Ubuzima

A Healthy People. A Wealthy Nation

ISSUE 2. A PUBLICATION OF THE HEALTH SECTOR

REPUBLIC OF RWANDA

MINISTRY OF HEALTH

A focus on Patient Care

how much fun is safe fun?

Live responsibly and protect yourself from HIV and other STIs by always using a condom

KUNDA UBUZIMA

Irinde Sida
Ukoresha
Agakingirizo

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- RHCC

REPUBURIKA Y'URWANDA
MINISITERI Y UBUZIMA

Contents

Editorial 4

Charting the Health Sector's Course for 2012 and beyond 6

There is no Precedent to RBC 10

Celebrating a successful partnership in public health delivery By Dr. Peter Drobac 13

Streamlining Medical Production and Procurement 15

Decentralising referral services will increase access to quality health care 18

King Faisal Hospital, Kigali's journey towards excellence 19

King Faisal Hospital, Kigali's journey towards excellence 19

Rwanda's pursuit of shared wealth through Health for all 22

Health Financing in Rwanda: Towards Universal Coverage 25

A dream born in Dakar: Hôpital la Croix du Sud 29

The Provincial Coordinating Meeting: An innovation in tracking Health sector targets 33

Ramping up to national accreditation 34

DATA TALK: The Health Management Information system 36

Nursing the pillar of health 38

Adolescents and young people in the fight against HIV: 40

No Room for Complacence 40

Up close and personal with 42

A new focus on Non-Communicable Diseases 45

Community based provision of Family Planning 46

Male involvement in Family Planning: Vasectomy 48

Health Sector Awards excellent journalism 49

SPIU: Involving community leaders in the fight against HIV and AIDS 51

The Resilience Vis-A-Vis Trauma 52

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Editorial

By Arthur Asiimwe

If for nothing else, the results of the 2010 Rwanda Demographic Survey should at least be significant for two simple reasons. As a measure of progress, they show us exactly where we are on the track and; on the flip side, in graphic terms is the gap standing between us and the ultimate goal.

The news about malaria continues to be good; while with as many as 44 percent stunted, the nutritional status of children under five continues to be a concern. Equally, child mortality is decreasing across the board but there is a sharp variation in trends depending on geographical location and level of education.

This underscores the complex correlations between the problems we are trying to deal with and need for a multi-sectoral response to see the durable progress.

In the final analysis, we have reason to be both happy and cautious. Happy because the strategies we have employed are working; they have largely been vindicated by the progress posted and cautious because the gains are still fragile.
Just one moment of laxity and in much the same manner as the careless fisherman helplessly watches as the hook that slips out of his grip drops to the bottom of the pond, we risk seeing all these achievements sink to the bottom.

Lastly, I wish to thank all the contributors to this edition of Ubuzima for their valuable contribution and wish everybody nice reading.

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Aim High

Your future is bright, don't let premature sex, unwanted pregnancies, STI and HIV AIDS destroy your future goals.

KUNDA UBUZIMA Ibyiza biri imbere

This message is brought to you by

REPUBLIC OF RWANDA

MINISTRY OF HEALTH

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Charting the Health Sector's Course for 2012 and beyond

By Dr. Agnes Binagwaho

As the health sector embarks together on the journey of a new year, it is time to take our bearings and determine the direction we want to take our sector during 2012. While there is no fault in celebrating our past and recent achievements, maintaining those gains should be our overarching priority this year and beyond. Gains in health outcomes are always fragile, and could easily be lost if we do not maintain sufficient focus and vision.

Ten years ago, infectious diseases were decimating our population and crippling our potential to achieve our goals. Today, we have largely stabilized and advanced against the biggest killers such as HIV, tuberculosis, and malaria, but they have not been eliminated and we must not relax our vigilance. The gains made against HIV can be lost in as short a time as one year if we were to drop our guard.

This year, we will continue to see progress in these areas as we strive to work even harder. The effects of our achievements against communicable diseases are extending far beyond HIV, tuberculosis, and malaria, however; we have seen the incidence of childhood pneumonia plummet since introducing the pneumococcal conjugate vaccine in 2009, and we expect a similar impact against diarrheal diseases after rolling out the new rotavirus vaccine this year.

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In order to protect our gains in the health of our population, we are thinking regionally about challenges like malaria control and counterfeit medicines. Rwanda cannot be an island of welfare in a region of desperation, and infectious diseases do not respect national boundaries. Half of all new malaria cases in Rwanda occur near our borders, with 45% of those occurring in just three sectors – we very clearly need to work with our neighbors to address this. Together, we are working to systematize procurement of medications and to harmonize national malaria control efforts and policies. We will tackle these problems together by coming to consensus on the best policies based on the best science of the day, and we will be stronger for it.

An Aging Population

Rwanda has made good progress across all infectious disease categories, and our people are living healthier and longer lives. According to the National Institute of Statistics, the average Rwandan can now expect to live as long as 55 years. This is a modest number, but it is significant in our setting.

This year we need to begin focusing on long term health trends by anticipating new problems that are likely to arise in the not too distant future and preparing solutions now. As the health of our population continues to improve, they will start to experience health problems related to longevity, such as hypertension, heart disease, metabolic diseases, and cancer.

We are also beginning to see that deaths from motor accidents or other injury are beginning to overtake other causes. This is not necessarily because there has been an increase in the rate of accidents, but because of the reduction in other causes of mortality and morbidity. The simple message from these trends is that we need to focus on non-communicable diseases now that communicable diseases are largely under control in Rwanda.

There are many areas where we can act on non-communicable diseases immediately; one where we have already started is cancer. Rwanda is taking action today against cervical cancer, breast cancer, and childhood lymphoma through early detection and treatment. A vaccine against cervical cancer has been rolled out to all girls in Primary Six, providing an affordable and sustainable long-term solution to the challenge of prevention.

While our initial focus in addressing cancer is on women and children, this is not because we are neglecting men; rather, comprehensive solutions for some of the most significant cancers of women and children are affordable today. We cannot work on everything at the same time, but our goal is to introduce interventions for other cancers over time as well. The Ministry of Health plans to introduce radiotherapy facilities and oncology wards at CHUK, Kanombe, and Butaro hospitals in the coming year, where specialist care will be provided to cancer patients. We are also in the process of producing a large cohort of physicians and nurses with oncology skills, who will train and supervise other health care workers so that soon each district hospital will have a specialist trained in cancer care.

Rwanda will not wait for massive infrastructure to be built before acting – we will handle what we can today within our present means while simultaneously investing in facilities for cancer care and teaching. To meet the needs of those for whom it may be too late to offer successful treatment, we are increasing access to high quality palliative care.

Our nation's guiding philosophy is that we will always prioritize the most acute problem – focusing on improving outcomes, not only meeting a pre-determined budget. Today, we increase the scope of our focus to include non-communicable diseases, and we shall continue to increase it until we have attained the quality and reach of health systems in the developed world.

Quality and Value for Money

Another core focus for the Ministry of Health this year will be improved management of the health sector in order to achieve more value for patients despite the fact that resources for global health are decreasing. The quality of care delivered will come under increased scrutiny as we seek to maximize the patient outcomes generated per Franc spent.

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Improving quality requires a dual approach – generating the best science and actually implementing that science in the most effective, high-value way possible. After that comes the human dimension: customer care, where Rwanda is already seeing dramatic progress. When a population is healthy and empowered to know their rights, they are more demanding. Previously, expectations have been relatively low during the time when we had only two doctors per district hospital. But today Rwandans expect high quality care because human resource gaps have started to be filled, and the public sector continues to push our people to demand the best.

In the past, it was not uncommon find a doctor with excellent clinical skills who was critically lacking in customer care. Today, Rwandans are legitimately complaining to the Ministry of Health about poor customer care because they expect both quality care and dignity. I may be a highly skilled doctor, but if I am rude I undermine the quality of my overall output. On the other extreme, a health care provider may not be very well qualified, but if they provide excellent customer care patients may actually prefer to consult him or her. This happens frequently in our country and creates potentially dangerous gaps in our health system if people choose to seek care from non-professionals. So doctors in the formal sector need to provide the full package of clinical knowledge, evidence-based practice, and customer care.

The Persistent Challenge of Malnutrition

Health Minister Dr. Agnes Binagwaho feeds children in Gicumbi district during the launch of the campaign against malnutrition

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Malnutrition is another key priority for the Ministry of Health this year. The Government has committed itself to eradicating the root causes of malnutrition before the next Umushyikirano in December 2012.

Looked at objectively, malnutrition is not an insurmountable challenge despite its high prevalence and persistence. We have chronic childhood malnutrition not because we cannot produce enough food, but because we are using it wrongly. Often, Rwandan families say they don't have food, but they can grow the food. Others say they don't have land, but local government authorities can provide collective land for people to grow food. Malnutrition should not occur in this country – eradicating it is a matter of organization, management, and implementation.

Two percent of children under the age of five years currently suffer from severe malnutrition, meaning that they are not receiving sufficient calories. We have many more cases of chronic malnutrition: fully 11% of children under the age of five years are underweight, and 44% suffer from growth stunting.

We have learnt that the primary cause of malnutrition stems from what children and pregnant mothers eat. Most malnourished children in Rwanda are born that way as a result of mothers did not take enough micro nutrients vitamins throughout her pregnancy. The solution lies in increasing population knowledge around proper nutrition in order to fight the habit of not eating sufficient protein. This effort requires a revolution in the way we are feeding children, one that the Ministry of Health and our partners across all sectors are ready to start.

Human Resources for Health

A third major frontier to be engaged this year is the development of the national Human Resources for Health Program. One of our persistent challenges as we pivot to confront non-communicable diseases in addition to continuing to control infectious diseases is a lack of adequate mentorship and bedside teaching capacity.

At the district level at a minimum we need one surgeon, a paediatrician, one anesthetist, one internal medicine specialist and an oncologist to deal with cancer and related complications. We also need to develop the capacity to treat or manage metabolic diseases.

Were we to continue producing health professional at the current rate and sending nearly all specialists abroad for advanced training, it would take us decades to achieve desired staffing levels. Instead, the Ministry of Health is undertaking a home-grown solution to the human resources challenge by partnering with 18 American universities and medical schools to bring hundreds of international experts here. Over the next seven years, these partnerships will help us to build speciality capacity in Rwanda through the creation of high quality residency programs and by close mentorship to impart Rwandan clinicians with bedside teaching and managerial skills. By 2020, Rwanda will have attained the capacity to produce our own highly specialized workforce to meet the demands of a changing burden of disease by providing our population with high quality care in the most equitable way possible.

Mutuelle de Sante: The Key to Access and Sustainability

Making progress against infectious diseases does not necessarily free us from spending money on their control, as the cost of prevention is also high. The diligent pursuit of prevention to sustain the progress we have made is one major reason why the health sector has received an increasing share of national revenues with each year. We must also recognize the naturally unpredictable nature of international contributions to our health budget, meaning that we need to chart a course towards resilience and sustainability through revenues generated here in Rwanda.

Massive scale-up of community-based health insurance through the Mutuelle de Sante program is the cornerstone of our drive towards financial sustainability. Out-of-pocket expenditure in Rwanda has been increasing due to the overall improvements in economic welfare across the country. Since 2005, more than one million Rwandans have lifted themselves out of poverty, and are now economically empowered to pay for health insurance and invest in protection against the potential costs of future illnesses.

Mutuelle de Sante is a national institution that is still growing and maturing; if we are not diligent in its management and scale-up, we will undermine its great potential to improve the lives of our population and the quality of our health sector. Leaders at the local level face so many different challenges across sectors, so promoting the importance of and protecting the resources for Mutuelle de Sante requires vigilance day and night. Because of the nature of health insurance, the uninformed may perceive Mutuelle funds as lying idle and see them as an opportunity to act on other immediate concerns – we must continue to sensitize local leaders at the sector level in order to convince them that diverting Mutuelle premiums constitutes a financial crime.

Building a Better Future Together

The year 2012 holds great promise as we chart the health sector's course and continue to work towards our vision of a Rwanda where every person has access to high quality and high value medical care. In order to continue making great strides towards this noble goal, we need to take a wide view of our role in the Ministry of Health.

His Excellency the President of Rwanda Paul Kagame often encourages us to stay vigilant and driven to improve by reminding us of the difference between the "worried well" and the "complacent sick." Reaching our goals together through 2012 and beyond will require us to reject complacency and to continue advancing a person-centered and rights-based approach to fulfilling the promise of our Constitution that "the human person is sacred and inviolable." The Ministry of Health could not possibly take this declaration more seriously; the quest for improvement is a civil and moral duty that we embrace with great humility and resolve.

Dr. Agnes Binagwaho is the Minister of Health, Rwanda

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There is no Precedent to RBC

Dr. Peter Drobac

At the Rwanda Biomedical Centre (RBC), our motto is 'Healthy people, Wealthy nation.' What this means is that by investing in health we can unlock the potential of every Rwandan to improve their own lives and to contribute to the development of the nation.

Our vision is that by integrating education and research and high quality service delivery, the RBC will become an engine of prosperity for Rwanda.

We have two broad goals. The first is to foster dramatic improvements in the quality of care across Rwanda's health sector, and this will be seen at King Faisal Hospital which will continue to evolve into a world class teaching and referral hospital, eventually we hope to attract people from around the region to come and receive their medical care in the land of a thousand hills.

The fourteen agencies that we have will also work hand in hand with the Ministry of Health to ensure that every Rwandan will receive the best health care possible. And because this is Rwanda we will do so with a focus on equity and by equity we mean that we will be targeting the most vulnerable families and communities to receive services.

A second longer term goal is for RBC to help Rwanda's health sector to achieve financial sustainability. Vision 2020 envisions Rwanda becoming a middle income country that can thrive independent of external aid. Currently the Rwanda Biomedical Centre has achieved great success in providing health across the country. We do so in partnership with many partners providing a significant amount of investment in the health sector.

We greatly appreciate all that help but we also understand that for the long term, Rwanda needs to move towards financial independence. And at RBC we are going to help that in two ways. The first is that by integrating all these great institutions as one in the RBC, we can create efficiencies; we can eliminate redundancies in administration, in vehicles and many other things that can allow us to save money and run the health sector more efficiently.

The second way in the longer term is to develop means to generate revenue in the health sector that can support health services. We will do this for example by pushing King Faisal Hospital KFH, to become a world class teaching and referral hospital so that people from the East African region with means want to come to Rwanda because they can receive high quality services and instead of going to Europe or America to receive health care they will be coming to Rwanda. And they will be staying here in the hotels, in other words bringing money to the country.

