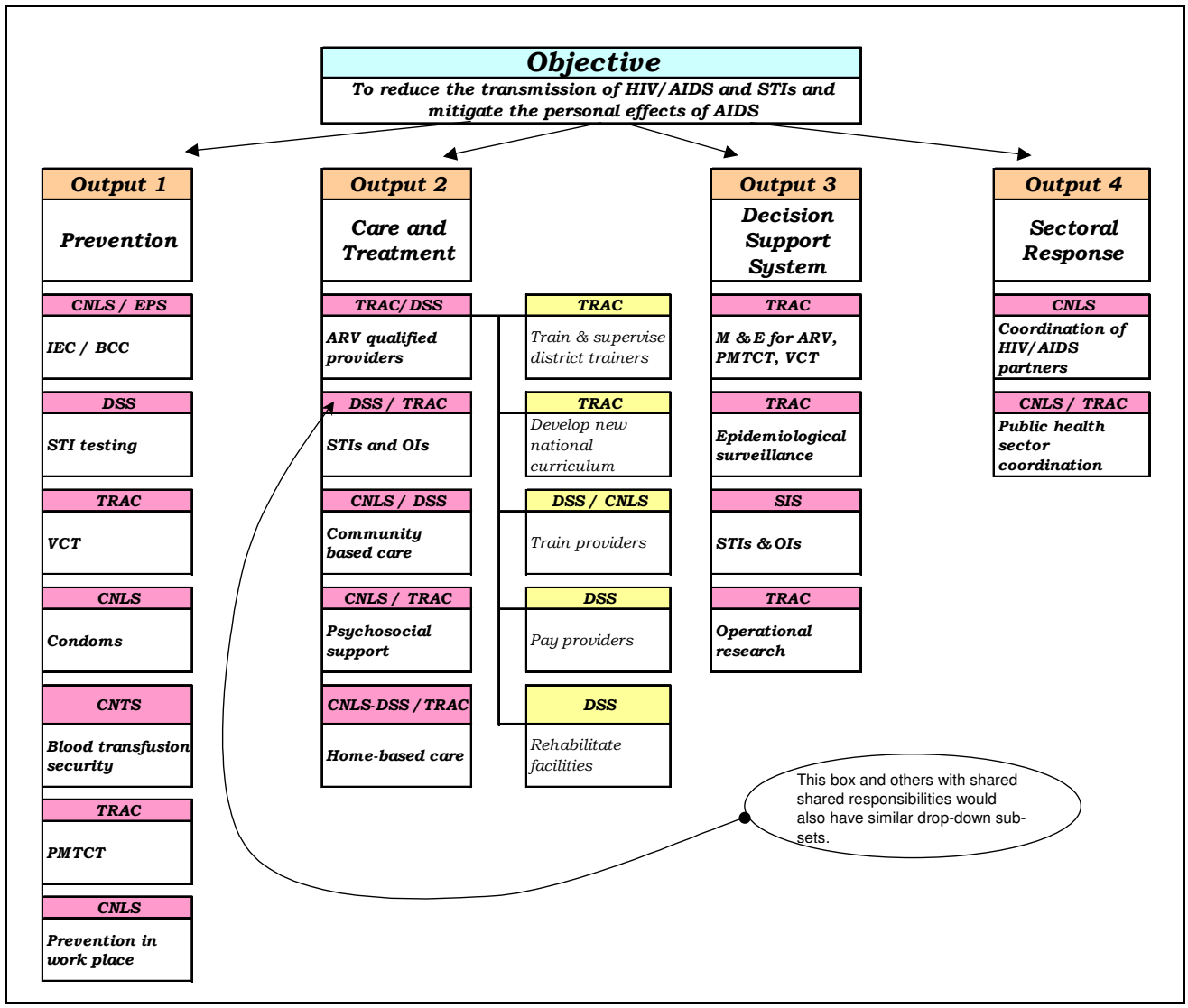
Implementation Arrangements

The main Government entities responsible for implementation are CNLS, TRAC, DSS, CNTS, Division for Health Education, and the health service providers themselves. Figure III.2 shows a diagrammatic representation of responsibilities for the implementation of the HIV/AIDS/STI strategic plan, according to the four outputs presented in the logical framework below. The government department or entity is shown at the top of each box above the broad category area of activities. For example, under prevention TRAC is in charge of the implementation of VCT activities. Where there is joint responsibility, the first entity shown is the primary responsible.

Implementation will remain focused on preventative activities, as these are the most effective means to control the disease. Treatment of AIDS patients will be delivered through the current health system as much as possible, requiring the reinforcement of the entire system.

At the provincial and district level, coordination and policy will be overseen by the HIV/AIDS control committees (CPLS), which are already in place.

Figure III.2. Responsibilities in the implementation of HIV/AIDS/STI strategy



Logical Framework

HSSP LOGFRAME: HIV/AIDS/STI			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Measures to prevent the transmission of HIV and STIs strengthened	HIV positive prevalence rate amongst population of 15-19 years	DHS Plus; Sentinel site surveys	Effective implementation of HIV/AIDS multisectoral strategy in other sectors
	The number of facilities offering VCT in line with national guidelines	VCT programme reports	Donor commitment remains stable
	% HIV-positive women provided with a complete course of antiretroviral therapy in pregnancy (PMTCT)	Health centre surveys and programme reports	There is sufficient capacity to absorb HIV/AIDS funds
	Condom utilisation rate at last higher-risk sex	AIDS indicator survey; Demographic household survey	
	Percentage of transfused blood units screened for HIV	CTS programme report	
	% of patients with STIs at health care facilities who are appropriately diagnosed, treated and counselled according to national guidelines	Site visits; Sentinel site surveys	
2. Care for those infected and affected by HIV/AIDS expanded and improved	Number of persons receiving ARV drug therapy in a given year	Programme reports	
	% of health districts implementing community/home based care system	Health district supervision reports; CNLS monitoring report	
	Number of health care providers trained in how to administer ARV drugs	Training reports; Programme reports	
	% of health care facilities providing ARV therapy according to national health policy	Programme reports	
3. Decision based information systems for HIV/AIDS/STI strengthened	Availability of information to determine HIV/AIDS/STI indicator values and monitor ARV, VCT, PMTCT, IEC and condom promotion programmes	HIV surveillance report; ARV, VCT, PMTCT, IEC and condom promotion programme reports	
4. Response of health sector partners to HIV/AIDS coordinated	Availability of mapping of HIV/AIDS interventions in health sector	Mapping profile of HIV/AIDS sector	
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Develop a national IEC/BCC strategy for HIV/AIDS 1.2 Develop an operational plan for prevention of HIV/AIDS/STI 1.3 Expand testing and early treatment of STIs within primary health care system 1.4 Train health care providers to integrate VCT services into activities of health facilities 1.5 Construct and/or rehabilitate health infrastructure to provide VCT services 1.6 Provide drugs, materials, reagents and consumables for VCT services 1.7 Supervise activities at all levels of service provision 1.8 Put in place provision and distribution structures to promote the utilisation of male and female condoms 1.9 Increase the number of blood collection sites in both urban and rural zones 1.10 Provide blood transfusion centres in materials and reagents	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans

1.11 Construct a new building for blood transfusion centre in Butare and rehabilitate existing ones 1.12 Put in place a programme of blood quality assurance 1.13 Integrate PMTCT services into antenatal consultative services in all health centres 1.14 Develop directives on the protection of health professional from HIV exposure 1.15 Distribute instructions on post exposure prophylaxis in case of accidental exposure 2.1 Provide ARV drugs 2.2 Train health professionals in administration of ARV drugs in all hospitals 2.3 Put in place committees to select and monitor those persons under ARV drugs 2.4 Ensure the biological monitoring of people on ARV treatment 2.5 Train health professionals in the treatment and management of opportunistic infections 2.6 Provide training, drugs and an STI treatment protocol for care and treatment of STIs in health facilities 2.7 Put in place an integrated system of supervision 2.8 Put in place a home-based care system 2.9 Put in place a procurement system for HIV/AIDS/STI related drugs and products 3.1 Standardise data collection tools and indicators relevant to HIV/AIDS in health sector 3.2 Integrate HIV/AIDS data into the health information system 3.3 Carry out second generation epidemiological surveillance 3.4 Carry out surveillance of ARV resistance 3.5 Carry out operational and epidemiological research 3.6 Conduct experimental research into vaccines 4.1 Make a mapping of partner interventions in HIV/AIDS within health sector 4.2 Ensure the monitoring and evaluation of partner activities			

C. Tuberculosis

Background and Problem Analysis

Rwanda is a high risk country for tuberculosis with an estimated annual risk of infection of 2% (WHO). The yearly incidence of smear positive pulmonary tuberculosis is estimated at 100/100,000 and at 220/100,000 for all forms. TB targets the most economically active age cohort, with 79% of smear positive pulmonary TB found in those aged 15-44 years[22].

The immediate causes of the high rates of mortality, morbidity and transmission of tuberculosis are: (i) a low treatment success rate of 58%, (ii) a low case detection rate of 31% for all forms and 45% for sputum smear-positive cases and (iii) the poor monitoring of performance in case management and supervision at both central and district levels[23].

Objective(s):

To reduce the mortality, morbidity and transmission of tuberculosis.

National Targets by End of 2009:

- Increase the treatment success rate of TB cases registered under DOTS from 58% to 85%.
- Increase the percentage of all estimated new smear-positive TB cases detected and registered under DOTS from 45% to 70%.
- Increase the percentage of gender specific estimated new smear-positive TB cases detected and registered under DOTS from 31% to 70%.
- Reduce the number of TB deaths (all forms) per year from 3.6/100,000 to 3.0/100,000.
- Reduce the number of smear-positive cases per year from 100/100,000 to 75/100,000.

Implementation Arrangements

The Ministry of Health established a national TB control programme (PNILT), which is responsible for developing national policy, mobilising funds, national supervision and carrying out advocacy duties. It is well recognised that the implementation of the TB strategy will require strong coordination between PNILT and corresponding programmes which fight HIV/AIDS and malaria.

The implementation of TB activities will largely be integrated into the general health system with the exception of a few activities. This will mean an expanded role for the provinces and health districts, who will be responsible for the execution of anti-TB activities, training, and supervision within the district hospital, health centre and community. The community will be involved in the planning and implementation of anti-TB activities through the health committee at the health centre level, and will also be active in the implementation of the community DOTS activities through CHWs.

The main beneficiaries of the TB control programme will be women, HIV/AIDS co-infected persons and prisoners. Women will participate in planning through their role as community representatives. In TB care they will be involved as CHWs and as nurses in antenatal and under-five clinics. In prisons, inmates will act as service deliverers themselves for the implementation of DOTS.

