Republic of Rwanda
Ministry of Health

Rwanda Biomedical Centre
Healthy People, Wealthy Nation

Maternal, Child and Community Health Division

Annual Report

2020-2021

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Acronyms and abbreviations

AEFI	Adverse Event Following Immunization
ANC	Antenatal Care
ASM	Agent de la Sante Maternelle
ASRH	Adolescent Sexual and Reproductive Health
BCG	Bacillus Calmette Guerin
B-EmONC	Basic Emergency Obstetric and Neonatal Care
bOPV	Bivalent Oral Polio Vaccine
C/S	Caesarian Section
CBMNH	Community Based Maternal Newborn Health
CBP	Community-Based Provision
CCEOP	Cold Chain Equipment Optimization Platform
CCM	Community Case Management
C-EHO	Community Environmental Health Officer
CEMD	Confidential Enquiry into Maternal Death
C-EmONC	Comprehensive Emergency Obstretric and Neonatal Care
CEPD	Confidential Enquiry into Perinatal Death
CFR	Case Fatality Rate
C-HMIS	Community Health Management Information System
CHWs	Community Health Workers
cMYP	Comprehensive Multi year plan
COVID19	Coronavirus Disease 2019
CPR / mCPR	Contraceptive Prevalence rate / Modern Contraceptive Prevalence rate
DG	Director General
DHIS 2	District Health Information System version 2
DMPA	Depot medroxyprogesterone Acetate
DQA	Data Quality Assessment
DTP-HepB-Hib	Diptheria, Tetanus, Pertussis, Hepatitis B and Haemophilus INfluenczae type B
ECD	Early Child Development
EDPRS	Economic Development and Poverty Reduction Strategy
EmONC	Emergency Obstetric neonatal care
EMR	Electronic Medical Record
EPI	Expanded Programme on Immunization
EVM	Effective Vaccine Management
FP	Family Planning
FY	Fiscal Year
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender Based Violence
GoR	Government of Rwanda
HBM	Home Based Management
HC /HF	Health Center / Health Facility
HCP	Health Care Provider
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome

HMIS	Health Management Information System
HPV	Human Papilloma Virus vaccine
HSS	Health System Strengthening
HSSP	Health Sector Strategic Plan
ICC	Interagency Coordination Committee
iCCM	Integrated Community Case Management
ICD	International Code of disease
IMCI	Integrated Management of Childhood Illness
IOSC	Isange One Stop Centre
IPV	Inactivated Polio Vaccine
ISS	Integrated Supportive Supervision
IUD	Intra Uterine Device
KMC	Kangaroo Mother Care
LAM	Long Acting Method
LARC	Long Acting Reversible Contraceptives
LLINs	Long Lasting Insecticide treated bedNets
M&E	Monitoring and Evaluation
MCCH	Maternal Child and Community Health
MCCOD	Medical Certification of Cause of Death
MCH	Maternal and Child Health
MDSR	Maetrnal Death Sruveillane and Response
MINECOFIN	Ministry of Finance and Economic Planning
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
MPCDSR	Maternal Perinatal and Child Death Surveillance and Response
MR	Mewasles and Rubella
MUAC	Mid Upper Arm Circumference
NCDs	Non Communicable Diseases
NITAG	National Immunization Technical Advisory Groups
NITWG	National Immunization Technical Working Group
OPD	Outpatient Department
PCV 13	Pneumococcal Conjugate Vaccine
PIH	Partners In Health
PMR	Perinatal Mortality rate
PMTCT	Prevention Mother to Child Transmission
PNC	Post Natal Care
PPE	Personal Protective Equipment
PPFP	Post-Partum Family Planning
PPROM	Preterm Premature Rupture Of Membrane
RBC	Rwanda Biomedical Centre
RBF	Result Based Financing
RDHS	Rwanda Demographic Health Survey
RIB	Rwanda Investigation Bureau
RMNCAH	Rwanda Maternal Newborn Child and Adolescent Health

SARS-Cov-2	Severe Acute Respiratory -Covid-2
SBR	Stillbirth rate
SDG	Sustainable Development Goals
SDP	Service Delivery Point
SPIU	Single Project Implementation Unit
SPRP	Stunting Prevetion and Reducstion Program
SRMNCAH	Sexual Reproductive Maternal Newborn Child and Adolescent Health
TFR	Total Fertility Rate
tOPV	Trivalent Oral Polio Vaccine
TT	Tetanus Toxoid
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPT	Urinary Pregnancy Test
USAID	United States Aids
WHO	World Health Organization

Foreword

It is my honour and privilege to avail the Maternal, Chid and Community Health (MCCH) Annual Report 2020-20201to all our partners and specifically our MCCH stakeholders. The key achievements presented in the report reflect the performance of MCCH division and partners through its three units: Health Facilities Programs, Community Health Programs and Vaccine Programs Unit. The reporting period corresponds with the second year of implementation of the Health Sector Strategic Plan (HSSP) IV.

I would like to acknowledge and thank the ongoing collaboration of different organs and institutions from National to Decentralized level including local administration authorities, hospitals, health centres and Community Health Workers in supporting the implementation of MCCH activities throughout the 2020-2021 Fiscal Year. Development and implementing partners, the private sector and civil society organisations involved in MCCH have provided invaluable support to the improvement of reproductive, maternal, new-born, child and adolescent health.

Our achievements in 2020-2021 would not have been possible without the hard work and dedication of MCCH Division staff, and the support received from colleagues of other divisions of Rwanda Biomedical Centre (RBC) and the Ministry of Health (MoH).