We are also developing other strategies to develop for example the pharmaceutical industry in the country so that we can be producing drugs in Rwanda for Rwanda and also for sale to elsewhere in the region. These are a couple of the examples of the things we are looking to in the longer term to generate revenues that will help support health care delivery.

No precedent to RBC

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Some RBC staff together with partners

Within public health sectors to my knowledge, there is no precedent for one institution that integrates all the different institutions in the health sector into one, particularly by integrating service delivery and training and research.

We have seen over the last 10 years how Rwanda has been a pioneer and leader in so many areas. RBC is itself an innovation and an example of how Rwanda is leading the world to find a new way forward.

In collaboration with the ministry of health and Harvard University last February we launched the first ever Harvard Global Health Delivery Course in Rwanda. For five days the ministry of health training centre at Rubavu in Kayonza district became a campus of Harvard. We brought the faculty from Harvard together with the Hon. Minister of health and other leaders in Rwanda's health sector to teach a course in health care delivery that can bring the best of academic global health together with the experience that we have in the country to train the next generation of public health professionals in Rwanda.

The course was so successful that we envision in the future that a cadre of Rwandan faculty from the health sector will be teaching public health professionals in Africa and around the world. As Rwanda continues to outpace almost every other country in improving health outcomes, other countries are increasingly looking to us for a new way of doing things. And the importance of academics in teaching is that we cannot only use academics to continue to improve what we are a doing in Rwanda but eventually also to be leaders in the rest of the world by helping to share our experiences and successes here.

Getting innovation to work to expectations

I am very confident in the abilities of the team that we have assembled at RBC. There is no doubt that we have very ambitious goals but this is Rwanda. I have been very impressed serving my first months as board chair to see that we have some of the best minds and with the greatest experience anywhere in Africa are within RBC.

With such strong talent, a shared vision and a strong commitment to achieving these goals, we will succeed in improving healthcare for every Rwandan.

In the initial stages of RBC we focused on administrative integration, helping the different institutions start to develop common processes for procurement, administration, vehicle use, human resources etc.

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These administrative efficiencies can save money and also help us to start working as one unit.

In December we came together as units of RBC, all directors of RBC, for 3 days for a retreat and we established a mission and vision for RBC. That was really the time at which we started to think as one team and establish the long term vision we were embarking on. Now there is a five–year strategic planning process so that we can define exactly how we are going to achieve these very ambitious goals and what the indicators of success are.

At the end 5 years we want to measure our success not in terms of what we have achieved in processes but in terms of outcomes for the people of Rwanda first and foremost. We have seen dramatic successes in the last five years in improving access to HIV care and the big killers like TB and Malaria and reductions in maternal mortality.

We are not going to rest it there. The only way to continue improvements now is by driving quality improvements and to that end RBC is going to be working closely with the Ministry of Health and also with educational institutions at the national university faculty of medicine and the school of public health to train the next generation of health professionals in Rwanda to improve the quality of care at every facility.

We are also going to help to innovate and push the next frontiers of health care moving beyond infectious diseases like HIV malaria and tuberculosis into other diseases that affect the people of Rwanda -non-communicable diseases such as heart disease, diabetes, cancer, epilepsy to specialized areas like neonatology and surgery.

If you look now at under-five mortality in Rwanda, at least a third to 40 percent of under-five deaths are happening in the first month of life. What that means is that by pushing to improve maternal and neonatal health, by providing neo-natal services in hospitals and health centres, we can eliminate those preventable deaths. Our goal now is not to reduce preventable maternal and child mortality but to eliminate it in the same way that we aim to eliminate new infections of HIV by 2015 as well.

So we expect to see some very tangible products of RBC's work as well. I think King Faisal hospital by 2015 will have been transformed into a much larger and more modern world class health facility. It will become a flagship teaching hospital for the country. The ministry of health has laid out a very ambitious human resources for health strategy for the nation - a whole generation of health professionals including specialists of every kind so that we can have a world class health sector.

In partnership with the US government and several US universities, we are hoping to embark upon the largest investment in human resource development in the history of the continent and RBC will be helping that effort in any way we can ●

Dr. Peter Drobac is the Board Chair at RBC as well as the Rwanda Country Representative for Partners in Health (Nshuti mu Buzima) and a Faculty Member at the Harvard Medical School teaching global health and social medicine.

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Butaro hospital, Burera District.
Photo by: *Iwam Baan*

Celebrating a successful partnership in public health delivery

By Dr. Peter Drobac

Partners in Health (PIH), is now one of the largest nongovernmental health partners in Rwanda. It is a health and social justice institution that is affiliated with the University of Harvard. We have been around now for 25 years and we are working in twelve countries.

Our work started in Haiti many years ago and we have been working in Rwanda since 2005. PIH came in 2005 at the invitation of the government of Rwanda to help to develop the health sector especially in rural areas.

At that time, in the years after the 1994 genocide, the health care infrastructure outside of Kigali was still very weak and HIV care was still available only in certain areas of the country. We were asked to come and help rebuild the health care infrastructure of the country in some of the most vulnerable rural districts of the country and also then help provide models for how to develop country's entire health sector.

We have worked in close partnership with the Ministry of Health in these past six years and grown to a point where PIH is supporting 3 hospitals and 37 health centres in the three districts of Kayonza, Kirehe in the eastern province and Burera district in the Northern Province. We have helped to either renovate or build all three of those hospitals including Butaro hospital.

Butaro hospital opened its doors just over a year ago in January 2011 to the public and we think it can set a new standard for what is possible at a district hospital in the country and it has really helped to raise the norms and standards for hospitals that are to be built in the future. So the health sector across the country including where PIH is working now is very strong and we are continuing support to those areas which are focusing on two things where we can help to have a national impact.

The first is helping to implement the health sector strategic plan at the highest possible quality providing

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a model for the country and becoming a training site so that health professionals from other districts can come and learn the best ways to deliver health care.
The second is in terms of innovation and we have been working hand in hand with the ministry of health to push the boundaries towards the next frontiers of health care delivery -the areas where Rwandans are afflicted but not receiving services for example cancer and other non-communicable diseases.

We are also working to develop an electronic medical record again in collaboration with the Ministry of Health which will be rolled out nationally so that we can start using ICT's to improve service delivery. Doctors can have access to records at their fingertips when they are in the clinic seeing patients. Am very proud to say that as of July this year Butaro hospital is going to open a national cancer care Centre of excellence. It will be accredited as a speciality hospital in the country and serve as a national referral hospital for cancer meaning that any Rwandan suffering cancer anywhere in the country can receive their care at Butaro hospital. We are doing this in partnership with Dana-Farber Institute at Harvard and other partners to bring in the best expertise possible to build models of care delivery so that cancer care is not an insurmountable obstacle or death sentence but something that we can manage.

Butaro hospital has 150 beds and provides all the services that a modern district hospital should have – internal medicine, pediatrics, maternity services and 2 modern operating rooms. There is a small intensive care unit, a neonatal unit and neonatal intensive care unit, and all modern brand new medical equipment including digital x-rays. We have wireless internet throughout meaning doctors can view an x-ray and using telemedicine they can review the x-ray with a specialist in the Us at the same time if they need to get some specialist feedback. The cost of the hospital was $4.4m for construction of the facilities and $1.4m for all the medical equipment.

The $4.4m for construction was donated by partners in health and the medical equipment was all purchased by the government of Rwanda. So the total cost to build and equip the entire hospital was $5.8m about 25% of which was contributed by the government of Rwanda and 25% by PIH.

What was very interesting about this process is that we worked together with the ministry and a volunteer group of architects to design the hospital and hired the people of Butaro to come and work to build the hospital. We estimate the cost of construction is probably only 50% of what a similar sized hospital may cost to build elsewhere if you hired an international contractor.

We saved a lot of money in the process but I would argue that the quality of the hospital was much higher than many of these other hospitals in the country and even more importantly, using local labour created many jobs for people in the community and so all the investment did not go out to a contractor in Europe but to the community. That also contributes to economic development. What we have seen now is that Butaro which used to be a very small town, with few businesses, no electricity, poor roads, these investments have really catalyzed development thanks to the leadership of Burera district.

There is now a new Bank of Kigali that just opened up there, new businesses, a guest house, the roads have improved and electricity has reached the district for the first time. This is a sign of how a strong Private Public Partnership between PIH and the government as well as these smart investments in health care has triggered a lot of economic development.

PIH is working in Haiti which is the largest project and Rwanda is the second largest. We are also working in several African countries as well as Russia and Peru and in a few other places. PIH always works in partnership with governments to support development of the public health sector, not creating standalone hospitals or a parallel system.

After having done this work for 10 years I can say we could not have asked for a better partner than the government of Rwanda. We are very blessed to work with a government that has a strong vision, that is very progressive, results oriented, that holds us accountable and holds themselves accountable. We don't have any situation like this in any of the other countries where we are working and I think that is one of the success factors for our partnership here and why we have achieved so much together●

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Streamlining Medical Production and Procurement

By Dr. Pierre Claver Kayumba

Medical Production and Procurement is one of the three departments under the Rwanda Biomedical Centre (RBC) structure. It is a merger of Medical Procurement and Distribution Division, the National Centre for Blood Transfusion Division and the Medical Production Division.

Under the previous structure, those three divisions worked independently. With the creation of RBC, the three have been merged into a single unit and we are trying to create synergies between them. We also hope to achieve significant cost savings as a result of a consolidated budget outlay.

To create synergy, production is being aligned to procurement needs. Since we don't have sufficient internal capacity to produce all required medical supplies, we still largely depend on imported drugs. However, even the few drugs we were able to produce locally were not aligned to procurement channels because there was a lack of coordination between production and procurement. The result was that products either got expired in the stores or were sold to the private sector – not the public system yet the government was spending money on the production.

The first goal therefore is to align production to what is needed on the Rwandan market. A meeting of head of divisions and high level technicians analysed what we need in the domestic supply chain which has resulted in a focus on particular drugs. About seven essential medicines were identified and they will be produced according to what is needed on the market.

Antibiotics are the most consumed drugs in Rwanda and we now concentrate on their production. Since malaria is declining there is a high risk of immunity decrease in Rwandan population. The strategy is to strengthen preventive measures including availability of Long Lasting Insecticidal Nets (LLINs). There is plan of locally producing such nets with support from the UK Department for International Development (DFID) which has committed 4.3million Sterling Pound to support production of mosquito nets.

This means that we shall be in a position to sustain these supplies even after the Global Fund has stopped to support us. We are exploring linkages with UTEXRWA although at the moment they appear to lack the capacity. Once the money is available we shall look at other possible partners. We shall not manufacture as such but offer contracts to private producers.

The pharmaceutical plant we have in Huye is too old and we need to focus efforts towards its renovation and modernisation. The factory was designed to produce both solid dosage formulas and infusions. What we need to do is to upgrade the infrastructure and ensure that the factory is able to execute contracts for drugs.

Currently, they cannot produce more than 10% of national needs but after rehabilitation we expect them to supply 25%. The remaining 75% will be made up of drugs for treatment of HIV/AIDS and TB and others that will continue to be imported not because we don't have the capacity but more because they are still under patent protection. To produce such drugs would also require a huge investment to bring the factory to a level accepted by the WHO. That would take us longer and a lot of investment so it makes sense to begin with those drugs that don't involve a lot of global red tape to produce.

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We shall get manufacturing licenses from the Ministry of Health and as we progress we shall scale up to ARV's, anti-malarial and TB medication.

BLOOD SERVICES

The other department under MPP is blood and blood products. Current these products are given for free but after review, we found that most of the tests to ensure the safety of blood and its products as well as the logistics for its collection and distribution have a cost element. While blood is donated for free, we have to collect it from donors, test it and separate it into different components. This process costs about $110 for every quart of usable blood.

The blood division is now funded 83% by donors with the government footing 17%, mainly the salaries for workers. If we are not able to recover that cost and donors are not there or are not able to support us, the service would collapse. That is why we need to find a feasible way of recovering that cost if the service is to be sustained.

One option we are considering is to look at blood as a drug so that we can negotiate with health insurance providers to cover blood products. Even at the cost of $110 for 450mls it would be very expensive for patients to afford on their own.

Fortunately, at the level we are, everybody who needs blood in Rwanda can get it. We have also decentralized the system and we have blood centers in Kigali, Huye, Karongi, Musanze and Rwamagana. We are planning to have smaller centers in Gihundwe and Rubavu. Our goal is to ensure that each hospital has a blood bank.

ACTIVE DISTRIBUTION

The other aspect of MPP that we have reformed relates getting drugs from our stores to users. In the past people used to queue here at central level to get drugs. Now the policy is to take drugs where they are needed so that health facilities can spend their time on patient care rather than queuing for drugs. We call this active distribution. The idea is that patients find drugs at their health facility down to the lowest level of our health system.

Under Active Distribution, health facilities quantify their needs based on their consumption data. They place orders according to their estimated needs and then we feed that into our distribution lines and supply on a regular basis. This happens on a monthly basis.

COST SAVING

We are also examining further the scope for cost reduction in this supply chain. For instance we are spending Rwf 27 million a month on storage facilities. We now plan to build our own warehouse not only for MPP but for the whole RBC because everybody is renting storage. The Blood Centre is renting, the National Reference Laboratory is renting so a lot of resources are spent on renting storage space. We need to embark on building our own warehouse. This will save us a big portion of the rent budget.

REVENUE GENERATION POTENTIAL

The other aspect is revenue generation from existing resources. For instance the blood transfusion center has some very good tools that besides analyzing blood can be used for other specialized tests such as hepatitis, pregnancy, syphilis etc. This means they can generate some revenue from providing those services to other arms of the system.

The same applies to procurement and distribution. We are charging management fees for products specific to programs (HIV, TB and Malaria) that are distributed through our supply chain. A 15% charge is applied to other essential medicines. So we are able to generate

Drugs in a Pharmacy

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income supporting daily activities of the division including salary wages.

We are also looking at reducing expenditure across the entire spectrum of RBC. Imagine the costs associated with each division having its own security company, cleaning company etc and the potential for savings through consolidated procurement for such services for the whole RBC. We also spend a lot of time on parallel procurement by programs that are funded by donors. We spend a lot of time trying to meet their requirements which generates duplication and wastage.

QUALITY OF DRUGS

Quality assurance is our priority because the effects of bad medicine on the community can be quite far reaching. Under national law, counterfeiting is a criminal act but unfortunately, it is a widespread practice globally. I cannot say with certainty that we don't have counterfeit drugs here but we don't have clear figures. We have figures from Kenya, Uganda and Africa in general but worldwide, more than 20 percent of drugs are counterfeit meaning we can have counterfeits on the market here.