Logical Framework

HSSP LOGFRAME: TUBERCULOSIS			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Treatment of tuberculosis improved	% of treatment facilities implementing full quality DOTS treatment	Health district supervision reports, PNILT annual report	GDF will supply anti-TB drugs as planned for the years 2005 and 2006
	% of smear-positive TB cases registered under DOTS successfully treated	Health district quarterly TB report, PNILT annual report	
	Number of health districts having introduced community DOTS	Health district quarterly TB report, PNILT annual report	
	% of PTB+ cases being cared for by community DOTS	Health district quarterly TB report, PNILT annual report	
	Availability of TB drugs at CAMERWA	CAMERWA annual report	
2. Infectious tuberculosis, especially in women effectively detected	% of all estimated new smear-positive TB cases detected under DOTS	PNILT annual report	TB component of HIV/AIDS programmes including VCT projects will be carried out as planned
	% of all estimated new smear-positive TB cases detected under DOTS for female population	PNILT annual report	
	Number of health workers trained and re-trained in procedures for early detection of TB	PNILT annual report	
3. Multi-drug resistant TB cases effectively detected and treated	Availability of protocol for the detection of MDR cases	MDR taskforce report	GoR will release the provided funding of second line anti-TB drugs as planned for the pilot phase of MDR treatment
	Establishment of a MDR treatment centre	MDR taskforce report, PNILT annual report	
	% of new smear-positive cases registered under DOTS who default or transfer out of treatment	Health district quarterly TB report, PNILT annual report	
4. TB institutional capacity reinforced	% of health districts with fully functioning recording and reporting system	PNILT supervision reports	HMIS will be upgraded according to the HMIS strategy
	% of planned supervision visits to health district carried out	PNILT annual report	TB and malaria programme will coordinate to carry out joint supervision of activities
			Civil service reform will improve efficiency and incentives as expected
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Train health personnel in DOTS implementation for treatment at facility level 1.2 Develop and implement a community based DOTS strategy, including providing performance based incentives 1.3 Provide first line anti-TB drugs 1.4 Implement a referral system for TB patients to access HIV testing 2.1 Create awareness and behavioural change at population level through intensive IEC and social mobilisation 2.2 Expand sputum smear preparation to all health facilities 2.3 Train health staff and laboratory technicians for early detection 2.4 Create partnerships with private sector for TB detection 2.5 Put in place a referral system for access to TB testing for HIV/AIDS patients	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans
2.6 Expand communication network between health facilities and health districts			

3.1 Elaborate and introduce a protocol for the detection and treatment of MDR cases 3.2 Establish a treatment centre for MDR cases 3.3 Train health staff in improving treatment adherence of PTB+ cases to reduce risk of MDR TB development 4.1 Simplify and strengthen procedures for case recording, follow-up, referral, tracing and reporting at hospital, prison, health centre and district level 4.2 Integrate the TB reporting system into the national health information system 4.3 Strengthen management and carry out supervision at the national, health district and health centre level 4.4 Establish a quality assurance system for microscopic diagnosis of TB 4.4 Perform operational research on seven topics			

D. Epidemic and Disaster Prevention, Management and Response

Background and Problem Analysis

This programme component area combines the prevention, management and response of epidemics with that of disasters. Rwanda, in the past, has been prone to disasters such as volcanic eruptions, floods, drought and famine and these have led to a massive displacement of populations, and epidemics. The Government will aim to improve emergency preparedness and response to disasters and epidemics to ensure that resulting morbidity and mortality from such events are minimised.

The current situation is characterised by the late detection of cases and epidemics, the non-involvement of laboratories in the confirmation of cases, poor integration of the different specific disease surveillance systems, lack of preparation and readiness, lack of sensitisation in the community, and no coordination structure for partners intervening in this domain.

Objective(s)

The overall objective is to reduce mortality and morbidity linked to diseases of epidemic potential and other transmissible diseases. Within this objective, the programme component intends to:

- Provide free treatment to those affected by epidemics and disasters.
- Ensure a national stock of emergency materials, drugs, food, and water etc.
- Put in place a functioning disaster management unit.
- Sensitise the population to the risks.

National Targets by End of 2009:

- To respond to all confirmed epidemics within 48 hours of outbreak.
- To ensure the functioning of an integrated disease surveillance system.

Implementation Arrangements

At the national level, the Division of Epidemiology defines the national strategy for prevention and control of epidemics, as well as carrying out national surveillance, in-service training of health district teams, technical supervision, and providing drugs and materials to the periphery. Furthermore, the division promotes operational research into disease control in collaboration with research institutions. The national reference laboratory carries out biological diagnosis of suspected cases and monitors the continued effectiveness of antibiotics to microbes responsible for epidemics. The Rwandan Red Cross plays a vital role in carrying out sensitisation activities and responding to epidemics and disasters.

At the provincial and health district level, epidemiological information, in particular the monthly reports on priority diseases, is collected, validated, analysed and transmitted to central level. Surveillance activities are supervised down to the level of the health centre, and the provision of drugs, consumables and vaccines is ensured.

The community is the first link in the chain of epidemiological surveillance. It plays a crucial role in the detection of disease through the community health workers, who receive basic training to recognise the symptoms of the priority diseases. The CHWs refer suspicious cases to the health centre, and promote the use of modern health care services in the case of illness.

Logical Framework

HSPP LOGFRAME: EPIDEMIC AND DISASTER PREVENTION, MANAGEMENT AND RESPONSE			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. System of disaster and epidemic prevention, preparedness and response in place	Disaster Management Unit functioning Number of health care providers trained in surveillance and emergency response Existence of a national emergency stock of materials, drugs, food, and water	DMU meeting minutes Training records Stock observations	Multisectoral commitment exists for a functioning DMU
2. Disease surveillance system functional	Proportion of epidemics detected and successfully controlled	Disease surveillance system; DEHP reports	
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Conduct vulnerability study 1.2 Put in place a disaster management unit (DMU) 1.3 Maintain an emergency stock of essential drugs, materials and food 1.4 Equip emergency services in national referral hospitals and hospitals in high risk districts 1.5 Sensitise authorities and communities as to the risks of disasters, and to recognise the signs 1.6 Create a budget line for disaster relief in MoH annual budget and establish a bank account to finance disaster relief 1.7 Make an inventory of personnel to respond to emergencies 1.8 Put in place an intersectoral committee for the management of disasters 1.9 Carry out IEC campaigns at community level on the causes and prevention measures for epidemic diseases 1.10 Train members of rapid response teams 1.11 Inform population about and provide free treatment for epidemic cases 2.1 Assess disease notification system and propose mechanism of expansion of system to include all diseases of epidemic potential 2.2 Update and standardise tools to register and collect data on epidemics 2.3 Computerise surveillance system at health district level 2.4 Put in place a system of data analysis and feedback 2.5 Reinforce the capacity of investigation teams and health personnel in disease detection 2.6 Carry out operational research on the prevalence and risk factors of different transmissible diseases	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans

III.8.2 Maternal and Child Health, Integrated Management of Childhood Illnesses, Primary Health Care, Expanded Programme on Immunisation, and Reproductive Health

A. Integrated Management of Childhood Illnesses

Background and Problem Analysis

The Integrated Management of Childhood Illnesses aims to prevent, detect early and treat the leading childhood killer diseases. It is broad, cross-cutting approach which focuses on not only the treatment of childhood illnesses, but also prevention of illness through education on the importance of immunisation, micronutrient supplementation, and improved nutrition – especially breastfeeding and infant feeding.

The high rate of child mortality can be attributed to a number of main diseases, namely malaria, acute respiratory infections, HIV/AIDS, malnutrition, and diarrhoea. IMCI attempts to address directly the key underlying causes of child mortality and morbidity, that is: (i) the low skills of health professionals to manage and treat childhood illness within health facilities; (ii) inadequate health system support to health facilities in terms of equipment, drugs and transport and (iii) ignorance and poor practices within the family and community to ensure the prevention of illnesses.

Objective(s)

- To reduce child mortality and morbidity through an IMCI approach.
- To integrate school health into the IMCI approach to extend its reach and effectiveness.

National Targets by End of 2009:

- Increase the percentage of health districts implementing the IMCI approach from x% to y%.
- Increase the proportion of sick children checked for presence of cough, diarrhoea and fever from 34% to 60%.
- Increase the proportion of health facilities that have all pre-referral essential medicines for care of sick child from 67% to 95%.
- Increase the proportion of health facilities that have essential preventative and examination equipment for assessing a sick child from 12% to 50%.
- All schools included in annual health check and vaccination programme.

Implementation Arrangements

IMCI will seek to reduce childhood mortality and morbidity by improving family and community practices for the home management of illness, and improving case management of skills of health workers in the wider health system. At the national level, it will be important to coordinate the different disease programmes, community health worker programme and development partner activities to ensure effective implementation of the IMCI strategy. Health districts will be responsible for the planning, coordination and supervision of IMCI activities at their level.

A particular focus of the programme will be the inclusion of schools. Pupils will undergo yearly general health checkups, with particular focus on blindness related diseases and vaccination and refresher campaigns. Implementation will be planned in close cooperation between the Ministries of Health, Education and Local Government, and will be realised at decentralised levels.

Improving child health through the community is at the core of the IMCI strategy. Implementation at the community level will depend on the network of community health workers who will be trained over time in the 16 essential family and community practices grouped within the four categories: (i) physical and psycho-social development; (ii) disease prevention; (iii) essential care of childhood illnesses; and (iv) stimulating demand for health care. The CMWs will be provided with necessary equipment, drugs and materials, including ORT, anti-worming pills, anti-malarial drugs, impregnated mosquito nets, and vitamin A, to carry out their work.

Logical Framework

HSSP LOGFRAME: INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES (IMCI)			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Skills of health workers in IMCI improved	Number of health care providers trained in IMCI strategy	LIME report; Training reports	Technical expertise from partners continues to be provided
	% of sick children checked for presence of cough, diarrhoea and fever	Service Provision Assessment Survey	
	% of health districts with guidelines for monitoring IMCI activities	LIME report; Supervision reports	
2. Health system support to IMCI strengthened	% of health facilities that have essential preventative and examination equipment for assessing a sick child	Service Provision Assessment Survey	
	% of health facilities that have all pre-referral essential medicines for care of sick child	Service Provision Assessment Survey	
	% of schools participating in pupil health check and vaccination campaigns	Service Provision Assessment Survey; MINEDUC reporting	
3. Family and community practices improved	Number of health districts implementing community based IMCI strategy	LIME report	
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Train relevant health personnel in the implementation of IMCI at all levels 1.2 Produce and distribute training modules for IMCI 1.3 Integrate IMCI into the curricula of nursing schools 1.4 Develop monitoring and evaluation tool for IMCI activities 2.1 Provide health facilities with recommended drugs and consumables for IMCI 2.2 Provide districts and health facilities with transport and communications (ref: ICT) 2.3 Integrate IMCI campaign into school curriculum 3.1 Develop communication tools (flyers, posters, presentation packs etc) 3.2 Train community health workers and health personnel in essential family practices 3.3 Carry out formative supervision of community health workers 3.4 Provide community health workers with IMCI kits (ORT, anti-malaria drugs, mosquito nets...) and necessary materials (balance, registers...)	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans

B. Expanded Programme on Immunisation

Background and Problem Analysis

The Expanded Programme on Immunisation is a cost-effective way of improving child health and ensuring prevention against the eight vaccine avoidable diseases. The EPI in Rwanda is one of the most successful in Africa. In 2003, full vaccine coverage for children under one was over 80 percent, with little significant variation between provinces. There are, however, areas where improvements to the EPI can be made in an effort to further reduce child morbidity and mortality caused by measles, meningitis, tetanus and polio. Studies recently carried out show there are health districts where coverage remains inadequate and that the quality of immunisation services can be improved. Furthermore, there is poor epidemiological surveillance of those diseases targeted by the EPI, and there is a question mark over the financial sustainability of the programme over the medium to long term.

Objective(s):

To improve child health by reducing child morbidity and mortality caused by vaccine avoidable diseases.

National Targets by End of 2009:

- Ensure full vaccine coverage of children under one is over 85%.
- Maintain DPT3 vaccination coverage of children under one over 85%.
- Maintain measles vaccination coverage of children under one over 85%.
- Maintain the elimination of maternal and neonatal tetanus (rate of neonatal tetanus below 1 per 1,000 live births per year) and eradicate polio and measles.
- Work towards national vaccine independence by ensuring Government's share of the total EPI cost is at least 33 percent.