The only to avoid counterfeits way as a public institution is to pre-qualify suppliers. The WHO has benchmarks for pre-qualifying a suppliers' related to manufacturing processes and practices by particular suppliers against which we work. These cover the human resource, equipment, raw material and processing. The WHO conducts inspection before pre-qualifying supplies. So we only procure drugs from WHO pre-qualified suppliers. That is the only way to avoid counterfeits medicines in the public health system.

The challenge is that those pre-qualified will supply drugs at a higher cost while private pharmacies can buy wherever they can find good prices. The results are that the cheaper sources can be linked to counterfeits so the supply chain in private pharmacies needs to be regulated closely.

Apart from buying from pre-qualified suppliers', once the consignments arrive at MAGERWA, we take samples for analysis to preclude deterioration in quality while in transit. The drugs are first quarantined before we go back to WHO accredited labs outside the county to test their efficacy. It is only after the results are positive, that the drugs are removed from quarantined and put in the supply chain. So we need a national quality control laboratory.

ENLIST PUBLIC SUPPORT

We have conducted a workshop where we shared information on basics of detecting counterfeit drugs. We began with pharmacists and other health workers, the police, Rwanda Bureau of Standards, Rwanda Revenue Authority, the National University of Rwanda, Rwanda Development Board and many other institutions before rolling out an awareness campaign to the general population. We shall also have some portable devices- True-Scan that carry a database of genuine drugs so by scanning on site it will use its memory to discriminate fake medicines.

Unfortunately public perception is that fake drugs come in bottles yet those are more likely to be safe than those that come blister packs because they have been procured from pre-qualified suppliers. Secondly, counterfeiters focus on quick generation of money so they target high price genres that are expensively packed. So, expensive antibiotics, Viagra, and ARV's are more likely to be counterfeit than simple and cheap aspirin.

We also have standards of design for a pharmacy at district level covering – how they control, humidity and temperature, which are key factors in determining the quality of drugs.
We also have a pharmaco-vigilance system meaning to track side effects associated with consumption of drugs. It is a reporting system recording and tracking adverse reaction incidents right from the health facility to central level. This way we can recall the incriminated product. Through good monitoring, we know which quantity to recall because we have an electronic system that gives details of exactly how much was sent where and the consumption rate.

LMIS

All this will be harmonized under the Logistics Management Information System that we are going to install. It will allow us to monitor the drug quantities level countrywide in real time.

Dr. Pierre Claver Kayumba is the Deputy Director in charge of Medical Production and Procurement as well as the Acting Director General of the Rwanda Biomedical Centre (RBC)

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Decentralising referral services will increase access to quality health care

By Dr Jean de Dieu Ngirabega

When all primary health facilities in a country refer patients to only three referral hospitals, there is a probable challenge that the number of patients at the referral hospitals will be overwhelming at some point. This is the case in point for Rwanda's health sector.

The country has a systematic way of dealing with patients right from the health centre level to district hospital level and finally to the referral hospital level however the need to introduce another level has resulted from government's desire to further decentralise services and ensure equal access to quality care.
Today, the referral hospitals receive a lot of patients yet most of the referred cases can be handled by another authority in between and that is why this new level will be placed at provincial stage. CHUK alone handles 75 percent of all referral cases but this will be solved soon.

Rwanda has five provinces so under the new system; the ministry of health is set to empower one district hospital per province which will in turn become the provincial referral hospital. The hospitals include, Kibagabaga in Kigali, Rwamagana hospital in the Eastern province, Kabgayi hospital in the Southern Province, Ruhengeri hospital in the North as well as Gihundwe hospital in the Western province.

Introducing the new provincial referral system is already underway with the implementation phase at developing equipment and human resources that will ensure success of the process. It is a gradual course of action that could take about five years to be fully functional so 2012 and 2013 are the years set for ensuring full capability of the chosen facilities to handle provincial referral cases.

Increasing access to quality health care for all Rwandans implies that the entire population will have access to all medical specialities since they will be closer to them and organisation of work will be improved with less numbers going to the top referral level. The current referral hospitals are normally teaching hospitals with specialities such as internal medicine, Gynaecology and Obstetrics, surgery and paediatric services among others with sub specialities such as ophthalmology, Ear Nose and Throat health services as well as Neurosurgery among others.

Referral systems must be seen against the background in Rwanda as a key measure of ensuring that all people rich and poor across provinces and between districts, access the available health services in a timely manner.

Dr. Jean de Dieu Ngirabega is the Director General of clinical services in the Ministry of Health.

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King Faisal Hospital, Kigali's journey towards excellence

By Dr. Alex Butera

In a few months' time, RBC/ King Faisal Hospital, Kigali will be due for its biennial date with the Council for Health Service Accreditation of Southern Africa (COHSASA) for a review of the accreditation it received on February 2011.

That much heralded achievement came after five painstaking years during which RBC/ KFH, K improved its score from 41 percent in 2006 to 99 percent points above the pass mark at the time of final accreditation. While it was a well-deserved recognition of our efforts, COHSASA accreditation in the same regard imposed upon us the challenge of maintaining that status.

As a national and regional referral health facility, our primary role is to promote, maintain and restore the health of Rwandans and other nationals within the region as we engage in education and research to keep up to date with trends in a fast changing world. High quality service relies heavily on evidence based medicine which if followed diligently, allows our patients to get the same level of care as they would anywhere in the world.

And because people live in different micro-environments, research tells us what exactly happens in our locality. It also shifts paradigms and emphasizes important issues and provides us the evidence to guide our work.

In any hospital setting, quality plays central role because quality care sells itself. In quality however, there are a couple of things that have to be there.

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The hospital and the environment has to be very clean because the hospital people are working with infection and other things, you would want to protect your customers from to the extent possible. If for no other reason this makes hygiene and cleanliness of paramount importance.

The other aspect of quality relates to the quality of services you give, the equipment, the people providing those services and the way they are maintained. One of the ways of ensuring that quality is consistently delivered is to subject the institution to external criticism or accreditation which will score you without bias.

That is what we did in 2005 when we invited COHSASA to audit our services. The international accreditation agency turned the whole institution inside out, leaving no stone unturned to rate us against a global standard. Though coveted, it is a difficult, demanding and hard earned recognition. To get an idea of what it means, consider the fact that KFH is the only COHSASA accredited government owned hospital in East Africa.

To earn accreditation, we looked at the variety of services that were available to the population from this facility. To choose the variety of services we looked at the diseases profile of the area which allowed us to prepare for the problems with big impact to our population. We also looked at the trend of disease and using that we were able to predict the likely diseases patterns in the future. That was basis on which we used and continue use in planning improvements to our clinical and managerial services to meet standards. Even as we pursue this quality however, that quality can only be of use to the population if our staff has good customer care. Our ultimate goal is to give good services to the extent that we can convert customer experiences into customer loyalty.

A loyal customer will contribute to quality sustenance by having the patience and courage to provide feedback on any negative experiences they may encounter during interaction with the institution. That can only be achieved when customers believe that their comments will lead to corrective or remedial action.

KING FAISAL TODAY

KFH offers specialized and super–specialized services. Specialized services include such care as is offered by a surgeon or a physician. But when you come to services such as neurology, cardiology, you have transited into super-specialized services. Because we are able to offer such services here, we are at the apex of the referral system. Patients come here only after exhausting the range of services available at the lower end of the system or situations of an emergency that requires immediate referral here.

THE GOLDEN HOUR

While under ordinary circumstances road ambulances are used to move patients around, because we are concerned about the golden-hour, we use the fastest means to get patients here. When somebody is gravely injured, you stand better chances of saving his life within the first hour of injury. If you cannot achieve that, then this patient should get the care he needs within six hours and if that fails you move into the next day or the 'Sliver day.'

That is not desirable and that is why we have a helipad here. If you are too sick get or get injured anywhere in Rwanda and the first care givers judge that it is a case to be best handled by KFH, without looking at the social status of the victim, the patients are transferred by Helicopters with trained medical staff. This is one of the ways used to evacuate people after major accidents and this affected their outcome. This service is maintained in conjunction with the air wing of the Rwanda Defence Forces and Akagera Aviation. The helicopter is equipped to allow treatment to begin on board and more equipment can be added depending on the requirements of the particular mission. The army and Akagera Aviation are just a phone call away. So even before we talk about services, people have access to the hospital because it is a different thing to have services available and quite another for those services to be accessible.

Fortunately most district hospitals now have 4 to 5 ambulances while an improved road infrastructure allows good access to KFH even by road. What we need to do now is to train ambulance crews over and over again so that they can bring patients safely to hospital.

SERVICES

I usually divide our services into two categories - clinical and support services. Clinical services include Internal medicine as a department, Surgery, Obstetrics and Gynecology, Pediatrics, Anesthesia and Critical Care and their specialities.

These are usually common in most hospitals up to referral level but to go a step further, at KFH we have added other departments such Orthopedics, Neuro-surgery, ENT surgery as well as Head and Neck surgery.

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Surgeons at work at King Faisal Hospital, Kigali

We also have urology, plastic and reconstructive surgery, maxillo-facial surgery, cardio-thoracic, cardiology, ophthalmology for the eyes, pulmonology, nephrology, dental and oncology services all operating as independent departments.

We have all these as part of our efforts to cover the scope of the problems in the country and the region.
Support services include an Imaging Centre with MRI (Magnetic Resonance Imaging), CT (Computerized Tomography Scan), and digital radiography. Our imaging is fully digitalized and printing of X-Ray films for instance is quite optional. Once an image is captured, it is immediately archived and can be retrieved from any of the remote terminals in the hospital.

To ensure that critical operations are not disrupted, we have a multiple-redundancy power supply. Like all major institutions, we are connected to the mains grid electric power supply. To guard against the threat a disruption to power supply would pose to patients, we have a set of two generators that are designed to switch on in a sequence should there be a failure.

In the event that the two backup generators fail, this unit which has the capacity to power the entire hospital can be looped to supply electricity. We believe that the time bought by this arrangement is sufficient to allow measures to restore normal supply to be pursued without putting any patient be it in the operating theatres, or on life support at risk.
It is with a reasonable degree of confidence therefore that we look forward to this year's COHSASA audit as part of our continuing commitment to provide the best clinical care in this part of East Africa •

Dr Alex Butera is the Acting CEO King Faisal Hospital

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Rwanda's pursuit of shared wealth through Health for all

By Dr. Agnes Binagwaho

Rwanda is determined to join the ranks of middle-income nations by the year 2020. This determination is largely driven by one thing: the demand for what Rwandans call 'agaciro or 'dignity for our people.

In pursuit of agaciro, the Rwandan people are continuously compelled to find better ways of doing things. Our economy must be vibrant and more independent; our politics must be inclusive and founded on consensus building; and our people must live a decent and dignified life, able to fulfil basic social needs.

To achieve these ambitious goals, the Government of Rwanda has adopted a number of innovative approaches to policy making and implementation, including both universally applicable and home-grown solutions that effectively account for context in addressing Rwanda's most pressing challenges..

Indeed, seeds sown since the 1994 genocide against the Tutsi are beginning to bear fruit. The recent publication of the countrywide household survey indicated that Rwanda has reduced poverty levels by 12 percent over the past five years, from almost 56 percent of the population in 2005 to 44 percent in 2010.

The understanding underlying this success is that for a nation to be successful, it must invest in and rely upon the human asset or capabilities of its own people. Rwanda's philosophy for growth starts with a shared vision that a well educated and healthy population is the starting point for any economic development.

This is why the health sector been a key priority for the country's Government; 18 years down the road to recovery after 1994, the achievements in this sector speak volumes.

Documenting Recent Progress

The recently released Demographic and Health Survey (DHS) of 2010 revealed several areas of dramatic progress in health outcomes since the last survey in 2005. Across the spectrum, the findings demonstrate significant progress in combating infectious diseases, improving child and maternal health, and addressing both financial and geographical barriers to accessing health care.

A Rwandan child born today has more hope than ever before of living to celebrate his/her first and then fifth birthdays. Between 2005 and 2010, the infant mortality rate dropped from 86 to 50 per 1,000 live births, while the under-five child mortality rate plummeted by fully 50% from 152 to 76 per 1,000 live births.

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Rwanda remains dedicated to surpassing the Millennium Development Goal targets for infant and child mortality by 2015, but as a result of our deeply rooted conviction that our children must enjoy the right to life and hence a right to adulthood, we know that we can drive these figures down even further.

These declines have not come as a surprise; they are partially attributable to the fact that more and more of Rwanda's mothers are enrolled in and retained by antenatal care programs throughout their pregnancy. This has led to an increase in the number of women giving birth at a health facility from just 30% in 2005 to 69% in 2010.

To adequately address issues concerning maternal and child health (MCH), Rwanda has employed many synergetic interventions along the continuum of care, but all of these are built upon the foundation of a strong community health system driven by Community Health Workers (CHWs) deployed in all villages across the country. These community health workers have bridged crucial access gaps in the health system and have brought prevention, treatment, and care services closer to the people.

One clear result of CHW's effectiveness can be seen through Rwanda's active immunization campaign, which has achieved over 90% coverage of all children and ensured the provision of new vaccines targeting emerging diseases to the population. In 2009, Rwanda was the first country in Africa to roll out the pneumococcal vaccine, and in 2010 became the first low-income country in the world to roll out the human papilloma virus vaccine. Both initiatives have attained over 90% coverage by building on the country's pre-existing robust vaccination program.

Investing In Our Population

It is well known that Rwanda does not have major natural resources like oil, gold, and diamonds; but our Government knows that our greatest asset is our people themselves. To ensure that we deliver appropriate services in an equitable way that allows each Rwandan to reach their full potential, we have continuously worked to educate our people on the need for smaller families.

Rwanda needs a population whose growth does not outpace that of our economy. Declines in birth rates over recent years are not as dramatic as those that will be needed in the future, but they do show that we are achieving concrete results. Between 2005 and 2010, total fertility rate (the number of children a woman is expected to have throughout her entire life) dropped from 6.1 to 4.6.

Uptake of modern family planning methods jumped by 450% during the same period, from just 10% in 2005 to 45% in 2010. Taken in the context of other socioeconomic indicators discussed earlier, we can see a strong relationship between improving child survival and declining birth rates – as fewer children die premature deaths, families feel the need to have fewer children.

Combatting Infectious and Non-Communicable Diseases

With the support of our global partners, Rwanda has made substantial gains in the fights against HIV/AIDS, tuberculosis, and malaria. HIV prevalence has fallen from 13.9% in 2000 to 3% today due to an integrated approach to tackling the pandemic with urgency and equity.

As of December 2011, fully 100,656 patients at 390 health facilities across Rwanda were receiving antiretroviral therapy for free, accounting for 84% of all patients clinically in need of treatment. When compared to the 870 patients at just 4 facilities who had access to these lifesaving drugs in 2002, it is clear that we have come very far.

A combination of effective policies for malaria prevention and control have likewise contributed to a reduction in prevalence and mortality associated with malaria by almost 50%. This is largely due to an increase in the usage of mosquito nets from 56% of households in 2005 to 82% in 2010, but also tied to the provision of effective diagnosis and treatment at the community level by CHWs.

However, Rwanda and its leaders will not be complacent following progress against the major infectious killers: we recognize well the need to turn our attention to the growing burden of non-communicable diseases such as heart disease, Cancer, Diabetes, and respiratory diseases. As more Rwandans live longer, we must focus on the long-term needs of the population by anticipating health problems that are likely to arise and preparing solutions now.

There are many areas where we can begin to act immediately on non-communicable diseases, such as the prevention and treatment of paediatric and female cancers where the market and partnerships have made new opportunities available today. The Ministry

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of Health is currently in the process of planning for comprehensive national early detection and treatment programs for breast and cervical cancer for women, who will also benefit from access to the human papilloma virus vaccine to prevent cervical cancer in the first place.
We are currently in the final stages of assembling protocols, guidelines, and policies for paediatric cancers, beginning with those that are most prevalent and most amenable to immediate action. Non-Hodgkin's Lymphoma, for example, affects many children in Rwanda, and there is something that can be done about it now even as we work to build the capacity to address more complicated cancers.

While we understand the urgency of obtaining sufficient infrastructure, Rwanda will not wait for the last brick to be laid or the last road to be paved before we act – we will handle whatever illnesses we can within our present means while striving for a stronger system at the same time. For those who it is too late to offer successful treatment for cancer or other non-communicable diseases, we shall ensure the provision of palliative care.

Persistent Challenges

As we take pride in Rwanda's achievements, we are also mindful of the challenges ahead. Much as the DHS 2010 results provide a roadmap for further improvement of infectious disease control programs, we need to adopt innovative new approaches that will provide quick solutions for transforming our sector across all initiatives.

Through our Community-Based Health Insurance scheme, known as Mutuelle de Santé, we have addressed the issue of financial accessibility in the health system. More than 80% of Rwandans today are enrolled, guaranteeing them access to quality services. However, gaps persist in geographic accessibility that can be addressed by constructing more health facilities across the country. The Government's aim is to have one health center serving each local government sector population of 20,000 to 25,000 people, meaning that significant further investment in infrastructure will be needed.

The Ministry of Health and health providers around the country understand that access alone is not enough – we must also strive to provide the highest possible quality of care to our population. Rwanda aspires to become a hub of exemplary services for the entire East African region, and we will need to continue improving quality if this vision is to be achieved. Such efforts will include not only the acquisition of newer and better equipment, but also bridging the ratio of providers to population.

Today, the ratio of physicians to population remains unacceptably high at 1 per 17,000. Our target is to reduce this figure to 1 per 10,000 in the near future. The Ministry of Health seeks to have at minimum a surgeon, a paediatrician, an anesthetist, an internist, and an oncologist at each district hospital.

To this end, we have reached an innovative $34 million agreement with the United States Government that will bring more than 100 senior medical faculty from American universities to Rwanda over the next seven years to train and work with our physicians to build speciality capacity and create new residency programs. This program will begin in July 2012; with sustained commitment and sufficient vision from all involved, it has the potential to affect a massive paradigm shift in global health partnerships and medical education around the world.

Looking to the Future

As a core element to Rwanda's Vision 2020 national strategic plan, the Government of Rwanda has established ambitious targets for the health sector that must be realized by the end of the decade. The under-five mortality rate, for instance, should be reduced to 30 per 1,000 live births from the current 76 and current prevalence of severe malnutrition must be reduced six-fold. These and many other goals will require concerted efforts from every stakeholder, including our development partners.

In assessing our current situation and where we want to go, we can see that the good news is that Rwanda has built the basics of a dynamic and equitable health system. In order to take the health sector to the next level, we must build upon our solid foundation and continue to seek out ways to improve the value, quality, and compassion of services we deliver.

It is written in Rwanda's Constitution that "the human person is sacred and inviolable." The Ministry of Health could not possibly take this declaration more seriously; the quest for improvement is a civil, moral, and human duty that we accept with great humility and determination.

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Health Financing in Rwanda: Towards Universal Coverage

By Andrew P Makaka

The uniqueness of Rwanda's health financing model lies in the success it has achieved in bringing the informal sector, particularly the poorest and the most vulnerable groups within the Social health protection loop

Rwanda is one of the few countries that have rapidly progressed towards universal health insurance coverage and attained significant improvements in the health status of its population. In just over 16 years post-conflict, the Ministry of Health was able to rebuild its health system to a point where the majority of the population has access to health services thereby contributing in no small measure to the attainment of sustainable human development and economic growth.

A key strategy that has contributed to the progress the sector has witnessed has been the focus on health financing reforms, particularly community-based health insurance(CBHI) and performance-based financing (PBF).

In support of the strategy, several policies aiming at universal coverage have been developed based on the principles of equity, risk-sharing, solidarity, empowerment, community participation and partnerships. With the vision to "achieve the goal of health for all through universal health insurance" by 2020, the Social Security Policy (2009). The National Health Insurance Policy (2010), Community Based Health Insurance Policy (2010) and the Health Financing Policy (2009) were developed.

In 2010, a Health Financing Unit in the MoH was established to oversee and coordinate the implementation of the health financing policy within the government and with development partners. The Unit was tasked to oversee the attainment of five strategic objectives -strengthening risk pooling for improved financial access and household income protection of Rwandan families; improving efficiency in the allocation and use of health resources and coverage of high impact interventions; increasing internal resource mobilisation for sustainable funding of the health sector; improving the effectiveness of external assistance in the health sector; and strengthening the institutional environment for sustainable financing of the health sector.

Health Financing Contribution to Health Outcomes

The growth of CBHI has, together with the fight against Malaria and HIV programs, the performance-based financing approach, the community health and quality assurance program, led to improved scores across several health indicators.

According to the 2010 Demographic Health Survey, assisted deliveries rose from 52% in 2008 to 69% in 2010 while infant mortality declined from 62/1000 in 2008 to 50 per 1000 live births in 2010. Bucking the same trend, maternal mortality rate saw a dramatic decrease from 750 deaths/100,000 live births to 487 deaths for every 100,000 births in 2010. Under-five mortality fell from 103/1000 in 2008 to 76/1000 live births in 2010 reflecting an improving socio-economic status in the general population.

Utilization of health services has also improved at

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1.8 out-patient visits per capita per year for women and 1.5 out-patient visits per capita per year for men. As well, out-of-pocket cost at $4.14 per capita per year for women and $4.37 for men (DHS 2010) accounts for about 12% only of the total cost of health care per capita of $34 per capita spent in 2006.

Covering the informal sector

Social health protection, mainly in the form of Community Based Health Insurance (commonly known as mutuelle des santé) is a means for the informal sector, particularly the poorest and the most vulnerable groups, to access health services in health facilities. With the strong leadership of the Ministry of Health, the social safety net in health is ensured for the indigents which comprise a quarter of the population. Their membership to the CBHI scheme is subsidized by government and donors and access to health care services at all levels is guaranteed without any co-payment. It actually addresses the issue of lack of money as a key perceived barrier to access as reported by 53% of respondents in the DHS 2010.

CBHI was piloted in 1999 and was extended to the whole country in 2005. All 426 health centres in 30 districts in the country shelter a CBHI section and in 2010[1], covered 91% of the population. With the issuance of CBHI cards to members, they are made aware of the comprehensive benefit package they can avail from the health centre, district hospital and referral hospitals. In addition, complicated cases needing higher levels of care are referred to national hospitals.

Table 1:Health Services provided to CBHI beneficiaries by level of health facility

Health Facilities	Package of Services Provided
Health Posts	Outreach activities (immunisation, family planning, growth monitoring, antenatal care)
Dispensaries	Primary health care, outpatient, referral
Health Centers	Prevention activities, Primary health care, inpatient, referral, maternity
District Hospitals	Inpatient/outpatient services, surgery, laboratory, gynaecology obstetrics, radiology
National Referral Hospital	Inpatient/outpatient services, surgery, laboratory, gynaecology obstetrics, radiology

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Source: Adapted from Ministry of Health Annual Report 2009-2010

Effective July 2011, the Ministry of Health introduced a wealth-based premium contribution based on the Ubudehe system. This was in line with the government's thrust to develop an equitable and sustainable system and to ensure that beneficiaries will have access to better health services. Previously, each person paid a flat-rate contribution of 1,000 RWF per year while the government met the other 1,000 RWF for each enrolled member.

Wealth-based Premium Contribution

CBHI Category	Premium Contribution per person/ per year
Group1- Indigents (Ubudehe category 1&2)	**2000 RWF**, fully supported by the government; this group is exempted from paying; No co-payments
Group 2- People who can afford to pay (Ubudehe category 3&4)	**3000 RWF** paid by themselves With co-payments: 10% at DH/ RH and 200 RWF at Health Centres
Group 3- People who are rich (Ubudehe category 5&6)	**7000 RWF** paid by themselves With co-payments: 10% at DH/ RH and 200 RWF at Heath Centres

Performance Based Financing: Incentives for Quality Care

In Rwanda, Performance Based Financing was piloted in 2002 before nationwide roll-out in 2007. It was seen as a means to increase the quantity as well as quality of health services through provision of financial incentives as a motivation to health workers. Further, to the Ministry of Finance it presented an option for increasing resources, while improving health results through better public financial management. This would allow the hiring of more personnel for the sector without affecting the wage bill.

The national PBF model is made up of three basic components - a PBF model for health centers; PBF for district hospitals; and (3) Community PBF. It is a combination of Results Based Funding and Results-Based Aid. The outputs that are financed and the criteria used for payments vary depending on the model:

At the Health Centre level, there are 14 PHC indicators and 10 HIV/AIDS indicators. The payment is computed as Quantity of service * fee for the service* % achievement on Indices of Quality and paid after thorough verification by the district steering committee.

At the district hospital level, the PBF model is slightly different in the sense that it focuses on quality assurance, self-evaluation and review by peers similar to an accreditation scheme. Payment is linked to performance in 52 nationally standardized indicators that are grouped into 3 categories - clinical services, functioning of the hospital and supervision of health centres in area of coverage. Assessment is done every 6 months through a peer review mechanism (grouping of 4 hospitals) allowing exchange of experiences and unannounced and random central level assessment by the MOH and the donor involved in financing using a tool similar to a balanced score card with 350 variables; that aim at checking the peer review results. The internal allocation of PBF is generally left to the hospital but it is encouraged to use around 40% for incentive payments to the staff and the remainder for running costs.

At the community level, a community PBF was embedded in the National Community Health Policy under the strategic direction of the MoH and implementation by the Ministry of Local Administration. The PBF indicators are (1) mutuelle enrolment; (2) deliveries at HC; (3) use of insecticide-treated nets; (4)management of dehydration due to diarrhoea among under-fives; (5)personal hygiene; and (6) reporting. The community health worker cooperative is paid based on timely and reliable reporting of a set of indicators.

Two years into the national roll-out, the over-all performance of health facilities based on program level data shows a significant increase of some indicators. As of 3rd quarter 2010, the over-all measured quality score of district hospitals in the country was 72.2% (range 33%-96%) (MSH,2011). Likewise, a rigorous impact evaluation of the health centre PBF found positive impacts on maternal and child health outcomes. Institutional delivery increased

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over-all by 7% more in PBF facilities between 2006-2008 while prenatal care quality increased significantly with a 15% standard deviation (WB/NURSPH, Jan 2010). The increases in service utilization, often linked to PBF, have to be seen in the light of the nationwide introduction of the CBHI.

SWAP: Aligning and Harmonizing Donor Support

The key components of the Sector Wide Approach (SWAP) include a multi- year sector strategy, medium-term expenditure framework (MTEF), public financial management systems, broad consultation mechanisms, performance monitoring, development partner coordination, strengthening and use of government systems and a memorandum of understanding between the government and its partners. The principles of SWAPs are the same as the Paris Declaration Principles, namely ownership, alignment, harmonization, managing for results and mutual accountability.

The foundation of the Sector-Wide Approach (SWAP) in Rwanda's health sector was laid in 2007, with the cooperation among the twelve most important development partners and the Ministry of Health (MoH). The SWAP is financed with the following instruments: the Rwandan contribution derived from the Government budget, sector budget support from four donors, basket financing (Capacity Development Pooled Funds) and on-plan projects.

The Joint Health Sector Review (JHSR) is the most important element in the mutual accountability process within the health sector and helps show how far sector budget support is being used for its intended objectives and what relevant benchmarks have been reached. This is complemented by the institutionalization of the comprehensive joint financial reporting tool known as Health Resource Tracker developed in 2010. A steering committee was (re)established under the leadership of the MoH with the mandate to decide on the use of CDPF resources for training, studies, consultancies and other measures targeting capacity development of personnel within the health sector.

Moreover, the Ministry of Health developed in 2010 with the support of development partners a SWAP Manual, defining the principles, aid modalities and regulation of the Health SWAP in Rwanda. The SWAP Roadmap outlines the areas and priorities of intervention to further develop a coordinated approach.

Good Governance: Key to Rwanda's Move to Universal Coverage

The success of CBHI in Rwanda and the move towards universal coverage is attributable to a handful of factors including good governance and strong leadership of the government in particular, a conducive environment for universal coverage,decentralized national health insurance system management, evidence-based and participatory policy development, and strong local support for insurance coverage.

On the supply side, Performance-Based Financing is a powerful instrument in the health system that led to significant improvements on quantity and quality of health services as well as incentives for health worker motivation.

As a cross cutting element, harmonization and alignment of donor support is a key contributing factor to the impressive progress in Rwanda's health sector. This is also recognized in the HSSP II Mid-Term Review conducted in 2010.

Challenges

Although Rwanda is already in the path of universal coverage, many challenges still need to be addressed. Ensuring institutional and financial sustainability of CBHI, strengthening population awareness on the concept of CBHI and its benefits, sustaining the high membership coverage and engaging the private sector for a more balanced development of the health system, strengthening strategic purchasing by linking CBHI provider payment with PBF, increasing predictability of aid and further improving donor coordination are some of the challenges that need to be addressed going forward ●

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A dream born in Dakar: Hôpital la Croix du Sud

By Dr. Jean Chrysostome Nyirinkwaya

When you are used to deal with patients, it is not easy to deal with papers. That is something I learnt soon after I returned to Rwanda after liberation in 1994 when I was appointed Regional Medical Director for Kigali by the then Minister of Health the Honorable Doctor Karemera.