Implementation Arrangements

The EPI strategy will be implemented through existing structures and supported through multisectoral partnerships. At the national level, an Interagency Coordination Committee, made up of Ministry of Health delegates, donor agencies, and other stakeholders, plays a technical and advocacy role, guiding immunisation policy. A coordination unit will strengthen collaboration between different Ministry of Health departments as well as between other Ministerial departments who are implicated in the mobilisation of the community. Over the next five years, the EPI will focus on those hard to reach districts, with the aim of reaching those children not covered by the programme.

Health teams at the health district level are in charge of the coordination, strengthening of capacities, supervision and monitoring of activities. Vaccination activities at the health facility level are fully integrated into their routine services, as will be the provision of vitamin A supplementation for children and women in their first two months after delivery. These services are provided both within the facility and as outreach services for those hard to reach communities. When necessary, additional vaccination activities, such as campaigns and vaccination days, will be organised to reinforce routine services.

At the community level, the EPI will be supported by the network of community health workers, who will carry out sensitisation activities and active identification of those children not covered. They will work closely with administrative authorities and community leaders to ensure communities are mobilised in favour of the programme.

Logical Framework

HSSP LOGFRAME: EXPANDED PROGRAMME ON IMMUNISATION (EPI)			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Immunisation coverage maintained nationwide and increased in hard to reach districts	% of health districts with a DPT3 coverage rate of more than 80% % of one year old children immunised against measles % of children who have received three doses of DPT under age one	HMIS; EPI survey report Household surveys (DHS, MICS); HMIS; EPI survey report Household surveys (DHS, MICS); HMIS; EPI survey report	Financial sustainability of EPI is assured
2. High quality of service provided by EPI maintained	% of health care providers trained in immunisation % of providers using safe injection practices % of health facilities with functioning cold chain equipment % of health facilities with stock of all vaccines	District training reports WHO assessment tools – EPI tool; Sentinel site survey HMIS; Service Provision Assessment HMIS; Health district supervision reports; Service Provision Assessment	
3. System of surveillance and monitoring fully functional	% of health districts with an active surveillance system of measles, neonatal and maternal tetanus and acute paralysis	EPI programme report	
4. Share of Government financing for EPI increased	% of total EPI annual cost funded by Government	Annual Finance Law	
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Purchase and distribute vaccines and injection equipment 1.2 Carry out national immunisation campaigns, targeting those communities poorly served (hard to reach districts) 1.3 Provide outreach services to those communities poorly served 1.4 Carry out formative supervision at district level 1.5 Conduct a review of the EPI and reinforce monitoring system appropriately 1.6 Conduct a survey every two years to evaluate immunisation coverage 1.6 Sensitise administrative and political authorities and community leaders annually 1.8 Train community health workers 1.9 Carry out IEC campaigns targeting parents 1.10 Integrate the distribution of vitamin A into the EPI 2.1 Produce training and technical guidelines 2.2 Train EPI personnel at all levels 2.3 Construct incinerators at health facilities 2.4 Purchase, replace and repair cold chain equipment according to needs 2.5 Integrate the EPI into the curriculum of nursing schools 3.1 Train community health workers in active surveillance 3.2 Conduct investigations of cases of polio, neonatal tetanus and measles	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans

4.1 Develop and incorporate immunisation financial sustainability plan into MTEF 4.2 Organise national symposium on immunisation to advocate for FSP			

C. Reproductive Health

Background and Problem Analysis

In view of high maternal and under-five morality rates in Rwanda, this component of the HSSP is of the highest priority. The proportion of births assisted by a health professional is 31 percent and there is limited capacity to provide emergency obstetrical care, particularly in rural areas[24]. Family planning services are under-utilised and even though knowledge of modern methods of contraception is high (95 percent of women are aware of at least one method of contraception), the utilisation is extremely low (4 percent for women with a partner)[25]. With respect to the huge number of adolescents in the country, availability of reproductive health services is low and they are poorly adapted to their needs.

Based on an analysis of the major problems, the national reproductive health policy has identified the following six priority areas of focus: (i) safe motherhood and infant health; (ii) family planning; (iii) prevention and care of genital infections and HIV/AIDS/STI; (iv) adolescent reproductive health; (v) prevention and care of sexual violence; and (vi) social change for the empowerment of women. These priority areas correspond to the outputs of the reproductive health strategic plan, except for component three which is addressed in the HIV/AIDS/STI section. The national reproductive health policy should be referred to for a more detailed description of strategic interventions, priority actions and indicators for monitoring.

Objective(s)

To reduce the rate of morbidity and infant/maternal mortality by improving access to quality reproductive health care and promoting equality and equity between men and women

National Targets by End of 2009:

- To increase the utilisation of modern methods of contraception from 4% to 20%.
- To increase the proportion of deliveries attended by skilled health workers from 31% to 60%.
- To increase the proportion of pregnant women who receive at least three antenatal (ANC) visits from 43.5% to 65%.
- To increase the percentage of district hospitals who offer quality comprehensive essential obstetrical care from 29% to 60%.
- All health facilities offer health care to victims of sexual violence.

Implementation Arrangements

Implementation of the reproductive health strategy requires a multisectoral approach and a mechanism to coordinate all those intervening at every level. Furthermore, it requires an approach, which integrates the six priority components as specified above. Effective implementation of the reproductive health strategy is particularly reliant on a well functioning health system; that is a health system with well-qualified health professionals, good availability of drugs, transport for referral services, and affordable services to the majority of the population. Interventions should be based around the fundamental principles of the country, namely gender equality, and the respect for human rights.

At the national level, the Department of Health Care will guide policy development and oversee implementation as well as ensure activities are monitored and evaluated. It will work closely with other ministries, such as MINALOC, MIJESPOC, MIGEPROFE and MINEDUC to ensure the six priority areas of the reproductive health strategy are effectively implemented. The implementation of the strategy

will require an efficient monitoring and evaluation system, which feeds information regularly back and forth between the different levels of the system. Integration of reproductive health information needs into the HMIS will be sought.

At the health district level, district hospitals will be reinforced in order to improve the quality of emergency obstetrical care and a referral system will be expanded to ensure better access. Health centres, community health workers and the community will play a crucial role in promoting birth spacing and contraceptive use amongst women.

Logical Framework

HSSP LOGFRAME: REPRODUCTIVE HEALTH			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Maternal and infant health care in health facilities and in the community improved	% of health facilities offering basic (health centres) and comprehensive (district hospitals) obstetrical services	Service provision assessment survey; District supervision reports	Gender equality is progressively realised
	Proportion of births attended by skilled health personnel	HMIS; Demographic household survey; MICS	
	% of pregnant women who received at least two antenatal care (ANC) visits	HMIS; Demographic household survey; MICS	
	Proportion of deliveries taking place in a health facility	HMIS; Demographic household survey; MICS	
2. Utilisation of modern contraception methods, especially amongst women of reproductive age increased	% of FOSA offering modern family planning methods (temporary clinical methods of contraception)	Service provision assessment survey; District supervision reports	
	Contraception prevalence rate amongst women	Programme reports; Demographic household survey	
	% of health professionals trained in family planning	Training records	
3. Adolescent and reproductive health services improved	% of FOSA offering family planning services targeting adolescents	Service provision assessment survey; District supervision reports	
	% of FOSA offering HIV/AIDS counselling and VCT adapted to the needs of adolescents	Programme monitoring reports; Site visits	
4. Prevention and care of victims of sexual violence strengthened	% of health care providers trained in care of victims of sexual violence	Training records	
5. Gender equality in the utilisation of health care promoted	Number of IEC campaigns carried out		
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Provide health facilities with basic and/or comprehensive obstetrical medical equipment 1.2 Train health care providers in maternal and child health care, especially in obstetrical care and complications 1.3 Train and regular supervision of health staff and home birth attendants in pre-natal counselling 1.4 Procure home-birth kits 1.5 Sensitise community health workers, TBA, healers, teachers and community leaders 1.6 Increase number of midwives in rural districts 2.1 Distribute family planning products to all health facilities	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans
2.2 Update training tools for family planning training of health personnel			

2.3 Expand training in family planning to providers of health 2.4 Carry out an IEC campaign advocating use of modern methods of contraception 3.1 Integrate adolescent targeted reproductive health services into all health facilities, including distribution of condoms and contraceptives, and testing and treatment of STIs 3.2 Carry out IEC campaign targeting community leaders to promote adolescent reproductive health services 3.3 Integrate adolescent reproductive health into primary, secondary and high school curricula 4.1 Develop a protocol for the care of victims of sexual and domestic violence in collaboration with relevant institutions 4.2 Train health care providers in the care of victims of sexual violence 4.3 Elaborate tools and train TBAs in sexual violence care 5.1 Develop advocacy tools for gender mainstreaming in the community 5.2 Carry out IEC campaigns for behavioural change to mainstream gender equality in the community			

III.8.3 Nutrition

Background and Problem Analysis

Malnutrition is not only a major direct cause of death, particularly amongst children and women, but also an underlying cause of many other health problems in Rwanda. Underweight (weight for age) is widespread throughout the country, observed in 24% of children under five[26]. Malnutrition manifests itself in a number of ways, namely stunting (chronic malnutrition), emaciation (acute malnutrition), underweight, and micronutrient deficiencies. Vitamin A deficiency can cause nutritional blindness, and increases a child's susceptibility to infectious diseases, such as chronic diarrhoea and measles. Iron and iodine protect against infections and above all improve academic performance. The WHO recommends exclusive breastfeeding for the first six months of a child's life to ensure the child is not exposed to pathogens and an increased risk of disease.

Objective(s)

To reduce mortality and morbidity attributed to malnutrition.

National Targets by End of 2009:

- To reduce stunting amongst children under five from 43% to 35%.
- To reduce severe wasting amongst children under five from 7% to 3%.
- To reduce the proportion of underweight children under five from 24% to 18%.
- To increase the coverage of vitamin A supplementation for children 6-59 months from 69% to over 85%.
- To increase the proportion of pregnant mothers receiving iron supplementation from 16% to 60%.
- To reduce anaemia amongst children 0-59 months from 43% to 28%.
- To increase the proportion of mothers practicing exclusive breastfeeding at 6 months from 60% to 80%.
- To increase the proportion of households consuming iodised salt from 76% to 90%.

Implementation Arrangements

A multisectoral approach must be adopted in the implementation of the nutrition strategy given the nature of the causes of malnutrition. Stakeholders in other sectors will be implicated under the coordination of the Ministry of Health. At the national level, the Ministry of Health will guide policy, ensure multisectoral coordination, mobilise resources, develop technical protocols, define standards and monitor the implementation of the strategy down to district level.

At the district level, activities will be planned, coordinated and supervised by the district health team. Health facilities will provide nutrition services, and carry out supervision of the CHWs. Implementation in the community will be through local authorities and CHWs.