It was in part this frustration with being trapped into an administrative position while I felt my vocation was in helping people heal that drove me back into private practice in 1995, opening the way to events that would culminate in the establishment of Hôpital la Croix du Sud nearly a decade later.

To understand my practice you need to go 40 years back to my father's clinic in Bujumbura. Nyirinkwaya senior was a private doctor and proprietor of Nyirinkwaya Clinic in Bujumbura, so I picked an interest in medicine from a very early age. Years later when I studying medicine in Senegal in 1976, I used to work as night nurse in a private clinic. This gave me time to think about my father's small clinic in Bujumbura and understood what it really took to equip and run a full scale hospital.

I realized that in terms of pure set up, it was not as complicated as one may think. Like a car it has basic components such as the power train, the wheels, cabin etc. When I looked at a hospital in these terms I realized that it was not so difficult to set up a hospital or an advanced clinic. From this moment, I caught the bug of building a hospital not just a clinic.

When I returned to Burundi where I stayed as a refugee in 1988, I wanted to work in my father's clinic but the authorities in Burundi advised that although I was under no obligation to work for the government, it would be good if I worked in a public hospital environment to gain experience. So for the next two years I worked as a Gynaecologist at the Prince Regent Charles Hospital in Bujumbura.

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That was a blessing in house. I was able to get some experience and yet because I had specialized in gynaecology, working in this hospital exposed me to broader practice. When I returned to work in my father's clinic I was like a general practitioner because at that time in Burundi, few people knew that I am gynaecologist and was CP clinic. I was really helping my father's practice because he was sick and he subsequently died in 1991.

I carried on his practice but in 1993, I commissioned architectural plans for a small hospital. I was doing general medicine but I was keen to practice my speciality. I asked an architect friend to advise me on how I could transform the small building that housed the clinic to have 10 rooms one of which would be a delivery room so that I could start carrying out deliveries at my facility.

I was actively looking for a loan to implement this plan when genocide broke out in April in 1994, culminating in the July liberation. This development completely changed my plans and I came back to Rwanda as soon as Kigali fell in July.

On return I was appointed by the then minister of health at that time Hon. Dr. Karemera as Regional Medical Director for Kigali. This was kind of a setback for me as it was different from what I had been taught. I was becoming an administrator and as I sat in my office, I constantly asked myself what I was doing there.

But because there was a lot of training going on at that time we started to appreciate what we needed. But I kept reminding myself that this was not my calling and I had to find a way of practicing real medicine because when you are used to dealing with patients, it is not easy to deal with papers and there were many problems in the field of gynaecology and obstetrics at that time.

So as I worked as regional medical director, I was also looking for a suitable location for a clinic. In 1995, I found suitable premises in Nyamirambo. It was previously a hostel that had been partially destroyed during the war.
I asked the owners of the property and they accepted to restore it and give me tenancy. I applied for credit from the Bank of Commerce, Development and Industry BCDI (now called Ecobank) and they advanced me a loan of Rwf 4 million.

I had no collateral but the Chairman of the bank trusted me. He accepted to use the equipment we were buying as the collateral. He told me "If you don't succeed, I will take this." That loan was to cover equipment and running costs for three months.

Eventually I did not need the money for running costs because the practice picked up very fast. Many of the people who came in from Burundi, Uganda and elsewhere at the time did not trust public hospitals because of the overhang of the terrible things that had happened at some facilities during the genocide.

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There was no trust and the public services were also weak, they lacked capacity. So the business boomed. It was then called Polyclinique du Croix du Sud. It had 12 beds, one delivery room, and a simple laboratory. We had one gynaecologist, 1 General Practitioner and 1 Paediatrician.

The clinic made many deliveries and today I see so many children in Kigali that were delivered in this clinic. We started this poly clinic on 15 October 1995. After sometime, we shifted to bigger premises next door which was on 3 levels. This gave us more space for doctors and most importantly we had a theatre so there was no need to transfer patients to CHUK for operation and other places any more. Then I was able to handle complicated deliveries there.

I made this move because I was always looking at how to deal with the limitations the operating environment imposed on us. In many cases, If you have a complicated situation, you have just about 15 minutes to deliver a person but if that included 20 minutes to transfer a mother in distress and perhaps another 25 minutes or more for admission, you did not have much time left. The unborn child could suffer a lot of complications that were avoidable. If you had a theatre, all this could be avoided. If you have a theatre and you deliver a kid that needs urgent intervention you immediately move them to neo-natal. In delivery a newborn child can suffer just as the mother can suffer. So these problems always drove me to look for a solution. My objective has always been to be more and more self-sufficient with all the essential departments, tools and skills available at one location. If am limited by one factor, I always try to look for a way to deal with it.

The deficiencies in capacity have in the past led to a bad relationship between private practitioners and the workers in public hospitals. In the beginning when we referred patients to the public hospitals because they had the facilities' that we lacked, the workers there would pour scorn on us, asking the patients why they wasted time first consulting "incompetent private practitioners" instead of going straight to the big hospital.

They portrayed us as gold diggers who were simply interested in financially exploiting our patients. This tended to damage our reputation. For a seasoned practitioner who was focused on positively changing the practice of medicine, it really hurt to hear such talk coming from a nurse or a doctor who had no idea what you were trying to achieve for the public good.

I went into private practice, motivated by a desire to give patients better care than what was common in our country. I thought it was necessary to change the orientation of the medical profession towards better customer care for patients. I thought that should be my contribution to medical practice in Rwanda. Fortunately, those insults simply drove me to develop more and more capacity on site. I wanted to do

Dr. Nyirinkwaya chats with some of his health workers at the hospital

something that could change the practice of medicine in Rwanda. I was the first to operate a poly-clinic in Rwanda and now there are many poly-clinics. I have set up the first private hospital on this scale that is not backed by a mother organization and I am sure many others will follow. This gives me a sense of achievement and satisfaction.

I am a mentor who wants people, not just practitioners to understand the true ethical practice of medicine so that the general public can know who is cheating and who is not cheating and my dream is that everyone can be proud of the medicine of Rwanda.

One of the major factors that have contributed to my success is trust. We have a good track record and that is why it hurt whenever nurses and doctors in public hospitals denigrated our efforts with such remarks as "oh this case from Dr. Nyirinkwaya; why did they take so long before referring you? It hurt so much."

When I started out in 1995, I had 60 deliveries (in only 2 months and half). In 1996 that number had risen to 600 deliveries a year. In 2009, the last year in Nyamirambo I delivered 1200. On 31, October 2009, we moved the practice to the present site in Remera.

Scaling up to Remera

I bought the land for the present site in 1995. That depleted all my resources but the Bank of Reconstruction and Development (BRD) was on hand. One day people from BRD walked into my office and asked if I had a bankable project. I opened my drawer and brought out the architectural drawings and the project proposal for a hospital.

They promised support based on my client base and reputation as a practitioner. My best ally in this project has been trust. People trusted me and it is something I guard jealously. The bank trusted me because the community I dealt with trusted me.

With the help of my brothers and sisters, who agreed to sell the family house in Bujumbura and combined with credit from the bank, I started construction in 2005. We spent Rwf 2.5 billion and it was ready for occupation four years later.

We have a headcount of 200 workers among them, 12 permanent doctors and 15 part-time doctors. We handle an average caseload of 325 outpatients a day. We have an in-patient capacity of 75 and if you take into account the beds in the emergency rooms, neonatology, delivery rooms, we have 95 beds spread across 3 classes of rooms.

Now we are trying to improve our services in the three departments of gynaecology, pediatrics and internal medicine. If we want to improve our country we need good medical facilities and I encourage further investment in health care facilities. People also have to change their mindset which is currently trapped into thinking that health care is free or cheap. People want good services but are not ready to pay for it and health care has a cost, a hospital has a big running cost.

In Rwanda a person who finds it easy to change a car tyre at Rwf 90,000 finds it difficult to allocate the same amount of money for the care of his pregnant wife. He can change his phone battery or buy a new phone altogether but will not spend the equivalent amount on his sick child, himself or his wife or even good to estimate for 50.000Rwf.

This is the paradox of the Rwandan mentality. It is driven by the history of free care in colonial times. Even as services declined after independence, they would rather spend time at a free health care facility where treatment is free but don't get adequate treatment. Faith based hospitals could offer cheap healthcare because they enjoy donations and grants from their promoters but the quality of care is not always up to the problems that emerge.

This situation has led to cases where those with means would rather fly out to get treatment and sometimes even die on the way.

I am convinced that as long as Rwandans don't change this mentality, we can't have permanent progress in medicine.

Relations

The relationship between players in the health sector is changing for the better. The ministry of health now looks at private practitioners as partners in health delivery and involves them in policy dialogue. In February, I attended a health ministry planning retreat in Musanze that plotted

›› Continued on 44

The Provincial Coordinating Meeting: An innovation in tracking Health sector targets

By Aime Bosenibamwe

The Northern Province is one of the 4 provinces that make up Rwanda. As is common across the country, the province has been the beneficiary of various government programs and initiatives over the past decade and half.

Recent years however, have seen rapid change in government policy and keeping stakeholders focused, tracking progress and meeting targets is a big challenge. To deal with challenge, we conceived the Provincial Coordinating Meeting for the Health Sector, a quarterly forum that brings together 150 stakeholders from the government, local communities and development partners.

The purpose of the forum is to facilitate the coordination of activities in the health sector. While we have the government policy for the health sector, provincial administrations have a role in coordinating the implementation of government policies at district level.

During the forum's quarterly meeting we review and analyse the implementation of government policies as they relate to health. We track progress against set national and international objectives such as the Millennium Development Goals, national targets for reduction of maternal and child mortality, access to health services and whatever else may be necessary. We coordinate every partner in the health sector across the province.

At the district level the deputy mayor in charge of social affairs, the medical director in each hospital, the director in charge of health, the heads of pharmacy, Mutuelle de santé and the heads of health centres at sector level attend the forum. We also have the community based workers who are responsible for organizing cooperatives at the village (umudugudu) cell level, attending. This enables us to have a picture of what has happened during the preceding quarter at the different levels in the province, in the space of just a few hours.

It is an opportunity for us to review progress and know challenges affecting implementation of government policy. During the forum we analyse, plan do monitoring and evaluation of government programs in the health sector across the province. The key things that are reviewed in this meeting include the functioning of hospitals and health centres, progress in terms of eradicating malnutrition, family planning uptake etc. We also analyse hygiene and sanitation in hospitals and service delivery in all health facilities down to sector level.

We are see tangible results from this effort. For instance when we first organized this forum, uptake of Mutuelle de Sante in all the province was standing at a paltry 20%. When we met next in February 2012, we were scoring above 80% on average and districts such as Burera had achieved 92% while Musanze had reached 87% in the past 3 months. This is a very big achievement given that uptake of Mutuelle de Sante must be viewed against the new policy on premiums. It takes particularly strong mobilisation to get people to buy into the new contribution thresholds.

We are proud and feel vindicated by the national response to our initiative as captured in the sentiments expressed by Health Minister Dr. Agnes Binagwaho when she described the forum as "a best practice where the local government owns its health sector through discussion of policies and strategies that harmonise the practice for the good of the population. I advise all the governors and mayors to emulate this type of forum for health."

Aime Bosenibamwe is the Governor Northern Province

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Masaka Hospital

Ramping up to national accreditation

Dr. Bonaventure Nzeyimana

Not too long ago Rwanda was uplifted by the news that King Faisal Hospital had attained the Council for Health Service Accreditation of Southern Africa (COHSASA) accreditation. It was well deserved jubilation given that accreditation is a process that results into the delivery of safe, quality care through sustained improvement.

As a country, we have decided to adopt accreditation as a tool for improving the quality of our health care system. In technical terms, accreditation is an objective exercise of external evaluation of an institution against known set of standards. Those standards depend on the context – domestic or international. For Rwanda we have decided to work against international standards for referral and district hospitals that are going to be customized internally to our setting according to the package of activities desired for each level. For health centers, the evaluation will be done against national standards.

The objective of accreditation is not only the evaluation itself but a continuous process through which we hope to build a culture of quality in our health delivery system. The process has about four phases. It all begins with the preparatory phase where you set up all documented tools related to policies and procedures that have to govern services for each level or institution. The second phase relates to the baselines that have to be carried out by an external body. This external body determines the zero level or start point for each institution against which the activities related to quality improvement for that particular cluster of institutions will be benchmarked.

The third phase is the facilitation phase where you have commencement of intensive activities related to continuous quality improvement. For Rwanda this is going to be carried out by the Ministry of Health in collaboration with its institutions specifically for the

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referral and the district hospitals. This does not mean that we are not going to have external assistance especially to build capacity in terms of continuous quality improvement. But this support is going to decrease progressively over time by as we gain capacity internally to a point where we can conduct the exercise ourselves. This will be less expensive than using external facilitation. Concurrently, each institution is going to do what we call self-assessment where they by themselves evaluate the level of their quality against standards (self-evaluation).

The fourth and last phase is external evaluation for accreditation. Over time we have had King Faisal scale up its internal processes up to a point where it has been accredited. Right now it is in a phase of continuous facilitation. We are going to come back in two years' time to see if the level of quality they reached two years back has been maintained.

Other facilities are also making progress. CHK has benefited from the second external evaluation where it scored 55%. But this mark cannot allow them to get accreditation. To be eligible for accreditation an institution under review must score a minimum of 70% against set standards. But we should not denigrate CHK's achievement given that they were coming from a baseline of 37%. We think that with the effort of facilitation, in a short time they are going to reach eligibility for accreditation. Accreditation requires a score of 95% and above. We are going to speed up the process for Butare and Kanombe Military Hospitals. We are in talks with COHSASA and we are hopeful that they are going to get their baseline assessment very soon so that they can embark on the process itself. Later, it is those high level institutions that will help the Ministry of health to mentor district hospitals.

We are about to complete the preparatory phase for district hospitals. We have already finalized the policy, procedures and guidelines that are going to govern all services. We are finalizing the definition of packages at all levels as well as the clinical protocol that will harmonize treatment across the country. We think that those documents will be ready for use very soon. Starting May, we are going to see how we can set up standards. This may require us to hire an international body which will help us customize them to the level of district hospitals. The last external evaluation for district hospitals will be carried out at the end of 2015 or the beginning of 2016.
The health centres will hopefully join the process in 2015. In summary, accreditation is a good way of having an objective evaluation of an institutions looking at all the parameters such as governance, infrastructure, human resource etc. When you find gaps you are facing in all areas, you try to improve area by area. This will be the role of supervision in its new framework, where supervisors will work as mentors (coaches) on field and train by doing.

The way our health sector is structured may sometimes mean that full responsibility may not be in the hands of the leadership of the institution themselves. There are some areas that are related to the system itself such as infrastructure, human resource etc. But there are other areas which are specifically related to change of behavior and how people are delivering services individually and as a team. This is related to the management itself and its efforts to improve customer care where you don't even need more resources.
Through this knowledge we are going to triangulate the results in each area and know the level of responsibility throughout the system.

Overall it is a very good exercise because it challenges everybody within the system to see what they can do within their means to improve the system. What we want to see is our health system meeting international standards. As Rwanda moves to improve standards across the board, beating records in improving the quality of life of its citizens and people visiting Rwanda, the health sector cannot afford to be left behind in that process. We have to follow the same trend.

The benefits of the exercise go beyond having all institutions accredited at the desired level. Even if a hospital is not accredited but there is some lesson to learn from that institution and everybody is going to learn what they should do to improve the system, it will help. People cannot improve if they don't know what to improve. So it is a positive process that also engenders internal competition that will orient people towards continuous improvement. So this is a tool for advocacy to the ministry or central government to get us more money to improve our infrastructure. It is also a tool for advocacy between the institutions and their partners. We cannot fix a cutoff line for all health facilities but we believe that with everybody pulling in the same direction we shall improve our health system in the shortest possible time.

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DATA TALK: The Health Management Information system

By Dr. Charles Ntare

Data driven or evidence based planning forms a central plank in the success that Rwanda has seen across several programs over the past ten years. The Health Management Information system or HMIS, seeks to achieve better outcomes by making health information more instantaneous for planners

By Dr. Charles Ntare

By simple definition, HMIS is a Monitoring and Evaluation tool which encompasses all Routine Information Reporting systems in the health sector. It functions around three major components - a Technological component comprising of soft and hardware parts as well as IT network for connectivity aspects as well as an administrative component made up of the people, procedures and policies that govern how the system is implemented. Last but not least is the Data component or the elements to be captured for calculation of indicators. It is these data elements that are later transformed into meaningful information that will eventually be used to guide decision-making. Over the last 10 years, we have been collecting aggregated data from the 474 Health Facilities in at different levels. From 2009 we increased the scope of health routine reporting when we started receiving aggregate reports from the Community Based Health Workers, on a monthly basis. Currently we are receiving monthly reports from over 400 Cooperatives of community health workers. In terms of progression, we continue to see a steady increase in data quality, and this is attributable to leadership that demands evidence or data-driven planning and evaluation of program outcomes.

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The improved quality of data is also attributable to the strategies we have employed to create a seamless data collection system.
Over time we have been able to place skilled data managers who collect at all health facilities. We have implemented an intensive capacity building program and we have developed guidelines for data management. Data collection has also been linked to Performance Based Financing, where monetary incentives are given to health workers for their services. In our case this is incentive is tied to performance as judged by the quality of data collected over a given calendar period.

A major achievement of the HMIS is the fact that a minimum list of indicators for the health sector, well defined with a meta-data dictionary has been developed. Currently, a data warehouse has been developed that will store data from both routine and non-routine sources as well as unique identifiers of the different registries like the Health Facility Registry for purposes of facilitating integration and interoperability of systems.

There has been harmonization and preparation of guidelines of key recording and reporting systems, including HMIS monthly reports. We have also been able to select and configure a new web-based system for HMIS as well as the National Data Warehouse. A new web-based HMIS is currently being rolled out and will host a number of applications.

In the past, the HMIS was poorly integrated, tools were not harmonized and much of the data collected has been under-utilized largely because the different systems were not talking to each other. The HMIS unit is currently focusing on harmonizing systems, coordinating data collection and building capacity for data use. This is an ongoing effort.

We are also developing the capacity of Data managers and Monitoring and Evaluation staff at central, district and health center levels in use of HMIS for data management and use.

Challenges

Given its centrality to the functionality and operability of HMIS, internet connectivity is still an issue at the periphery for data entry and data sharing. We are trying to mitigate that by using mobile phone technologies, because the coverage of mobile phones is now good, but this is rolled out in few facilities, yet to be implemented nation-wide. The second is that we need reliable electric power. Fortunately, the biggest number of our facilities has electricity but it is not as reliable as one would have wished. Thirdly are challenges of human resources especially at the level of health centers where we experience a high turnover in our data managers , a reason why we are obliged to implement sustained capacity building activities to make up for skills gaps every time new data managers are recruited.

There is also a limited culture of data use and there is a need to build data use into planning and routing of monitoring and evaluation activities in Health institutions and District administrations.

Way Forward

As part of efforts to boost the efficiency of HMIS, we shall proceed with Integration and Coordination of Monitoring and Evaluation activities. We shall implement a Re-alignment of all Planning and M&E reporting tools to achieve the desired levels of efficiency as defined by tools that deliver well and can talk to each other for inter-operability.

That should be complimented with improved coordination among M&E professionals in different units, as well as effective and coordinated data management processes through integrated approaches. We also intend to further harmonize data recording and reporting by supporting health programs to streamline their systems.

The current multiplicity of systems will also be integrated and migrated from their current platforms to DHIS-2. This will include data from private health facilities which should help give a more comprehensive picture of the sector.

It is also essential that we develop routinely produced feedback reporting mechanisms; enhance health sector staff capacity to analyze and use data to track progress of the national development priorities with tangible evidence.

As regards data demand and use, we are scaling up strategies to enhance data use in the health sector by designing standardized report for integration in the DHIS 2 tool, to automatically generate and pull through user-specific dash boards that are being designed for data managers and users.

Along the way we shall operationalize the health data warehouse and dashboard. The dashboard is a web-based information portal that will enable staff across the ministry to access and analyze the data stored in the data warehouse. Finally, in the years to come, we want to see routinely collected data improving in quality and getting closer to replacing population surveys data like the DHS (done every 5-years) in evaluation of program outcomes and impact ●

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Nursing the pillar of health

By Sr. Mary Murebwayire

Despite its centrality to delivery of healthcare, nursing is a role that is under appreciated in many countries. It is considered the pillar of the health system because worldwide nurses constitute about 85% of the workforce in the health sector.

Organizing the nursing profession in post-genocide Rwanda has been a herculean task because in the first place it did not exist as a profession at the level of the Ministry of Health. Before 1995, Rwanda did not have a Nursing and Midwifery department in the Ministry of Health and nursing services were neither coordinated nor recognized. Midwifery was not in existence in any form.

In 1995 we organized nurses into an association for the first time in Rwanda's history. About the same time, we visited some health and training institutions to see how nurses were being trained and performing in hospitals. What we discovered was that the training of nurses at that time was not coordinated by the Ministry of Health. The Ministry of Education was in charge of all forms of education in the country nurses were being trained to enrolled level, even in secondary schools.

The A2 nurses qualified from these facilities, many of which were not even attached to a hospital were more of general nurses doing everything. They were playing the roles of nurse, midwife, mental health nurses laboratory assistants just to mention a few. In some situations they were even doing things that should be the preserve of a doctor. Subordinate to these were A3 nurses whose level of training even more wanting.

It was not surprising to find that the quality of services they were rendering was not good. We came up with a proposal to the ministries of Health and Education and the WHO Rwanda office suggesting that the training of nurses should be elevated to a Higher Diploma level. We thought that if we trained registered nurses and registered midwives and the allied professions, the workload on the nurse would be reduced and allow her to competently do the work she was trained to do instead of dabbling in every activity.

Under normal circumstances, a nurse's role is to offer care to the patients. She is supposed to attend to patients' bedside needs, help them take prescribed medicines. At her level she can prescribe non-prescription drugs and then refer patients to doctor for further assessment. She does preventive treatment and promotes health lifestyle and counselling services. She works with the community giving advice on hygiene and identifies cases that require intervention at a higher level.

At that time however, there was thinking that these nurses could do everything including midwifery even though their training programme was quite shallow. Because this nurse was doing even midwifery, in 1997, we started the Kigali Health Institute, to train registered nurses. We also introduced registered midwifery

A nurse attends to a baby in hospital

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because we did not have midwives at the time. But KHI also started training paramedics like laboratory technicians, physiotherapists and anesthetists. They kept scaling up until they could produce the broad array of allied professions whose presence would free nurses to do their work.

KHI gave the ministry the upper hand in training health professional which had never happened before. Before 1997, we had so many schools which were training nurses to A2 level but the quality was poor because most of these schools did not have the appropriate facilities. Even secondary schools could train nurses. Currently, KHI has a mandate to train higher cadres of health professionals.
We had to stand up and oppose this. We proposed and the government took a decision to phase out all those schools that were training enrolled nurses. We had so many of them but they lacked basic knowledge because most of the owners of the schools were approaching it as a business. While nursing was supposed to be post-secondary, here it was part and parcel of secondary school.

We began by phasing out A3 nurses although we continue to employ A2 but they have to upgrade to enrolled level.
It was unfortunate because some nurses were joining A2 nursing as early as primary six level. At such a tender age, it is difficult for one to make a sensible career choice and nursing can be a psychologically challenging job. After much debate it was agreed that new entrants could join the course at senior three level. So the few schools that remained after that decision could only admit students from senior 3 onwards.

IN 2004, the government decided to begin training registered nurses and phasing out enrolled nurses. Among the former 40 secondary school based nursing schools, we opted to work with those schools that were not running a mixed curriculum.

That left us with six schools that we worked with on condition they only offered nursing and midwifery. And these started in 2007. Two were faith based and four were government run. However the government run schools were still young while the faith based ones were much older. These schools are now using the new Competence Based Curricula which was developed while phasing out the training of A2 nurses. At the end of the course, all students sit for the Final National Examination both written and practical.

This decision resulted into an immediate crisis of capacity in the government schools with neither tutors nor equipment so we decided to begin training tutors in collaboration with some Partners for example, the Belgian Cooperation.
We recruited tutors from neighboring countries for nursing and midwifery. We had a bilateral cooperation pact between Rwanda and Nigeria and they had been sending us nurses, so we started with those as we waited for our own tutors who would graduate in 2006.

Three classes have now graduated and we have managed to deploy them in the university teaching hospitals, district hospitals and we are now going down to sector level hospitals.
We have got more than 7000 enrolled nurses but they need upgrading. We need 4000 midwives but we have only 700 now. We have produced small numbers of midwives because of the limited training capacity and we still need tutors for both nursing and midwifery. However, Rwanda Government has trained some nurse and midwife managers and educators at Degree and Masters Level and these assist in the training and mentoring of students.

We are now using the same schools to upgrade in service enrolled nurses. Though they take a shorter time to train we also have direct intake classes from A-level. We have now opted for e-learning to train in-service nurses to free capacity to accommodate the direct entry classes. Some 320 students are now on e-learning through the same accredited schools. We are using the same curriculum but broken it into modules for e-learning.

Based on where we started and where we are; we still have some way to go. But it should not take us more than 6 years to meet our demand for nurses. We are also collaborating with some American universities to help us improve the training of health professionals which will include upgrading nurses training to degree level and specialized nursing. The future is bright also because nursing that previously was not recognized is now recognized.

Sr. Mary Murebwayire is the Chief Nursing Officer in the Nursing, Midwifery, Education and Services Department of the Ministry of Health

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Adolescents and young people in the fight against HIV: **No Room for Complacence**

By Dr. Placidie Mugwaneza

In Rwanda, Adolescents and young people make the majority of population and constitute the good future of the country. According to the general population census in 2002, around 60% are young people under 20 years. Adolescence is critical period of growth whereby some of adolescent start their sexual relationships that expose them to HIV and other sexually transmitted infections.

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According to 2005 and 2010 Demographic Health Survey, the prevalence of HIV in the general population aged 15-49 is still stable at 3% while HIV prevalence increased among youth aged 15-24 from 0.5% to 1% during the same period. The need of HIV prevention may not easily be perceptible because small numbers tend to create a sense that we are on top of the game. That underside to that kind of thinking is that we can easily slip into complacence.

Moreover, HIV comprehensive knowledge is still a challenge for an effective and sustainable behavior change among adolescent and young people. According to 2010 DHS, the comprehensive knowledge of HIV among men in the age group of 15-20 was at 47.2 % while it was 52.6% in women in the same age group. In order to optimize interventions for HIV prevention and care and treatment for adolescent and young people, the government developed a multi-sectoral response on HIV and AIDS, and each sector's strategic plan includes areas of action on HIV and AIDS including adolescent and young people.

In the health sector, a national strategic plan for HIV was developed and youth are among the defined priority groups. In addition to that, the adolescent desk was created in the Ministry of Health and the Rwanda Biomedical center established to improve HIV care and treatment for adolescents living with HIV by availing HIV adolescent friendly services and developing national guidelines and appropriate tools that facilitate their follow up in HIV program.

A number of strategies, policies were developed and different interventions are being implemented to ensure that HIV prevention interventions and messages, care and treatment are reaching adolescent and young people. Among others that were developed is an adolescent sexual reproductive health policy and strategic plan of 2011-2015, communication guide between parent and children on sexual relation and reproductive health and HIV/ AIDS.

Different campaigns were conducted with the objective of reducing risk behaviors among adolescents and young people. Between 2008-2010, two campaigns were conducted; one was called WITEGEREZA "Don't wait" campaign conducted in 2008 aimed at promoting parent-child communication about sexual reproductive health another one was SINIGURISHA (I'm not for sale) campaign aiming at fighting against cross generational sex.

New strategies are implemented to increase access to sexual reproductive health services to adolescent and youth, the example is the youth friendly centers created in the districts with the aim of providing sexual reproductive health service and increase awareness of HIV/AIDS. Here, adolescent and youth are given information on reproductive health, HIV prevention, and provided STI screening to both in and out of school youth and these centers ensure the linkage of those who need further care and management with health facilities.

Health facilities complement the package provided in the youth friendly centers with clinical services such HIV counselling and testing, treatment of sexually transmitted infections (STIs), care and treatment of HIV/AIDS, provision of psychosocial support through adolescent support groups.
Beside health facilities and youth friendly centers, HIV/AIDS is taught in schools whereby many of adolescent and youth spend most of their time. This is done through anti-AIDS clubs and course on HIV/AIDS done trained teachers.

In order to continue the scale up of youth friendly services, the national program is planning to integrate adolescent and youth friendly services in the routine services at the health facility level which are well distributes across the country compare to one youth friendly center in each district. To address the issue of skills required for health care providers for appropriate service delivery, the program will continue to conduct their trainings.

Another plan is also to reinforce the multi-sectoral collaboration to HIV prevention among adolescent and youth in general.

Dr. Placidie Mugwaneza is the Ag. Director of HIV Prevention Unit

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Up close and personal with Dr. John Kalach

Interview:

Dr. John KALACH is the Medical Director of Ruhengeri district hospital, in this interview he discusses the challenges of running a health unit whose services are demanded beyond its geographical mandate and the opportunities and planned upgrade to Provincial Referral Hospital status presents for both the community and the health system in general.