Logical Framework

HSSP LOGFRAME: NUTRITION			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Nutritional status of population, particularly children, pregnant women and PLWHA improved	% of districts implementing community based nutrition programme % of children 6 to 59 months who received one dose of vitamin A in past six months % of pregnant mothers receiving iron supplementation % of health care providers trained in severe malnutrition management % of children 0-36 months weighed at health facility and/or community based nutrition sites	Health district supervision reports Household surveys (DHS, MICS); HMIS; EPI survey report Training reports; Health district supervision reports; Service Provision Assessment survey Health centre reports; HMIS	Other sectors contribute towards improved nutritional status of population
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Distribute the protocol for the community nutrition programme 1.2 Train health professionals in severe malnutrition case management, good feeding practices and control of iron deficiencies 1.3 Train community health workers in community based nutrition 1.4 Provide community health workers with anthropometric and cooking materials 1.5 Evaluate the community based nutrition programme and develop mechanisms for extension 1.6 Finalise and distribute protocol to integrate community-based growth monitoring and promotion into IMCI programme 1.7 Develop and distribute protocol regarding care of patients with moderate and mild malnutrition at community level and referral of severe cases to higher level of care 1.8 Update and distribute the protocol regarding nutritional rehabilitation in health facilities 1.9 Develop and print IEC materials promoting breastfeeding 1.10 Define a national directive regarding infant feeding practices and for PLWHA and those on ARV drugs 1.11 Elaborate a new directive on female nutrition 1.12 Develop a national legislation regarding the commercial sale of breastfeeding milk substitutes 1.13 Purchase and distribute vitamin A supplements through EPI 1.14 Monitor vitamin A coverage 1.15 Elaborate and implement an anaemia strategy 1.16 Purchase and distribute micronutrient supplements (iron) 1.17 Carry out IEC activities about local food production and consumption 1.18 Promote use of iodised salt in households and schools	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans

III.8.4 Non-communicable Diseases

A. Mental Health

Background and Problem Analysis

Psychological trauma is a common phenomenon and a health problem for every society. However, Rwanda's particular history with respect to the 1994 genocide has greatly magnified the problem of mental trauma and places a huge burden on health services in the country. Trauma not only affects an individual but also has repercussions for society in general, affecting whole families and communities. Often genocide commemorations and the Gacaca process provide the catalyst for further mental trauma amongst people and represent an on-going challenge for both the community and health system. A UNICEF study carried out soon after the genocide revealed 80 percent of children had lost at least one family member, 90 percent had felt in danger of dying, and 95 percent had witnessed scenes of violence. No study as of yet has been conducted showing the extent of post-traumatic stress and the burden of mental disorders amongst the population. Anecdotal evidence from health facilities suggests that psychological distress is widespread and accounts for a significant number of consultations, particularly during the months of April and May.

In response to the large mental health burden, the Ministry of Health has recognized mental health as a component of the Essential Health Care Package. Due to the severe limitations of qualified professionals and in order to provide access to as many of the population as possible, the Mental Health Programme has begun the process of integrating mental health into the primary health care system but is challenged by the following:

- The Mental Health Policy (1996) is outdated and in need of review.
- Need for a strategic plan with activities and a budget, integrating mental health into primary health care.
- Lack of standards and guidelines for the management of common mental disorders at the three levels of care.
- No mental health services for children and adolescents.
- Lack of understanding of mental health problems in the population resulting in discrimination.

Objective(s)

The overall objective of the mental health programme is to promote mental health care for the entire population. Within this objective, the programme component intends to:

- Integrate mental health services into all health facilities of the health system
- Revise the Mental Health Policy and elaborate a comprehensive mental health strategic plan.
- Develop standards and guidelines for the integration of mental health into primary health care.
- Establish a mental health service for children.
- Strengthen intersectoral collaboration especially with MINEDUC, MIGEPROFE, and MINALOC and between Government and NGO sectors.
- Strengthen IEC with regards to mental health and promote community care of mental health problems.
- Revise the legislation regarding mental health.

Implementation Arrangements

At the national level, the mental health programme in the Ministry of Health, in collaboration with Ndera Mental Referral Hospital, will develop policy, coordinate actions and supervise implementation down to the health district level. It will oversee the integration of mental health services into primary health care, providing strategic guidance and setting standards for health facilities to adhere to.

The health district and health facilities will be responsible for carrying out mental health activities, including the sensitisation of the community to mental health problems and the provision of basic services.

Logical Framework

HSSP LOGFRAME: MENTAL HEALTH			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Quality mental health services that are accessible to the whole population through their integration into primary health care	Coverage of adequate mental health care services at primary level % of population with mental disorders attending at primary health care centres	Periodic Household and Welfare Surveys MOH supervision of health facilities Performance audits of health facilities by 3rd party	Political uncertainties and reprioritization within the MOH would not significantly undermine the implementation of the objectives. Other factors that influence the mental health status of the population
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Develop and disseminate a protocol, standards and guidelines for the integration of mental health into primary health care 1.2 Review the Mental Health Policy and develop a detailed Mental Health Strategic Plan 1.3 Establish a children's mental health service in health facilities 1.4 Put in place a mechanism for collaboration between the Ministry of Health, Ministry of Education, Ministry of Gender and the Ministry of Local Government and Social Affairs 1.5 Put in place coordination mechanism between the Ministry of Health and NGOs carrying out mental health and psychosocial support activities 1.6 Carry out IEC activities in relation to mental health and promoting the communities' abilities to provide support to people with mental disorders 1.7 Revise the Mental Health legislation 1.8 Integrate national mental health data collection, analysis, utilization and dissemination into HMIS 1.9 Train health personnel in mental health care 1.10 Provide essential mental health drugs 1.11 Supervise primary and secondary level health care workers	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans

B. Blindness and Physical Handicap

Background and Problem Analysis

Blindness is a public health problem in Rwanda. Based on WHO figures, it is estimated that 64,736 people are blind and a further 180,000 suffer from significant loss of vision. Of the total number of blind, it is thought 70 to 80 percent of cases are either avoidable or curable. The principle causes of blindness are cataracts (32,368), glaucoma (9,708), child blindness (404) and refraction defects (no data).

Physical handicap is estimated to affect 10 percent of the population. The causes of physical handicap in Rwanda tend to be of a traumatic nature, neurological, infectious, congenital or orthopaedic.

Objective(s)

To improve eye care for the population and provide services to prevent, treat, and assist the physically handicapped in order to allow them to (re) integrate themselves into society. Within this objective, the programme component intends to:

- Integrate health care services for the physically handicapped and blind into primary and secondary health care packages.
- Sensitise (radio, training, TV, community meeting, newspapers etc.) the population as to the causes of blindness and physical handicap.
- Treat and care for physical handicap cases.
- Treat blind disease related cases.

National Targets by End of 2009:

- Increase the health care services for the blind and the handicapped in health facilities from 0% to 50%.
- Increase the sensitisation campaign to population from 20% to 100%.
- Increase the treatment and care for the handicapped from 2 % to 20%.
- Increase the treatment for the blind from 3% to 60%.

Implementation Arrangements

The technical office within the Ministry of Health will coordinate implementation of the blindness and physical handicap strategic plan. It will be responsible for providing equipment and consumables for district hospitals and mobile units, elaborating treatment protocols, training, advocacy in the integration of services into the primary and secondary health packages, and supervising activities.

At the district and community level, district supervisors, health centre heads, health community workers, and community leaders will be implicated in the coordination and implementation of activities.

Logical Framework

HSSP LOGFRAME: BLINDNESS AND PHYSICAL HANDICAP			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Eye care services progressively integrated into primary and secondary health care packages	Number of health care providers trained in eye care % of health centres and district hospitals offering basic eye care % of health facilities with eye care equipment according to norms	Training records; Programme monitoring reports Site visits; Programme monitoring reports Procurement records; Inventory of equipment	
2. Health care services for physically handicapped progressively integrated into primary and secondary health care packages	Availability of norms for provision of physical handicapped services within primary and secondary health care packages % of health centres and district hospitals offering care for physically handicapped	Norms for physically handicapped DSS supervision reports	
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Develop standards for eye care services at health centre and district hospital levels 1.2 Train health professionals in eye care 1.3 Provide health facilities with relevant equipment and consumables for eye care 1.4 Establish a mobile eye clinic 1.5 Develop a protocol for treatment of glaucoma 1.6 Integrate data collection regarding ocular disease into the health information system 1.7 Set up a central buying and maintenance service of eye care equipment 1.8 Develop a strategy to provide socio-economic support to blind people 2.1 Carry out a study on the prevalence, type and degree of handicapped in the country 2.2 Define norms for provision of physical handicapped services within the primary and secondary health care packages 2.3 Train health professionals 2.4 Put in place central buying unit of equipment for physical handicapped 2.5 Put in place 'Community Based Readaption' initiatives 2.6 Develop treatment protocols for all causes of physical handicapped and establish pricing norms for these services 2.7 Supervise physical handicapped health care services 2.8 Set up a maintenance service for orthopaedic equipment 2.9 Develop a strategy for the provision of socio-economic support to physical handicapped persons	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans

III.8.5 Environmental Health

Background and Problem Analysis

Environmental health focuses on improving access to safe water and waste disposal as well as promoting behavioural change to improve family hygiene. Poor hygiene and other environmental factors, often linked to poverty, are important causes of disease in Rwanda. Diarrhoeal diseases account for 21 percent of child mortality and are one of the top ten causes of morbidity in health facilities[27]. Household surveys show that only 7 percent of the population have access to improved latrines, 41 percent of mothers wash their hands with soap after the toilet and only 41 percent of people have access to drinking water.

The high mortality and morbidity associated with environmental health related diseases are caused by a number of factors. There is no legal and institutional framework and capacity is low to enforce environmental health standards. Access to safe water and improved latrines is low, especially in rural areas. Sanitation conditions in shops, restaurants and public institutions are unsatisfactory and there is little understanding in the population of the potential health risks related to poor hygiene.

Objective(s)

To reduce mortality and morbidity linked to diseases caused by poor hygiene and other environmental factors

National Targets by End of 2009:

- Increase the proportion of households with access to drinking water from 41% to 75%.
- Increase the proportion of mothers who wash their hands with soap after the toilet from 41% to 75%.
- Increase the proportion of households with access to improved latrines from 7% to 30%.
- Public hygiene code developed and available.

Implementation Arrangements

The implementation of the environmental health strategy is particularly multisectoral in nature and is the responsibility of not just the Ministry of Health, but also MINITERE, MINAFRA, MINEDUC and MIJEPROF.

The role of the central level is to develop policy, coordinate, supervise and monitor activities. Decentralised entities are responsible for the execution of activities and providing feedback to the central level.

In addition to media (television, radio, and newspaper), sensitisation activities will use both the Participatory Hygiene and Sanitation Transformation (PHAST) approach, implemented at the community level and the Hygiene et Assainissement en Milieu Scolaire (HAMS) approach, which targets schools. The PHAST team at central level contains representatives from the Division of Public Hygiene (MoH), MINITERE, and MINALOC. There are also PHAST teams at the province and district levels. The HAMS team at the central level consists of representatives from Division of Public Hygiene (MoH), Division of Water and Sanitation (MINITERE), MINEDUC, and MINALOC. The process has started to put in place a HAMS team at both province and district level and in schools.

Operational research is based on the 'Methode Correcte de Lavage des Mains' (MCLM) and will be carried out by the Division of Public Hygiene in collaboration with KIST, local pottery makers and plastic manufacturers. The KAP study will be carried out nationwide to assess the impact of interventions on public hygiene in the community.

Logical Framework

HSSP LOGFRAME: ENVIRONMENTAL HEALTH			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Policy and capacity in environmental health strengthened	% of health care providers trained in environmental health Availability of public hygiene code	Training records; Health district supervision reports Public hygiene code	Collaboration with other environmental health enforcement agencies is strong
2. Hygiene quality of water and food improved	% of households with access to drinking water Proportion of districts carrying out water quality surveillance tests	MICS; Household living conditions survey	
3. Personal and community hygiene promoted	% of households with access to an improved latrine % of mothers who wash their hands before handling baby Number of PHAST training sessions carried out	MICS; Household living conditions survey MICS; KAP study Training records	
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Develop a national policy on environmental health 1.2 Develop and adopt an environmental health code 1.3 Support technical training schools in environmental health (KHI, College St Andre) 1.4 Provide in-service training for personnel 2.1 Put in place a water quality surveillance system 2.2 Put in place a food quality surveillance system 2.3 Train hygiene inspectors in the surveillance of water and food quality 2.4 Establish a protocol for handlers of food 2.5 Promote the use of water purification products 3.1 Train trainers on new participative approaches for behavioural change in the community and schools (HAMS) 3.2 Organise PHAST training sessions (participatory hygiene and sanitation transformation) 3.3 Carry out IEC activities to promote better hygiene practices using media including radio spots 3.4 Carry out a KAP (knowledge, attitude and practices) study in environmental health 3.5 Prepare guides, directive and tools to monitor for health inspections 3.6 Make an inventory of all public and private establishments	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans

3.7 Make regular inspections of all establishments 3.8 Supervise health inspectors at all levels 3.9 Carry out operational research in environmental health (latrines, methods of handwashing, waste management)			

III.8.6 Information, Education and Communication (IEC)

Background and Problem Analysis

IEC activities are used to promote behavioural change and common practices, known to improve the health status of the population. An analysis of the problems reveals a number of key findings. There is insufficient information available to the public due to a lack of tools and effective interventions (posters, leaflets etc.). There are cultural, religious, social, gender, economic and geographic barriers to social change, which limit the impact of IEC messages. Coordination of resources and activities is poor, leading to coverage gaps in IEC. Finally, there is a lack of community interventions, where such messages are most effective when suitably designed in promoting behavioural change.

Objective(s)

To promote behavioural change in the population that is favourable to the health of the population through intersectoral collaboration and community participation. Within the overall objective of IEC, the programme component intends to:

- Promote the notion of excellence and set standards in the design and delivery of IEC messages amongst those responsible for health programmes.
- Reinforce the communication skills of service provider health workers.
- Promote the use of family targeted IEC messaging.
- Implicate the community in communication activities.

Implementation Arrangements

An effective coordination structure will be put in place to overlook the implementation of the IEC strategy. This structure will compose of a:

- Multisectoral technical group at the national level (exists)
- Health Education Division within the Ministry of Health (exists)
- Committee to mobilise IEC at district level
- Management Committee at the health centre level
- Community representatives within the administrative district.

At the national level, the multisectoral technical group will develop policy, mobilise resources, and propose legal texts to regulate IEC activities. The Health Education Division will assume role of coordinator of all IEC activities in the health sector. It will develop strategic plans for IEC intervention at the programme level, provide technical support in the development of IEC messages at the provincial and district level, develop standards, monitor and supervise activities and advocate for IEC.

At the district level, a committee will be put in place to develop operational plans for IEC, ensure the monitoring of IEC activities at the health facility level, mobilise community participation, and coordinate IEC activities in their health district. At the health centre and community level, IEC activities will be carried out by health professionals and community health workers based on the needs and problems of the community and households.

Logical Framework

HSSP LOGFRAME: INFORMATION, EDUCATION AND COMMUNICATION (IEC)			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. IEC / BCC programme strengthened at all levels	Availability of guidelines for developing IEC/BCC messages Availability of IEC/BCC materials at programmatic and district level Number of trainers trained in IEC/BCC Number of community health workers reached through distance training radio broadcasts	IEC/BCC guidelines EPS division report Training reports, EPS division report EPS division monitoring report	Cultural factors do not impede behavioural change
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Develop and implement an operational plan integrating IEC / BCC activities of all programme areas of health sector 1.2 Update and distribute guidelines for developing IEC / BCC messages 1.3 Develop and distribute a summarised national IEC / BCC policy and strategic plan to local authorities and community leaders 1.4 Facilitate the participation of journalists in national and regional health issues 1.5 Train teams of trainers in development of IEC / BCC messages at district level 1.6 Develop a communication reference guide with an emphasis on counselling and interpersonal communication for health care providers 1.7 Develop and broadcast distance training by radio for health community workers 1.8 Produce IEC / BCC materials for health community workers in accordance with integrated operational plan 1.9 Organise thematic open days and sensitisation campaigns targeting families 1.10 Mobilise community based organisations to carry out gender responsive IEC / BCC activities, targeting in particular women associations, religious groups and teacher associations	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans

III.9 National Referral Hospitals and Treatment and Research Centres

Background and Problem Analysis

National referral hospitals and treatment centres form the pinnacle of medical care in Rwanda. To date, capacity constraints have made it necessary to refer cases to medical institutions abroad. This situation presents a financial burden for the health system without contributing to the capacity for medical care in the country. Thus, the health sector needs to strengthen national referral hospitals for the benefit of the wellbeing of the population and of capacity in the health system.

In the field of diseases with high morbidity and mortality, emerging resistance poses a challenge to health sector policy that can only be addressed with local clinical research. The capacity for this research is currently not available.

Objective(s)

To strengthen the national referral hospitals and specialised treatment and research centres. Within the overall objective, the aim is to:

- Achieve significant progress towards national self-sufficiency in the field of secondary medical care.
- Invigorate the medical sector through the creation of two centres of excellence in Butare and Kigali with complementary areas of specialisation.
- Strengthen the skill base in the Rwandan medical sector through the education of specialised medical personnel.
- Formulate strategies and policies for the development of further areas of specialisation in Rwanda.
- Develop a policy framework for clinical research on high morbidity and mortality diseases and to increase research capacities.

National Targets by End of 2009:

- Decrease in number of internationally referred cases to 50% of 2004 level
- Education of x specialised medical doctors per year in the current areas of specialisation
- y clinical researchers active in treatment centres, researching high morbidity and mortality diseases

Implementation Arrangements

Development and implementation of policy regarding the National Referral Hospitals will be coordinated by the Department of Health Care in close cooperation with the hospitals. Policy will be guided by the Millennium Development Goals in general and the goal for self-sufficiency and sector specialisation needs in particular.

In the area of clinical research into diseases with high morbidity and mortality, the Directorate of Epidemiology will formulate policy and strategies in close cooperation with the Department of Health Care and treatment centres. Under the principles of the Sector Wide Approach, policy and goals will be formulated in close cooperation with donors and other stakeholders in the Health Sector.

III.10 Institutional Capacity

Background and Problem Analysis

Institutional capacity refers to three broad areas of action: (i) planning, management and supervision; (ii) ICT and research and (iii) training. The institutional capacity programme has important implications for the advancement of the SWAp process and the capacity of the health sector to absorb funds. An analysis of the problems and their causes in strengthening institutional capacity reveals a number of findings. First, planning, supervision and monitoring is under prioritised within the Ministry hence there is little in-depth analysis of past performance and weak links between planned / budgeted activities and policy objectives. This situation is further accentuated at decentralised levels. Moreover, there has been little progress by the Ministry in moving the health sector towards a more results orientated way of working, which includes MTEF monitoring of outputs and expenditures. Second, health information is under utilised since the national referral hospitals and the private sector remain outside of the system and capacity to carry out meaningful analysis of data is low. Third, management and public health skills of staff are woefully low.

Objective(s)

The overall objective of the programme is to strengthen the institutional capacity of the health sector in planning, management, monitoring and evaluation. In order to work towards this objective, this programme expects to:

- Strengthen linkages between planning and budget preparation to ensure budget allocations of both Government and donors are based on health sector objectives and a thorough analysis of the situation.
- Firmly institutionalise MTEF monitoring of outputs and expenditures, firstly at central level then at province level.
- Reinforce and advance the decentralisation process through the disbursement of block grants to decentralised entities of the health system.
- Expand performance based contracting schemes from the pilot stage to include Government funding.
- Strengthen and utilise better the health management information system.
- Develop the use of ICT to support the health system and training of health personnel.
- Increase the number of those trained in management skills and public health.

While capacity building activities under the six programmes described above focused on specific technical areas, activities under the current programme lay the ground for strengthening accountability and transparency in the heath sector. Institutional arrangements of health services will be reformed for a better articulation of the health sector organization to the institutional environment put in place by administrative decentralization reforms, and to increase the responsiveness of health services to the population. Resource allocation mechanisms will be reformed towards greater responsibility of decentralized administrative entities and proximity to specific local needs, alignment of resource allocation with performance in the production of high impact services to improve efficiency in public expenditures, and targeting the poor.

These institutional reforms will contribute to strengthening incentives and management in the health system in line with priorities identified in the PRSP and will reinforce the contribution of the health sector to poverty reduction. They will place greater demands, however, on the information, planning and

monitoring systems: hence, the efforts to strengthen the health management information system at all levels of the health system. These capacity strengthening efforts will be reinforced with the mainstreaming of the development and use of ICT in the health sector.

Implementation Arrangements

At the national level, the Department of Planning will be responsible for policy development, decentralisation and guiding the SWAp process. It will, in collaboration with the Department for Human Resources and Support Services, ensure policy objectives are translated into a coherent medium term expenditure programme for the sector. And in order to put into operation a comprehensive sector planning process, the Department of Planning will also support and reinforce capacity at the health district level through regional planning workshops and training sessions. Performance based contracting schemes will be overseen and monitored by the Department of Health Care to ensure contracts are adhered to by all parties.

The division contained within the Department of Planning will coordinate health information activities. It will be responsible for the analysis of health data, publishing quarterly bulletins, managing and integrating the private sector and national referral hospitals into the system. Skills development in public health, management and accounting will be coordinated by the Department for Human Resources and Support Services in collaboration with the School of Public Health and the government capacity building project.

Improved accountability of service providers to their communities will be encouraged through the introduction of citizen report cards and the reinforcement of community participation in health centre management committees.