What is your experience running a district hospital?

That is a good question. Running a district hospital requires a lot of effort because there are a lot of challenges. But as the saying goes in Kinyarwanda, you don't run away from a problem, you confront it head on and find for a solution. That is what we are doing here. There are a lot of challenges with both patient management and management of scarce resources. What we have in terms of finance and human resources is not adequate for us to manage things the way we would wish, but we try with what we have.

What kind of case load do you deal with at this hospital?

This is one of the busiest hospitals and it is probably among the top five most frequented hospitals in the country. As a district hospital we have a catchment area of 356,692 people. If you look at that population and combine it with the fact that we are also most of the hospitals around us prefer to refer any case that they cannot manage, to Ruhengeri district hospital. The reason is that we have got some capacity that you cannot find anywhere among those hospitals. Areas like surgical intervention, diagnostic interventions

Ruhengeri Hospital

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and even the availability of doctors, we have 19 General Practitioners and 4 specialists in the Major departments, this is something you cannot find anywhere else in the neighbourhood. Even the number of staff here is big (261) compared to what you find in other district hospitals.

What is the bed capacity?

We have 410 beds. That is the official capacity but in reality sometimes you will find situations where two patients are sharing a bed. That is an indication that we have more demand than the available bed capacity. That gives an insight into how hard it is to manage a hospital with limited resources setting. But also if you looked at the districts around us like Nyabihu district, you don't find any district hospital. The only hospital they have is located far from the population centres. As a result all health centres in Nyabihu district prefer to refer all their patients to Ruhengeri district hospital instead of CHUK. This exerts additional pressure on the available capacity because we serve more than two districts, including: part of Burera district, and Gakenke district; and these are evidences that we cater for a bigger catchment area than what id designated for the hospital.

What is your average daily caseload?

Every day we receive between 350 and 400 patients; considering the different departments of the hospital (Surgery, Internal medicine, Pediatrics, Gynaecology and Obstetrics, Dentistry, Physiotherapy, Orthopaedics, Radiology services, Intensive Care Unit, Laboratory, Pharmacy, Mental Health Services, HIV/AIDS and Antiretroviral Services, Maintenance, Ambulance services, Family Planning activities, and others.

What is the disease profile like and what are the most common complaints?

That varies with age group (Paediatric or Adult). The most common complaints so far if you go to pediatrics' relate to gastro-enteritis (diarrheal diseases) and respiratory infections. Then we have problems of premature and low-birth weight babies which always present as critical situations. But if you come to the adults, the biggest health problem currently is oral hygiene. We are receiving many people with problems of dental cavities (tooth decay) that require extraction or filling, gingivitis, and tartars, abscesses, pathologies of the tongue, etc. If you currently look at the statistics, dental problems are the leading causes of morbidity among people who are coming for consultation in our hospital, with a range of 20 -60 patients per day! Other profiles include physical trauma, where we admit many patients due to accidents, and other physical injuries; Malaria and Pneumonia cases are no longer serious health issues in this region due to various interventions coordinated by the Ministry of Health from the grassroot level (CHWs) etc.

What are the major causes of respiratory problems among children?

The major problems are upper respiratory tract infections, pharyngitis, laryngitis, rhinitis, nasal congestions, and tonsillitis. These cases are associated with allergic conditions like bronco-asthma; but all have common precipitating factors (allergens) like cold weather, rainy seasons, pollens, dust, smoke, animal fur, or other inherited conditions. We still experience pneumonia but there has been a significant reduction in the number of cases probably this is may be an outcome of the introduction of the pneumococcal vaccine in the country. Most of the respiratory problems start as allergic condition that progress into an upper respiratory tract infection.

What needs to change at the community level to reduce further the burden of these diseases?

At the community level we have involved Community Health Workers (CHWs). The ministry of health trains the CHWs how to manage these cases. There has been introduction of kits that are used by CHWs in the management of common cold, pneumonia, detection and management of simple malaria, management of fever and diarrhoea in the community. They have also been taught how to identify and detect danger signs presented by newborns. The danger signs are indications of a serious underlying sickness or illness baby who could die from a certain disease that previously could not be detected by a CHW. When CHWs detect such signs, the baby is referred to a health facility for further management, in order to help the baby, but also reduce the infant mortality rate.

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Ruhengeri is one of the health facilities earmarked for upgrade to a Provincial Health Hospital. What do you expect this to change?

We know that the Ministry of Health will upgrade the hospital working budget. That budget will be utilized to access further equipment, increase on the staff numbers and also the diagnostic capacity will improve. This will give us the capacity to manage the cases that we cannot manage now. We also expect to get specialists in every major department - a gynaecologist- obstetrician, a paediatrician, internal medicine specialist and a surgeon. There are others that are going to be connected to this system like dentistry and dermatological complications that will now be managed locally. We also expect to have an anesthesiologist. The surrounding hospitals will be able to refer patients here while we will be able to reduce on the number of cases we have been referring to CHUK. This will bring the services close to the community, vertically and horizontally reconfigure and integrate the national health system for dynamic provision of health care.

‹‹ Continued from 32

the sector plans for the next 5 years. For a long time, the public sector ignores the contribution of the private sector but since two years ago, this has changed. There is more engagement now.

The structure of the health sector has also changed in the past few years – health insurance has become almost universal in Rwanda, many doctors simultaneously work in both public and private health facilities and nurses are crisscrossing between public and private health facilities. This has improved the relationship between the two.

Challenges

Human resource capacity is my biggest problem. I now have to hire doctors from outside and they are expensive, adding to the cost of health care which is very high for a hospital and the tariff remains low even if we are still pushing to get tariffs reviewed.

Future plans

I now want to build a good diagnostic center and improve my laboratory. I have one of the best laboratories in Rwanda but I still want to scale up to international standards. So I want to make an extension of this hospital to have facilities for dialysis, an advanced theatre where we can do orthopaedic surgery and cardiac surgery and other complex operations and many other tends of treatment.

I want a hospital where Rwandans can get very good care in all fields so that it will not be necessary to go outside for common problems. I imagine the kind of hospital where the population can get updated treatment in gynaecology, surgery, paediatric services, dentistry, urology, dialysis, modern theatre room and good diagnostic center, etc..

Dr. Jean Chrysostome Nyirinkwaya is the owner of Hospital la Croix du Sud

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A new focus on Non-Communicable Diseases

By Dr. Rosette Nahimana

Over the years a lot of efforts by have been geared towards curbing and managing infectious diseases like HIV/AIDS, Tuberculosis, malaria and the related illnesses but with great progress at hand there is a major turn to focus on the non-communicable diseases.

A new division for non communicable diseases was instituted under the Rwanda Biomedical Centre to ensure prevention and control of these diseases. Establishing mechanisms and structures that handle such diseases is very important because non communicable diseases are chronic in nature and since they do not cure, the result is that they always impact negatively on families.

For a nation with a health system that is developing so fast, we need not leave room for the existence of such diseases among the population. Many can be prevented and so far we are taking huge strides in a bid to encourage behaviour change for prevention.

Apparently, the NCDs division is still new and most of the focus is on policy but the development of a five year strategic plan is ongoing. Major work also constitutes spearheading awareness campaigns as well as celebrating international days that equally serve as platforms for communicating key messages.

Rwanda is set to give cancer treatment to the population and this will start in the four hospitals of CHUK, Butaro, King Faisal and the Rwanda Millitary Hospital. The process is now at planning level but we are certain that this will be a successful initiative. Tackling particular cancers like cervical cancer is already ongoing and the health sector is currently vaccinating the second cohort. We are moving on to screening which will successfully roll out by the end of 2013.

Apart from cancer, statistics from hospitals show that there are many other non communicable diseases including hypertension, Diabetes and Asthma among others. The NCDs division is also undertaking steps towards acquiring a good data base of these diseases and so far population based surveys are also ongoing which will enable us to better understand the risk factors and inform policy.

The health sector is determined to curb mortality that arises as a result of non communicable diseases so when interventions begin to pay off, more research will be done to gauge whether the mortality resulting from such diseases is at bay or not.

It is believed that with a new focus on non communicable diseases, the government will be able to accelerate achievement of health related development goals through ensuring wider access to services that were initially accessed at top health facilities.

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Community based provision of Family Planning

By Thomas Nsengiyumva

There is an eternal contradiction between economic production and population growth and Planned Parenthood or family planning, is an attempt at reconciling these two mutually opposing forces. In Rwanda perhaps more than anywhere else, a number of factors mean family planning is not an option but an imperative.

As a result we have got a policy which primarily aims at increasing the coverage of family planning. The policy is designed in line with MoH aspirations under the MDG's and the Rwanda Vision 2020 strategy.

According to results of the 2010 Demographic Health Survey, family planning coverage among married women in Rwanda has almost doubled in the past five years with 45% of married women using modern methods while another 6% used natural methods leading to a combined total of 51%. This contrasts with the 27% in the same bracket that were using Family Planning in 2005.

This is evidence that we have made progress and that our focus in recent years to promote access to family planning services to the population through different methods such as pills, Intrauterine devices injectables, condoms, circle beads and other suitable methods are paying off.

A significant contributor to this result has been the Community Based Provision that began in 3 districts- Kicukiro, Gasabo and Rusizi in November 2010. Community Health Workers were trained to dispense pills, cycle beads, injectables and condoms. After 3 months we did an assessment whose results showed a good response with the Community Health Workers for the community based provision of family planning services, performing quite well.

CBP has now been expanded to 12 districts. At the end of June 2012, CBP will be implemented in 17 districts and a year later, it will be rolled out across the entire country. We expect to replicate the good results we have seen elsewhere such as in Gasibo district where 80% of women are receiving family planning services at the community level.

Our minimum target is to extend national family planning coverage to at least 70% of married women and we have several strategies for achieving that goal. The first one is mobilization of the population at all levels and this will be done by different ministries and at all levels down to the community. The other strategy for reaching the target is to mobilise funds to pay for family planning products and every year, the government spends 3 billion francs on family planning products. But to the population the family planning services are given free of charge.

The services are available in both public and private health facilities. In public health facilities even permanent methods such as vasectomy and tubal ligation are provided free.

The Ministry of Health also collaborates with media to promote family planning. Family planning services are being pushed to all levels including religious facilities. The Ministry of health in collaboration with the Ministry of Local Government has built family planning posts

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A man together with his family in Rwamagana

outside those faith based hospitals that are opposed to modern methods of family planning while cycle beads are provided at faith based hospitals to promote natural family planning methods. Every public hospital now offers family planning services.

We encountered some gaps but the Ministry of Health works to fill them. The first challenge was the misconception of the Catholic Church towards modern contraceptive methods but this has been resolved through an agreement with the Catholic Church which allows them to promote those methods that are acceptable to them.

We are also collaborating with the private sector to help implement family planning through training and provision of tools, family planning commodities and social mobilization through Population Services International to get the population to participate and use family planning products although in the case of PSI, users pay for the service and products.

Thomas Nsengiyumva is an expert in Charge of Family Planning in the Ministry of Health.

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Male involvement in Family Planning: **Vasectomy**

By Dr. Leonard Kagabo

Initially, family planning was perceived as a birth control tool used especially by women so there was little involvement of men in this important procedure that remains key in improvement in maternal and child health.

Researchers have shown that women are more concerned when it comes to family planning but still most men are not even interested in accompanying their wives to health facilities to decide on which family planning method should be more preferred by the couple.

In Rwanda, the perception is changing. Progress that today, male family planning methods such as vasectomy are now appreciated and take up of these services is on the increase. This has been mainly as a result of communication campaigns which have promoted behavior change among the population.

This permanent family planning method targeting men (Vasectomy) has been practiced in Rwanda for a long time ago, but Rwandan men didn't use it due to various reasons.

In the past, the vasectomy operation turned out to be painful due to inappropriate materials that were used in that time, the wound taking time to heal and besides this, there were several myths and rumors around vasectomy.
Today, Rwanda has well trained teams of national and international experts (Rwandans, Americans and Canadians) who have established a new technique of vasectomy that uses thermal cautery.

Its advantages are many and among these, there is no haemorrhage during the operation and therefore no big wound. The operation is not painful because improved and appropriate materials and local anesthesia are used and the small wound on the operation site doesn't need hospitalization so the client goes home the same day and continues their usual work as normal.

Another key advantage is that the technique doesn't need to be done at fully equipped hospitals as it can be done in outreach strategy in Health Centers near clients' villages.

This Male family planning tool does not have any side effects or complications once done by trained medical Doctors. What is important for the person seeking the service is that they must know that this is a PERMANENT METHOD.

Rwanda is the only country in Africa that introduced this new technique of No-Scalpel Vasectomy with cauterization nationwide. This technique of vasectomy has been practiced since 2010 and is operational in 38 District Hospitals and has been taken up by 2230 men since 2008 to-date.

Dr Leonard Kagabo is the official in charge of the Permanent Method of Family Planning in the Maternal and Child Health Unit of the Ministry of Health.

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Health Sector Awards excellent journalism

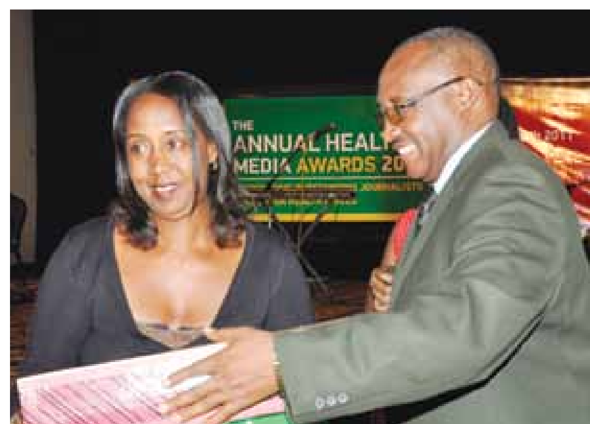
Achieving good health progress demands that the systems in place play a fundamental role in promoting behaviour change. Unlike other development initiatives, ensuring that a population utilises the available tools, messages and systems to lead healthy lives implies that the right communication channels meet the target audience.

One of the key channels is the media. The media in Rwanda is a key platform for promoting behaviour change. Over the years, the this medium has played a significant role in disseminating information on priority health issues that has positively impacted on positive behaviour change hence accelerating attainment of health related development goals.

It is against this background that the health sector decided to introduce the Annual Media Health Awards to acknowledge excellent journalism on health issues. This initiative by the Ministry of Health, through the Rwanda Biomedical Center/Rwanda Health Communication Center (RBC/RHCC), is a platform through which outstanding journalistic materials are showcased and media practitioners awarded.

At the 2011 awards, the award ceremony was equally as colourful with about 90 entries from media houses across the country. Together with partners, UNICEF and the World Health Organisation, the health sector

Health Minister, Dr. Agnes Binagwaho awards, the overall best journalist of 2010, Emma Claudine Ntirenganya, Radio Salus.



Cabinet Affairs Minister, Protais Musoni, awards Charlotte Karangwayire from La Nouvelle Releve.

Ministry of Health Permanent Secretary, Dr. Uzziel Ndagijimana awards Gloria Iribagiza A. from The New Times.

World Health Organisation Country Representative, Dr. Delanyo Dovlo awards, Emmanuel Ntivuruzwa of Umuganga.com

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awarded the top journalists in three different categories of (PRINT, BROADCAST and ONLINE) with a variety of items including, HP laptops, blackberry phones, audio sound recorders, digital cameras, an iPAD, certificates as well as trophies.

The winners are as follows;

NAME	MEDIA HOUSE	AWARD	CATEGORY
EMMA CLAUDINE NTIRENGANYA	Radio Salus	Overall best health reporter 2011 best broadcast journalist	Broadcast
LOUISE NGANYIRA	Radio Rwanda	First runner up	Broadcast
JACQUILNE MONYONCHO	Contact FM	Second runner up	Broadcast
CHARLOTTE KARANGWAYIRE	Radio Rwanda	Best print journalist	Print
GLORIA IRIBAGIZA A.	The New Times	First runner up	Print
KAPITENI ALEXIS	Imvaho Nshya	Second runner up	Print
NTIVUGURUZWA EMMANUEL	Umuganga.com	Best online journalist	Online
ERIC MUVARA	Igitondo.com	First runner up	Online
CLAUDINE THIERRY UHAWENIMANA	Umuganga.com	Second runner up	Online

Since its inception in 2007, the award ceremony has contributed significantly to increased coverage of health related stories. Ahead of all the annual ceremonies, stakeholders conduct a one day training on health reporting to equip media practitioners with the necessary skills to cover health issues.

Various media houses were also recognized for prioritizing coverage on health issues as part of their routine programs. These included Radio Rwanda, The New Times publication, Radio Flash, Rwanda Television, Contact FM, City Radio, Radio 10, Salus radio, The Rwanda Focus Newspaper, La Nouvelle Releve and Imvaho Nshya among others.

Entries reveal that HIV, family planning, nutrition, malaria, tuberculosis, non communicable diseases and situations of health facilities are among the key topics that are covered across the country.

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SPIU: Involving community leaders in the fight against HIV and AIDS

In an effort to scale up the fight against HIV, community leaders in the Northern Province have been equipped with skills and knowledge in Behaviour Change Communication aimed at integrating HIV prevention programs into district development priorities.

With Funding from the Ministry of Health through its Single Project Implementation Unit (SPIU), the Rwandese Association of Local Government Authorities (RALGA) trained forty eight district councillors in HIV life skills and Behavior Change Communication.

The councillors were given pertinent skills and vital information on health issues such as HIV and Family Planning. The information will help them to conduct sensitization activities at community level and strengthen the integration of HIV prevention programs and awareness on Family Planning into the district development priority programs.

Perpetue Uwamariya is a councillor from Kinoni Sector, Burera District, Northern Province, she believes that such trainings are important and demonstrate the commitment of the Government of Rwanda in the fight against HIV and AIDS.

Uwamariya is confident that the acquired skills will help her to disseminate HIV prevention messages to her community especially the youth. She says that silence on HIV, perceptions, lack of enough information and inadequate communication are barriers to achieving the desired results in the fight against HIV. "The youth need to be reached with sensitization programs," says Uwamariya.

During the training, it was recommended that similar trainings be conducted at the village level to increase and widen the scope of sensitization activities at the community level.

Similar trainings conducted by different implementing partners countrywide are supported by funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria provided through the Single Stream of Funding for HIV/AIDS Program. The training brought together participants from Musanze, Burera, and Gakenke and Rulindo districts in the Northern Province.

Cooperatives acquire management skills

Members of different cooperatives from four districts of Rusizi, Ngororero, Karongi and Rutsiro in the Western province received training on management of cooperatives.

The training was designed to equip them with skills that will enable them to efficiently manage the cooperatives, improve their economic status, living conditions, and designing projects aimed at income generating activities.

According to Minani Nasoro, a participant from Bugarama Sector, Rusizi district, the training will help them to properly manage their cooperatives with focus on increasing productivity expressed the importance of the training as associations and cooperatives towards expected interests are concerned. The training was organized by the Rwanda Cooperative Agency with funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria through the Single Project Implementation Unit of the Ministry of Health.

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The Resilience Vis-A-Vis Trauma

How, after experiencing the threat of annihilation, can one not to be subjected to the death drive? Only living is to knowing suffering while turning on the move.

By Dr. Yvone Kayiteshonga

The human race is universally recognized as vulnerable to living through extreme situations in a state of distress. Psychological problems which remain, with little differences are a common condition in all human being.

However in such situations, some people have not or will not develop significant psychological problems. Many people are resilient, which is defined as the ability to cope relatively well with adversity. Many interacting social, psychological and biological factors play a role in the fact that those affected develop psychological problems or, conversely, will show resilience.

This assumption has led some authors to question the causal link between an extremely stressful event and the onset of post traumatic stress disorder (Yehuda et al., 1995). It is recognized in some individuals "the abilities to stay healthy though they lived through events usually considered to cause a mental disorder (and in some cases, somatic problems)" (Ionescu, 2010, p. 271).

The author provides some guidance, «salutogenetic (focusing on mental health), which attempts to explain why some people live in the extremity of the continuum health pathology, even if they are experiencing traumatic events leading usually to the onset of mental disorders «(Ionescu,2010, p.271). In general, the answer is that some people have individual abilities to cope with adversity; which of these abilities are supported by external factors, we will develop further.

Indeed, the individual's amazing ability to cope with adversity is based on a fascinating complexity of genetic, developmental and environmental factors.

Some survivors of the Genocide against the Tutsi in Rwanda confirm this hypothesis and argue that it's worth fully enjoying life "after one's death». This is a surprising affirmation given the weight and toxicity of these experienced by most people. These people sometimes described as resilient do not see our mental health services and this leads many clinicians to simply ignore this reality.

Not having statistics on resilience, I illustrate it with a case of a female survivor of the Genocide against the Tutsi in Rwanda with whom I spoke one morning of April 2002 and who gave me her testimony. She overcame the confrontation with "the reality of death", as we shall see. Her name is Keza. She was aged twenty-four when she told me her story. I will always remember her deep and expressive voice when she first called me for an appointment unrelated to a clinical consultation. Hearing her voice, you would imagine you are speaking to a healthy girl to whom life has refused nothing. And even her physical conditions confirm this statement. Indeed, Keza is part of the category of individuals who have the ability to stay healthy though they have experienced events usually known to cause mental or somatic disorders.

This is an ability that Cyrulnik (cited by Munyandamutsa (2008)), described as something that makes you open your eyes and keep in memory, and even most of the times in hyper memory, the remembrance of the trauma while thinking for example, «I am somebody

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who has experienced rape, incest, who suffered losses ... «(Munyandamutsa, 2008, p.494) but who has the right to life.

Until April 1994, Keza led a happy childhood in an ordinary family from the South of Rwanda and was the youngest in a family of four children, two girls and two boys. Her mother was a nurse and her father was a teacher of high school. The memories of that time are perhaps not all positive but Keza members them with a touch of enchantment and nostalgia. A period that Keza would willingly wanted to extend until today.

In April 1994 the genocide began and Keza's family fled the killers in a state of panic and became dispersed. Keza is offered shelter by a neighboring family who agrees to hide her. She's 19 years old; she spends her days in the ceiling where meals are served to her in secret by her hosts. But she listens every night to reports of macabre exploits, of killings and torture inflicting on other Tutsi from the village.

Some are her neighbors; others are friends or friends of her parents. She says she spent three months with the certainty that she might pass away at any time. She had a fear of death, «that word could not express» to use her expression. It was not only her life which was in danger. She was also very afraid for her family, which she knew would not be the same when the genocide eventually stopped. But was not it crazy to think of the end of genocide when this was still in progress?

Three months later, chance or perhaps God gives reason to those hopes that could have been described as delusions at the time of the genocide. The genocide was over and she found her mother, sister and brother. She heard from her brother that their eldest brother was killed savagely, when he had come out of hiding. Her brother had also witnessed the scene which was beyond imagination in its horror. Of their father, who was killed, his feet hanging from a truck body and his head dragging on the ground.

Keza said she suffered terribly upon hearing of the murder of her brother and as if that was not enough, the punishment imposed on her beloved father. Her mother and her entire family were so affected by this situation that Keza was worried that everyone in the family would go crazy from the grief. This was in fact the case for her brother, who continues today to be under the care of the mental health services.

But Munyandamutsa (2008) was undoubtedly right to point out that there were people who could rise from the ashes after being burned, broken and crushed by extreme violence. Keza has indeed suffered from what she had experienced during and after the genocide. But the question is how to suffer and survive? ... This issue raised by Maillart and repeated by Munyandamutsa (2001, p. 61), has obsessed the mind of Keza until an alternative option presented itself. She said she decided after having almost experienced death, her only concern was «how can I live my life fully? How can I help my family to continue living? «. One can see this directly in Keza, in the activities she undertaken after the Genocide and in her manner of speaking of herself and discussing her history.

She returned to school the year that followed the events, she finished high school, pursued graduate studies and graduated as a medical laboratory technician in 2000. She engaged herself in the cause of genocide survivors and other vulnerable groups, studied social work and then began a care as a trauma counselor and provides psychosocial care for women living with HIV. She is the only one to financial provider for her retired mother, her mentally ill brother and her sister, a mother of two who has not yet graduated. In 2005, she met the love of her life and they were married the same year. In 2006, she gave birth to a daughter.

Every day we meet people who have experienced similar events and who instead exhibit a sort of «compulsion to repeat the painful» (Janssen, 2008) with no possibility to envisage the future. Keza chose to tell her life in spite of the pain while trying to relive some hope. It is possible that under the influence of everyday life, she may later experience a moment of exhaustion, but to this day, as she said, she is determined to live a full life and she feels she has done this.
Keza builds on the love of her beloved late father had for her. Indeed, this young woman tells me with an insight and an emotional equilibrium that I have rarely seen in adolescents who survived the genocide, the

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following words: «My father loved me very much, he was intelligent and honest, I am as intelligent as him. I have to keep the legacy he left me by behaving with dignity especially vis-à-vis men».

This memory of a loving and intelligent father, the personal psychological resources of Keza, her sense of altruism, the resources of her family and professional environment, these all became real life examples of resilience within the «Cyrulnikien» meaning and bring Keza to live her life today. She lives her life from a perspective that Mujawayo (2004, p.5), another survivor of the genocide against the Tutsi in Rwanda, who insists on be defined as living and not as a survivor, summed up in these words: «We try to stay alive more than tend toward death (...)the one who wanted me exterminated, will not see me over. Rather, I would really like that seeing how I've become corrodes him so that he tells himself" I did all this for nothing, she lives (...) «.

The interest of such a perspective is that it opens to the survivors, clinicians and social actors, the opportunity to work and support the development process despite the often negative outcomes. She rejects the simple and pessimistic equation that considers: unfavorable environment = weakening, pathology (Lighezzozo and De Tychey, 2004).

Cyrulnik (2001) cited by Anaut (2005, p.34) states that to speak about resilience, there must have been a confrontation with a traumatic event or a traumatic context. Indeed, following the traumatic experience, the person with these psychological resources becomes resilient by implementing mechanisms to cope with the trauma and focus on the task of living. Is it not that «... the suffering created by the war seem unnecessary as long as the survivors do not know why they live»? (Munyandamutsa, 2001, p.61).

Resilience applies to both an individual person, and a group of people. In this logic, Manciaux, Vanistendael, Lecomte and Cyrulnik (2001) all note that «resilience is the ability of a person or group to grow well, to continue to project into the future despite destabilizing events, the difficult living conditions of some severe trauma «Anaut (op.cit.,p.34).
Resilience is a fashionable topic on which more than four thousand publications have been made to date. The term was borrowed from physics. «In the context of metallurgy, resilience refers to ... the quality of materials which is both the elasticity and fragility and apparent ability to regain the initial state following a shock or continuous pressure «(Anaut, 2005, p.34). Some authors have found similarities between the «inert and living material and the simple and complex one» (Anaut, 2005, p.35), which has led to the migration of the physic of materials towards the concept of human sciences and psychology.

Anaut (2005, p. 35-36) joins the Encyclopaedia Universalis, which emphasizes that in the context of the physics of materials, resilience (as one of the qualities characterizing steel) changes rapidly on either side a certain temperature called transition temperature. According to this author, this analogy implies that each person has a different potential to resist pressures (resilience) that varied suddenly during a given circumstance (similar to the so-called transition temperature). In this perspective, a single person may sometimes be vulnerable but sometimes resilient, depending on the circumstances.

Thus, the subject could transition from vulnerability to resilience during a highly significant event for them, or during a rebuilding meeting. This hypothesis matches with current research on resilience, particularly when studying the implications of social networks. For human beings, psycho emotional, relational and social factors will also interfere.

Resilience is never fully acquired. Longitudinal studies have shown cases of individuals or families who are not resilient all the time nor under all circumstances.
Psychological disorders, even psychopathology, may be linked to behavior within the resilience, which is why some authors say that there is sometimes a price to pay for the development of resilience. In short, no one comes out unscathed from extreme situations! As a Rwandan proverb says: «(*Ahakize hitwa inkovu*"): there is no harm that has been healed without some subsequent fatal effects "(Nkongori and Kamanzi, 1957, p.10).

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MINISITERI Y'UBUZIMA

Kurinda abana indwara z'impiswi ni inshingano yacu twese

Mubyeyi, ubuzima bw'umwana wawe buri mumaboko yawe. Mwongerere amahirwe yo gukura neza umukingiza urukingo rw'indwara z' impiswi

URUKINGO RWA 1: Umwana yujuje ukwezi n'igice

URUKINGO RWA 2: Umwana yujuje amezi abiri n'igice

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Birakwiye k'umujyana gusiramurwa uyu munsi kugirango umurinde umwanda ushobora gutuma arwara indwara nka kanseri y'igitsina, kugira ibibazo mu muyoboro wo kwihagarikamo.

Ihutire kujyana umwana wawe ku kigo nderabuzima kikwegereye bamusiramure.

KUNDA UBUZIMA Muhitiremo Gusiramurwa

Ubu butumwa murabugezwaho na

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