Logical Framework

HSSP LOGFRAME: INSTITUTIONAL CAPACITY			
Output	Objectively Verifiable Indicator	Means of Verification	Assumptions
1. Health planning, management and supervision reinforced at central and district levels	Number of decentralised units receiving funds according to new allocation formula	Annual finance law; MTEF	National decentralisation policy is implemented effectively
	Utilisation of new MTEF tool	MTEF delivered to MINECOFIN on time	Human capacity is redeployed to decentralised levels
	% of total budget transferred to decentralised units as block grants	Calculated from annual finance law	
	Number of performance based payment schemes in operation	DSS monitoring report	
	% of health facilities with management autonomy	HMIS; Service provision assessment survey; Site visits; Health committee minutes	
	% of health districts with annual operational plans	DP workshop reports	
2. ICT development plan revised and implemented	Number of health facilities with operational telemedicine	Inventory records	
	% of health facilities with means of communications	Facility based surveys	
3. Health management information system fully functional in public and private sectors	% of monthly health facility reports returned to central level on time	HMIS quarterly bulletin	
	Availability to all stakeholders of quarterly HMIS bulletin	HMIS	
	Availability of data and analysis of private sector and national referral hospitals	HMIS quarterly bulletin	

4. Health personnel are trained in public health, accountancy and management skills	Number of staff trained in public health		
Activities	Objectively Verifiable Indicator	Means of Verification	Assumptions
1.1 Develop results oriented MTEF, ensuring linkages with planning, costing, monitoring tools & annual budget and integrating results of simulations from planning and costing tool (Marginal Budgeting for Bottlenecks) in 2005 budget 1.2 Publish decree clarifying roles and responsibilities of health centres in the autonomous management of facilities, and develop new accountability and voice mechanisms for the poor 1.3 Develop a decentralization plan for the health sector, including appropriations and transfer mechanisms & an allocation formula for providing funds to districts 1.4 Reform budget by increasing block grants to decentralised units (provinces and municipalities) 1.5 Design and implement performance based payment contracting schemes for high impact services (e.g. immunisation, assisted deliveries) with government funding including monitoring of contracts 1.6 Transfer hospital and health centres to corresponding decentralized authority including physical assets, operational responsibilities, including human resource responsibilities. 1.7 Develop accreditation & purchasing mechanisms for provision of hospital package 1.8 Strengthen capacity of districts to develop proposals to access funds from the Community Development Fund for health projects 1.9 Institutionalise planning at national and decentralised levels through annual joint sector planning and review missions and district workshops 1.10 Develop annual operational plans at all levels in health system 1.11 Implement MTEF financial and output monitoring at central and province level on a quarterly basis and disseminate reports 1.12 Carry out a Public Expenditure Tracking Survey periodically 2.1 Develop an ICT policy statement 2.2 Develop and implement a 5-year IT plan 2.3 Introduce a telemedicine system at district hospital level 2.4 Pilot continuing medical education using the resource of telemedicine 2.5 Implement a basic computing and internet usage training from directors down 2.6 Connect the Ministry of Health to Gov-net	Detailed OVIs to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed means of verification to be determined by programmes, provinces, districts and stakeholders in their operational plans	Detailed assumptions to be determined by programmes, provinces, districts and stakeholders in their operational plans

2.7 Develop a Ministry of Health website linked to GOR website with online document centre included 2.8 Develop the national nutrition and epidemic surveillance information system 2.9 Install a wide area network (WAN) linking health facilities and health districts nationwide 3.1 Conduct an assessment of the data needs of Ministry of Health programmes and districts 3.2 Integrate recommendations of assessment into HMIS by updating data collection tools and computer systems 3.3 Produce and distribute data collection tools at all levels 3.4 Publish quarterly HMIS bulletin for all stakeholders and as feedback down to districts 3.5 Carry out formative supervision of HMIS at all levels 3.6 Train selected personnel in analysis of health data at central and provincial level 3.7 Put in place a dynamic mapping of health information 3.8 Develop data collection tools to integrate private sector and national referral hospitals into HMIS 3.9 Train personnel in national referral hospitals and private sector for integration into HMIS 4.1 Train relevant MINISANTE staff in management, basic accountancy and public health			

IV. IMPLEMENTATION OF THE HSSP

IV.1 Roles of Different Actors

The implementation and on-going revision of the HSSP is the joint responsibility of Government and stakeholders. The Ministry of Health is responsible for defining policy, setting standards, regulating, training down to district level and monitoring activities in the sector. Tertiary level health care also falls under the remit of the Ministry of Health, who is responsible for appointing the management of the national referral hospitals. Activities that fall under the Ministry of Health are implemented through the MTEF of the MoH.

The delivery of primary and secondary health care services is the responsibility of the province and health district. The administration and management of district hospitals and health centres is responsive to the demands of the community through their active participation in health facility board and committee meetings.

The private sector is playing an increasingly important role in the delivery of health services in the country and the Government will continue to promote the expansion of the sector, seeking to build private-public partnerships particularly in areas where there are no Government services.

IV.2 Sector Wide Approach

The Health Sector Strategic Plan is to be implemented under a sector-wide approach, which, in its infancy, continues to be developed based on principles of partnership and collaboration and the common goal of achieving sustained improvements in health. Stakeholders are expected to contribute only within the framework of the HSSP, whereby all significant funding for the sector will support the Health Sector Policy, HSSP and associated expenditure programme. MINISANTE, designated as lead ministry for health sector development, will guide the SWAp process in close partnership with all other stakeholders. As government systems are strengthened, programmes will progress towards relying on government procedures to disburse and account for all funds.

Commitment and support of development partners to the Government's strategy of pursuing a health SWAp has been positive. Joint responsibilities and commitments between MINISANTE and all stakeholders will be formalised in the Code of Conduct and Memorandum of Understanding, which are at present in the drafting stage of preparation[28]. Common working arrangements will be sought and agreed upon concerning planning and review, procurement, public expenditure management, auditing, monitoring and evaluation and disbursement procedures.

The Ministry of Health, in line with the policy of the Government of Rwanda, encourages stakeholders to support the HSSP through general or sector budget support, whilst mindful of the fact that for such a shift to occur, it must put in place robust and transparent systems. Equally, the Ministry of Health recognises the preferences and agendas of stakeholders to use different aid modalities and continues to remain open to the means by which its partners support the sector.

IV.3 Coordination and Management

The HSSP provides a comprehensive framework for support to the sector, but is not sufficient alone to guarantee a coordinated approach to health sector development. The composition of stakeholders in the health sector is complex; there is a diverse range of partners who provide support in many different forms. Such an environment necessitates the need for aid coordination, which is deemed critical for the successful implementation of the HSSP. Effective coordination is expected to address the following issues:

- Lack of common monitoring, review and evaluation systems;
- Numerous and parallel systems of accounting, procurement and management;
- Duplication of efforts;
- Inappropriately designed, uncoordinated projects;
- High transaction costs associated with individual one-on-one negotiations and consultations between government and partners;
- Lack of information flows between government and partners.

Aid coordination and management of the SWAp process in general will be institutionalised at the national level through a number of committees that fulfil different and clearly established roles. Figure 4 shows the composition and role of the committees and their functional relations.

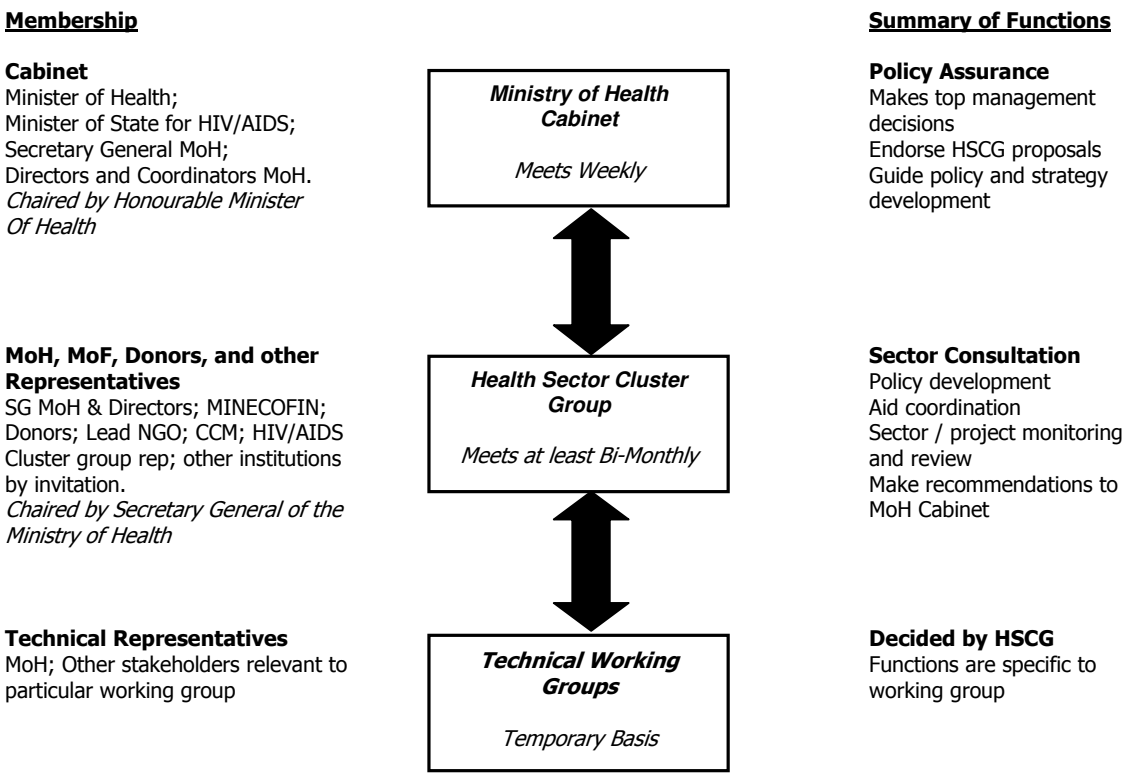
IV.4 Operational Plans

Within the decentralised environment that the health system is progressively moving towards, it is deemed inappropriate to develop a detailed five-year operational plan for the HSSP. Instead, the HSSP will be implemented through operational plans developed annually by MINISANTE and district health offices as part of three year rolling plans within the structure of the MTEF. The HSSP provides the overall framework upon which the operational plans will be based and health districts will receive technical support as needed from the central level in the elaboration of these plans. Annual operational plans will respect the budget cycle timetable and be produced in time to inform the following year's activities.

Between different districts, health needs and priorities differ and so it is entirely appropriate that the development of operational plans is institutionalised at decentralised levels for the identification of priorities, which are district specific.

Operational plans will show detailed activities and a schedule of when and by whom they will be carried, logically linked to each output. Each activity will specify a budget, based upon a calculation of required inputs. In this way, the activities of all actors at decentralised levels will be consistent with the overall strategic direction of the HSSP and ensure all components of the health system work towards the same objectives and goals.

Figure 4. SWAp Coordination Structure



There will be a number of technical working groups, some permanent and others created on a temporary basis to fulfil a specific role. The purpose, representation and function of the working groups will need to be decided in consultation with health sector stakeholders. A proposal for the structure of sub-sector working groups could be the first item on the agenda of the Health Sector Cluster Group.

It is also recommended that a separate committee of development partners be created, chaired by the lead donor, so that there exists a single coherent channel of communication between Government and development partners.

V. COST AND FINANCING THE HEALTH SECTOR STRATEGIC PLAN

V.1 Cost of the HSSP

V.1.1 Methodology

The costing framework shows the implementation cost of the HSSP and indicates resource needs and allocations across the seven different programmes for each year of the plan. The costing of the HSSP is based heavily upon the health MDGs, to which the Government of Rwanda is committed. Basically, the costing framework tells us how much money is required to attain the MDGs (more precisely the progress towards the 2015 goals) and the other national 'coverage' targets contained within the HSSP by the end of 2009. The tool, used to develop the costing framework, estimates the marginal cost of overcoming constraints within the health system and links this explicitly to the health MDGs, such as reduction in child and maternal mortality[29].

The costing and budgeting tool considers the marginal costs for overcoming gaps in access to packages of health services, human resource bottlenecks for implementation of packages, logistics bottlenecks, barriers to utilisation and demand stimulation, and bottlenecks relating to technical and organisational quality of packages in order to reach the MDGs. The costing exercise uses country specific unit costs for hundreds of line items, which are aggregated appropriately to estimate the cost of delivering certain health services that have been proven to have a given impact on the health MDGs (see Appendix II for a list of these health interventions). The cost items are categorised according to the following: human resources (remuneration and training); travel costs and incentives; commodities; drugs and supplies; buildings, equipment and facility running costs; demand stimulation; performance incentives; IEC outreach; subsidies; and monitoring.

The costs derived from the costing and budgeting tool represent the extra amount of money, additional to current levels of expenditure, required to reach the national targets specified in the HSSP. In order to calculate total annual costs for the implementation of the HSSP, these marginal costs must be added to the base level of health sector expenditure in the year zero. The base level of health sector expenditure has been extrapolated using results from the National Health Accounts 2002, and other reports on donor financing in the health sector.

Specific total costs (base value and marginal value) are then assigned to one of the seven health sector programmes according to which programme goal they contribute towards. For example, the cost of constructing a health centre will be found in programme 3 because it directly contributes towards improving geographical accessibility to health services. Assumptions have been made regarding the rates of inflation, salary increases, currency exchange rates and population growth to improve the validity of estimates.

The costing framework of the HSSP does not cost activities in the private-for-profit and traditional sectors of the health system. The HSSP is concerned only with activities in the public and 'agrée' Government assisted not-for-profit sectors.

V.1.2 Cost Projections

Table V.1 shows the breakdown of cost projections by programme according to the level of implementation for each year of the HSSP. Costs are presented by programme to be consistent with the policy objectives of the health sector and the structure of the HSSP. As already emphasised, this cost framework is explicitly linked and based on the attainment of national targets of the HSSP. Refer to Appendix for more detailed cost projections.

Table V.1 Programme Resource Allocations in terms of Cost Projections for the HSSP over the Period 2005 – 2009 (RWF x 1 million)

PROGRAMME	2005	2006	2007	2008	2009
Programme I: Availability of human resources	**5,478**	**5,754**	**6,199**	**6,385**	**6,581**
Primary	*1,331*	*1,460*	*1,729*	*1,816*	*1,908*
Secondary	*2,032*	*2,119*	*2,234*	*2,270*	*2,308*
Administration	*2,115*	*2,174*	*2,236*	*2,300*	*2,365*
Programme II: Availability of drugs, vaccines & consumables	**39,425**	**51,212**	**58,783**	**59,716**	**60,833**
Primary	*36,003*	*47,524*	*51,293*	*52,010*	*52,900*
Secondary	*3,305*	*3,569*	*7,372*	*7,588*	*7,814*
Administration	*118*	*118*	*118*	*118*	*118*
Programme III: Geographical accessibility	**4,124**	**4,606**	**6,034**	**6,259**	**6,497**
Primary	*2,027*	*2,133*	*3,491*	*3,611*	*3,738*
Secondary	*2,059*	*2,434*	*2,503*	*2,607*	*2,717*
Administration	*39*	*39*	*40*	*41*	*42*
Programme IV: Financial accessibility	**10,064**	**9,156**	**12,687**	**13,045**	**13,421**
Primary	*4,159*	*3,602*	*5,025*	*5,156*	*5,294*
Secondary	*5,874*	*5,523*	*7,632*	*7,858*	*8,097*
Administration	*31*	*31*	*31*	*31*	*31*
Programme V: Quality of & demand for services in the control of disease	**5,255**	**6,038**	**6,739**	**6,883**	**7,036**
Primary	*3,649*	*4,411*	*5,064*	*5,204*	*5,352*
Secondary	*986*	*1,006*	*1,055*	*1,059*	*1,063*
Administration	*620*	*620*	*620*	*620*	*620*
Programme VI: Strengthening of national referral hospitals & specialised treatment centres	**7,017**	**7,097**	**7,178**	**7,262**	**7,348**
Tertiary	*6,431*	*6,511*	*6,592*	*6,676*	*6,762*
Administration	*586*	*586*	*586*	*586*	*586*
Programme VII: Strengthening of institutional capacity	**1,531**	**1,534**	**1,543**	**1,548**	**1,553**
Primary	*18*	*22*	*31*	*35*	*40*
Secondary	*55*	*55*	*54*	*55*	*56*
Administration	*1,458*	*1,458*	*1,458*	*1,458*	*1,458*
TOTAL PROJECTED COSTS	**72,895**	**85,396**	**99,164**	**101,099**	**103,269**
USD$ per Capita	**$13.6**	**$15.1**	**$16.5**	**$15.9**	**$15.3**

The HSSP envisages an increase in nominal health sector expenditure from 72,895 million RWF ($13.6 per capita) in 2005 to 103,269 million RWF ($15.3 per capita) in 2009. Whilst these funding requirements are large, the MDGs will not be reached without such resources being available in accordance with these programme allocations. The resource allocations by level reflect the prioritisation to be given to primary health care[30].

Table V.2 Financial Cost Projections of the HSSP for the Period 2005 – 2009 (RWF x 1 million)

CATEGORY	2005	2006	2007	2008	2009	Total
Total Projected Recurrent Costs	**65,963**	**78,141**	**90,642**	**92,447**	**94,480**	**421,674**
of which						
Salaries, Benefits & Allowances	*7,603*	*7,930*	*8,443*	*8,708*	*8,985*	*41,669*
Drugs, Vaccines & Consumables	*38,778*	*50,545*	*58,096*	*59,017*	*60,122*	*266,558*
Insurance Subsidies for Drugs and Services	*10,033*	*9,125*	*12,656*	*13,014*	*13,390*	*58,219*
Other Recurrent Expenditures	*9,549*	*10,541*	*11,447*	*11,708*	*11,983*	*55,228*
Total Projected Capital Costs	**6,931**	**7,255**	**8,522**	**8,652**	**8,789**	**40,149**
of which						
Construction, Rehabilitation & Equipment	*4,227*	*4,349*	*5,545*	*5,646*	*5,752*	*25,519*
Basic Training	*567*	*594*	*608*	*613*	*618*	*3,000*
Other Capital Costs	*2,137*	*2,312*	*2,368*	*2,393*	*2,419*	*11,630*
TOTAL PROJECTED COSTS	**72,895**	**85,396**	**99,164**	**101,099**	**103,269**	**461,823**

Table V.2 shows that the total cost of implementing the HSSP is 461,823 million RWF, comprising 421,674 million RWF in recurrent costs and 40,149 million RWF in capital costs. It is clear the largest cost category is drugs, vaccines and consumables, which is projected to rise from 38,778 million RWF in 2005 to 60,122 million RWF in 2009. Anti-retroviral combination treatment for patients with AIDS accounts for the huge majority of this cost.

V.2 Financing the HSSP

V.2.1 Introduction

The financing framework is an integral part of the HSSP as it shows to what extent the projected cost will be funded and by whom. Health sector financing is complex due to the large number of different actors working within the sector and the different types of financing. A detailed analysis of financial flows in the health sector in Rwanda has informed the HSSP by providing a complete accounting picture of all health spending in terms of its origin, destination, and object.

The financing framework considers funds from three broad categories of financing sources in the health sector. It includes public funds, private funds, and external funds from abroad (rest of the world). In Rwanda, public sources include only central government revenue although in the future regional government revenue will also finance health services. Private

financial sources can be further divided into parastatal employer funds, private employer funds and private households.

Funds flow from these financing sources to a number of different providers of health care, classified accordingly: national referral hospitals, the mental health hospital, health district hospitals, private practices, health centres (public and agrée), blood banks, dispensing chemists, provision and administration of public health programmes, and general health administration and insurance.

As with the costing framework, the HSSP does not include projected financing for private for-profit practitioners and traditional health care providers. The cost and financing framework only considers funds to the public and 'agrée' Government assisted not-for-profit sectors from the three financing sources.

V.2.2 Projected Funding

The financing framework, shown in table V.3, gives an unconstrained or 'optimistic' scenario for the projected resources available to finance the HSSP. It shows the likely sources of funds available and the financing gap when compared against the total projected cost. The unconstrained scenario is considered the realistic scenario and makes a number of key assumptions, which are outlined in the notes following the table.

A constrained scenario has been developed as an alternative and is shown in appendix I. This scenario uses less optimistic assumptions to calculate the total funds coming from Government, donors and private sources.

Due to the uncertainty in funding, especially that from donors, these figures should be regarded as indicative only. Furthermore, it is unclear how much of the contribution through donor / NGO projects will actually support the HSSP. Whilst it is hoped all donor projects align themselves to the HSSP, it is uncertain to what extent they will directly finance the priorities of the HSSP owing to the more autonomous nature of projects. However, as donor financing is harmonised within the SWAp process, either through better designed projects or increased budget support, the greater the degree to which donor financing will offset the cost of the HSSP.

It should also be noted that the global figures in table V.3 are likely to hide disparities in resource allocations between the different programmes. Even if the total funds available match the total projected cost, it is unlikely that resource allocation will be perfect. Financing gaps at the programmatic level will exist and they will need to be resolved as the SWAp process advances through an improved analysis of external and Government funding. In the current situation, where the huge majority of health sector funding is planned for HIV/AIDS, the need for better targeted resource allocation to improve the functioning of the whole health system, is of the highest priority.

Table V.3 Unconstrained HSSP Financing Scenario (RWF x 1 million)

Projected HSSP Resources	2005	%	2006	%	2007	%	2008	%	2009	%
1. Government MTEF	**12,952**	**15**	**15,551**	**17**	**18,737**	**20**	**23,403**	**24**	**28,045**	**26**
MINISANTE	9,792		11,922		14,506		18,315		22,105	
Provincial Health Office	2,153		2,602		3,183		4,019		4,850	
Other Govt Health Expenditure	1,007		1,027		1,048		1,068		1,090	
2. Private Source Expenditures	**8,710**	**10**	**9,144**	**10**	**9,600**	**10**	**10,081**	**10**	**10,588**	**10**
Private Households	7,264		7,618		7,990		8,381		8,792	
Private Employers	867		929		996		1,068		1,145	
Parastatals	579		596		614		633		652	
3. Donors	**66,078**	**75**	**66,582**	**73**	**63,861**	**69**	**65,847**	**66**	**67,933**	**64**
Total Resources Available	**87,740**		**91,277**		**92,198**		**99,331**		**106,566**	
Total Projected Cost	**72,895**		**85,396**		**99,164**		**101,099**		**103,269**	
Financing Gap	**14,845**		**5,881**		**-6,965**		**-1,768**		**3,297**	

Notes:

1. *Real GDP will grow at 6% over the duration of the HSSP.*
2. *Government health expenditure as a proportion of total Government expenditure will rise from 7.7% in 2005 to 12% in 2009.*
3. *All donor funds for health will finance the HSSP.*
4. *Expenditure by private employers on health will increase by 8% per annum.*
5. *Inflation will increase by 4% per annum on average.*
6. *Donor projections are based on data collected through a survey on donor organisations.*
7. *Financing from faith-based organisations is not available although considered significant in Rwanda.*
8. *Other Government health expenditures include money spent by other Ministries on health services through RAMA and Rwanda's Social Security Fund.*
9. *Expenditure by private households is either out-of-pocket, through mutuelle health insurance, RAMA or Rwanda's Social Security Fund.*

V.3 Financial Overview

If the HSSP is be successfully implemented, the available resources should be sufficient to finance the projected cost of the plan. Table V.4 gives a financial overview, showing projected costs, available resources, and the resulting financing gap. It shows that resources in 2005 and 2006 are sufficient to meet the estimated cost of implementation. In years 2007 and 2008 there is a financing gap and additional funds to those projected will have to be raised to finance the strategic plan.

Table V.4 Financial Overview of the HSSP (RWF x 1 million)

CATEGORY	2005	2006	2007	2008	2009
Projected Cost	**72,895**	**85,396**	**99,164**	**101,099**	**103,269**
Recurrent	65,963	78,141	90,642	92,447	94,480
Capital	6,931	7,255	8,522	8,652	8,789
Available Resources	**87,740**	**91,277**	**92,198**	**99,331**	**106,566**
Government MTEF	12,952	15,551	18,737	23,403	28,045
of which Domestic	*9,973*	*11,975*	*14,427*	*18,020*	*21,594*
of which Budget Support	*2,979*	*3,577*	*4,309*	*5,383*	*6,450*
Private Sources	8,710	9,144	9,600	10,081	10,588
Donor Projects	66,078	66,582	63,861	65,847	67,933
Financing Gap	**14,845**	**5,881**	**-6,965**	**-1,768**	**3,297**

Note: *A negative financing gap means available resources are insufficient to meet the projected cost.*

VI. HEALTH SECTOR MONITORING AND EVALUATION

VI.1 Monitoring and Review Mechanisms

A monitoring, review and evaluation framework is an integral part of the HSSP as it provides the basis for measuring progress in relation to targets both during and after implementation. It addresses the need for accountability and ensures decision makers have the information at their disposal to reflect on and analyse performance so that they build lessons into future plans. As stakeholders increasingly use these health sector performance indicators to measure the returns on their investment, the requirement to put robust monitoring, review and evaluation mechanisms in place becomes all the more pressing.

An agreed upon set of annual and periodic indicators have been developed in partnership with development partners which will be used to monitor sector performance at both the national and health district level. Health districts will be encouraged to define more precisely their own set of SMART[31] indicators, using the same framework presented in the HSSP in recognition of the fact that information needs vary at different levels of the system.

The set of indicators defined in section VI.3 is a selection of the most important indicators for measuring the HSSP, integrating also the poverty reduction strategy indicators into the framework. It is inclusive of some of the most important indicators specified within the logframes, which aim to measure progress towards the attainment of the outputs. Such a set of indicators cannot measure all aspects of service delivery and support in such a complex sector. Instead core indicators have been chosen to cover the main areas of the health sector on the basis that they are valid, reliable, specific, sensitive, affordable, and feasible.

The main sources of data for monitoring, review and evaluation of the sector are: the health management information system, sentinel site surveillance systems, household surveys (DHS, MICS, CWIQ), health facility surveys, supervision reports, specially commissioned surveys, citizen report cards, and disease programme reports. The HMIS is an integral component of the overall monitoring, review and evaluation system and its reinforcement is regarded as a priority in the strategic plan.

VI.2 Joint Sector Review

Sector performance review will be carried out annually, led by the Ministry of Health, as part of the health sector joint review. The meeting will be attended by both internal and external stakeholders in the sector, and will use the annual and periodic performance indicators as well as process indictors and MTEF monitoring reports as the basis for assessment.

The main purpose of the annual health sector joint review is:

- To inform future strategies and plans
- To harmonise the annual reviews of development partners and thereby reduce the transactions costs of multiple external missions
- To address aid coordination problems and issues

VI.3 Sector Performance Indicators

INDICATOR	WHAT DOES IT MEASURE	MEANS OF VERIFICATION	FREQUENCY	BASELINE	2010 TARGET
NATIONAL LEVEL					
INPUT INDICATORS					
% of GoR budget allocated to health sector (MoH and provinces)	Government commitment to the health sector	Finance Law	Annual	6.1%	12%
Total allocation to health per capita $USD	Effectiveness of financing mechanisms in health sector	National Health Accounts; Public Expenditure Review	2 years	$8.25	$16
Health budget execution as a proportion of total budget executed	Efficiency in Government expenditure and capacity absorption	Ministry of Finance annual budget execution report	Annual	6.2%	12%
% of MoH budget transferred to provinces as conditional block grants	Decentralisation in the public health system	Finance Law	Annual	0%	
Ratio of health professionals (doctor and nurse) to population by province	Availability of health professionals in the public health system	Ministry of Health Annual Report	Annual	1 / 50,000 1 / 3,900	1 / 37,000 1 / 3,900
OUTPUT INDICATORS					
Average outpatient attendance per capita per year	Utilisation of public health services	HMIS Annual Report	Annual	0.33	0.50
% of estimated smear-positive TB cases that are detected and registered under DOTS each year	Efficacy of detection measures	PNILT annual report	Annual	45%	70%
% of children 6 to 59 months who received one dose of vitamin A in past six months	The coverage achieved through national vitamin A supplementation program effort	Household Surveys (DHS); Expanded Programme of Immunisation	Annual	69 %	85 %
% of health facilities with at least minimum staffing norms by level	Human capacity in health facilities	GESPER system	Annual	30%	50%

INDICATOR	WHAT DOES IT MEASURE	MEANS OF VERIFICATION	FREQUENCY	BASELINE	2010 TARGET
OUTCOME INDICATORS					
Proportion of TB cases registered under DOTS in a given period (e.g. one year) that are successfully treated (cured by confirmation of a final negative smear exam result)	Success of DOTS against TB	PNILT annual report	Annual	58 %	85 %
Proportion of births attended by skilled health personnel	Extent of women's use of delivery care services	HMIS; Household Surveys (DHS)	Annual	31%	60%
Proportion of pregnant women who received at least three antenatal care (ANC) visits	Women's use of antenatal care services	HMIS; Household Surveys (DHS, MICS)	Annual	43.5%	65%
Proportion of youth (15-19) reporting use of condoms in most recent premarital sex	Utilisation of contraception methods	Household Surveys (DHS)	4 years	0.3%	10%
Proportion of the population covered by mutuelles (community based insurance schemes)	Measure of financial protection of the population	Mutuelle Executive Secretary	Annual	12%	50%
Proportion of children under-five sleeping under insecticide impregnated mosquito net	Measure of malaria prevention	Sentinel site surveys; Household Surveys (DHS, MICS)	Annual	18%	70%
Proportion of pregnant women receiving intermittent preventive treatment or malaria prophylaxis, according to national policy	Coverage of IPT among pregnant women	Sentinel site surveys; Household Surveys (DHS, MICS); HMIS	Annual	0%	65%
Proportion of children who have received three doses of DTP under age one	The ability of the health system to deliver a series of vaccinations. It indicates continuity of use of immunization services by caretakers	HMIS	Annual	86 %	90 %
Proportion of children fully immunised	Success of the immunization program in delivering all recommended vaccines	HMIS; Household Surveys (DHS, MICS)	Annual	78%	> 85 %
HIV prevalence rate 15-49 years	Extent of HIV epidemic in the population	Sentinel Site Survey; Household Surveys (DHS)	Annual	5.2%	< 5.2%

INDICATOR	WHAT DOES IT MEASURE	MEANS OF VERIFICATION	FREQUENCY	BASELINE	2010 TARGET
IMPACT INDICATORS					
Infant mortality rate	Deaths that are a result of genetic and structural malformations, birth delivery complications and those that are associated with external conditions	Household Surveys (DHS)	4 years	107 / 1000	61 / 1000
Under-five mortality rate	The risk of dying in infancy and early childhood and reflects the social, economic and environmental conditions in which children live	Household Surveys (DHS)	4 years	196 / 1000	110 / 1000
Maternal mortality ratio	Overall health of the population, the status of women in society, and the functioning of the health system	Household Surveys (DHS)	4 years	1071 / 100,000	600 / 100,000
Prevalence of underweight (weight for age < 2 Z-scores) in children under five years	Malnutrition and more generally the health and nutritional risk in the population	Household Surveys (DHS, MICS)	4 years	24.3%	18%

Notes:

Inputs *refer to the human and financial resources, physical facilities, equipment, clinical guidelines, and operational policies that are the core ingredients of health programs and enable health services to be delivered.*

Outputs *refer to the results of these efforts at the program level. Although health program managers at the field level are interested in national/sub-national trends in child morbidity, nutrition, and mortality, they tend to limit the monitoring and evaluation of their own activities to program-based measures, especially measures of output.*

Outcomes *refer to changes measured at the population level in the program's target population, some or all of which may be the result of a given program or intervention. Outcomes refer to specific knowledge, behaviours, or practices on the part of the intended audience that are clearly related to the program, can reasonably be expected to change over the short-to-intermediate term, and that contribute to a program's desired long-term goals.*

Impact *refers to the anticipated end results of a program – for example, improving children's nutritional status, and reducing child morbidity and mortality.*

APPENDICES

I. Detailed Cost and Financing Projections

Table A1. Constrained HSSP Financing Scenario (RWF x 1 million)

Projected HSSP Resources	2005	%	2006	%	2007	%	2008	%	2009	%
1. Government MTEF	**12,816**	**15**	**14,690**	**16**	**16,694**	**19**	**19,062**	**20**	**21,782**	**22**
MINISANTE	9,680		11,215		12,831		14,756		16,969	
Provincial Health Office	2,129		2,448		2,815		3,238		3,723	
Other Govt Health Expenditure	1,007		1,027		1,048		1,068		1,090	
2. Private Source Expenditures	**8,652**	**10**	**9,074**	**10**	**9,518**	**11**	**9,985**	**11**	**10,476**	**10**
Private Households	7,264		7,618		7,990		8,381		8,792	
Private Employers	809		860		914		971		1,033	
Parastatals	579		596		614		633		652	
3. Donors	**66,078**	**75**	**66,582**	**74**	**63,861**	**71**	**65,847**	**69**	**67,933**	**68**
Total Resources Available	**87,545**		**90,346**		**90,073**		**94,894**		**100,191**	
Total Projected Cost	**72,895**		**85,396**		**99,164**		**101,099**		**103,269**	
Financing Gap	**14,651**		**4,950**		**-9,091**		**-6,205**		**-3,078**	

ENDNOTES

[1] National Population Census 2002
[2] Demographic Health Survey 2000, Ministry of Health
[3] World Health Report 2003, World Health Organisation
[4] World Bank estimate, 2004
[5] Household Living Conditions Survey 2000, Ministry of Finance and Economic Planning
[6] Finance Law 2002 and 2004, Government of Rwanda
[7] Demographic Health Survey 2000, Ministry of Health
[8] Demographic Health Survey 2000, Ministry of Health
[9] Based on calculation derived from the Multiple Indicator Cluster Survey 2000, UNICEF
[10] Health Management Information System
[11] 2004 Report on the global AIDS epidemic
[12] Breakdown taken from 2003 HIV Sentinel Site Survey, Ministry of Health
[13] National Tuberculosis Control Programme
[14] Department of Health Care, Ministry of Health
[15] Household Living Conditions Survey 2000, Ministry of Finance and Economic Planning
[16] Calculated from the Health Personnel Management System
[17] Calculated from the Health Personnel Management System and Division of Nursing registration exercise
[18] Country Status Report, Health and Poverty, Ministry of Health and World Bank
[19] Health Management Information System
[20] Breakdown taken from 2003 HIV Sentinel Site Survey, Ministry of Health
[21] Based on calculation derived from the Multiple Indicator Cluster Survey 2000, UNICEF
[22] National Tuberculosis Control Programme
[23] National Tuberculosis Control Programme
[24] Demographic Health Survey 2000, Ministry of Health
[25] Demographic Health Survey 2000, Ministry of Health
[26] Demographic Health Survey 2000, Ministry of Health
[27] Based on calculation derived from the Multiple Indicator Cluster Survey 2000, UNICEF
[28] A Memorandum of Understanding has been drafted and in the process of being presented to partners for revision and final adoption
[29] The 'Marginal Budgeting for Bottlenecks' tool was developed jointly by the WHO, World Bank and UNICEF
[30] The primary level refers to health centres, outreach and community activities; the secondary level refers to service provision at the district hospital level; the tertiary level refers to the national referral hospitals (CHUK, CHUB, King Faycal Hospital and Ndera Mental Health Hospital); and the level of administration refers to administrative activities in the MoH, the provincial health office, and the health district office.
[31] SMART means specific, measurable, attainable, relevant, and timely bound.