The compilation of the 2020-21 MCCH Annual Report was made possible by the active participation and commitment of staff from the three Units of MCCH Division, SPIU and partners. I would like to take this opportunity to thank everyone who contributed to the development of this report.

To this end, I would like to call upon all the organs and institutions involved in MCCH area to take heed of the recommendations of this report and to support implementation of the planned interventions in the financial year 2021-2022. I guarantee you the support of RBC to ensure coordinated and coherent implementation of these planned activities to realise the Division's objectives.

Dr Sabin NSANZIMANA

Director General

Rwanda Biomedical Center

Executive summary

The Government of Rwanda, through the Ministry of Health and its development partners, is committed to achieving the health-related Sustainable Development Goals (SDG) and particularly to maternal and child health (SDG 3: *Ensure healthy lives and promote well-being for all at all ages)* and the goals of the Global Strategy for Women's Children and Adolescent's Health, in line with Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) policy as well as both Family Planning /Adolescent Sexual and Reproductive Health (FP/ASRH) and Maternal, Newborn and Child Health (MNCH) Strategic Plans (2018_2024), which look beyond survival to focus on how to ensure that mothers and their new-born and children thrive.

In the health sector, concerted efforts have been made to address identified gaps that lead to maternal and child mortality and have built on the great achievements of last five years. According to preliminary results of Rwanda Demographic and Health Survey (RDHS) 2019/20, Rwanda has seen a reduction in maternal and child mortality from 210 to 203 per 100,000 live births and 50 to 45 per 1000 live births between 2014-15 and 2019-20 respectively.

This report presents the status of key MCCH indicators for FY 2020/2021 and relate activities. Interpretation of the trends of the results should consider that denominators are estimated from projections of the 2012 population census. Deliveries (facility and home based) were lower than projected expected pregnancies.

Key achievements for the year 2020-2021 are an increase of pregnant women attending ANC health services within the first trimester and four standard from 42% and 35% (2019-20) to 50 % and 41% visits during pregnancy. The majority of women utilizing these services were screened for malnutrition (92%), HIV (93%), Syphilis (82%) and anaemia (73%) and provided with iron and folic acid (92%) and Long Lasting Insecticide Treated bednets (LLINs) (74%). The RDHS showed the *use* of bednets by pregnant women was 78%[1]. A reduction in malaria in pregnancy and postpartum was observed. These achievements were possible through the efforts of the MCCH Division including a new guideline introduced to improve ANC service provision at Health Centres and 59 ultrasound machines installed for early detection of complications of pregnancy. The mentorship programme provides mentoring and coaching to health workers in provision of ANC services.

The Total Fertility rate decreased from 4.3 to 4.1 between 2014-15 and 2019-20 (RDHS 2019-20). In the HMIS total deliveries declined from 336,685 (expected 329,374) in 2015-16 to 327,484 (expected 379,346) in 2020-21 (health facility and home-based). The unmet need for family planning also decreased from 19% to 14% in this time period (RDHS). Post-partum family planning was introduced and stands at 53% all deliveries while contraceptive prevalence rates (CPR) increased from 51% (2019-20) to 54% (2020-21).

[1] Some ITNs will have been accessed through mass distribution campaigns and EPI services aswell as those purchased privately.

The most preferred methods are Implanon and Jadelle. In addition to the drive to provide family planning to women in the post-partum period other activities to increase uptake are the integration of counseling on family planning in antenatal and post-natal care services, expansion of social marketing for condoms and training of staff and provision of emergency and long-lasting contraceptives. The proportion of teenagers who have begun childbearing has fallen from 7% to 5% from 2014-15 to 2019-20 (RDHS). Those with lower education status and in the lowest wealth quintiles are more likely to begin childbearing.

While the number of deliveries is decreasing, the quality of care during labour and delivery, particularly during and after Caesarian Section (C/S), remain a challenge. Case fatality rates for infection post C/S is 1.1% of 1975 cases, 11.8% for complications of anaesthesia and 23.4% for pulmonary embolism of 77 cases. Rwanda has a well-developed Maternal, Perinatal and Child Death Surveillance and Response (MPCDSR) strategy and near miss audits aswell as trainings and mentoring on correct use of ICD-10 definitions and conducting near miss and death audits. Following delivery Post Natal Care services are provided for the mother and newborn. As with antenatal care a 'drop-out' is evident from a high of 92% for the first check-up to 62% for the the fourth for mothers. As expected the proportion for post natal services for the newborn are similar. .

Rwanda also provides a comprehensive vaccine schedule for children under the age of five years that is well utilized with rates of 98% for BCG found (see RDHS 2019-20). During the reporting period (2020/21 FY), the utilization rates for estimated children under one year of age were BCG (90%), Polio 0 (81%), Penatavalent first dose (87%) and Measles and Rubella 1st dose (89%). However a 'drop-out' is noted between first and subsequent doses. For example, Pentavalent doses 1 and 3 (88% to 87%) and between the two doses of MR as per schedule (89% to 88%). Training and mentorship on maintenance of the cold chain was a key activity in this financial year. The RDHS (2019-20) shows high protection of newborns against tetanus toxoid (TT) with 79% pregnancies in the five years prior to the survey protected. Those under the age of 20 and in the lower wealth quintiles had the lowest protection. The HMIS shows 92% pregnant women receiving TT vaccine. There were only four cases of neonatal tetanus reported in 2020-21.

Further key achievements in health indicators include the reduction of malnutrition. The proportion of underweight in children under the age of five years fell from 9% in 2014-15 to 8% in 2019-20 (RDHS). At the end of this reporting period 88% children under the age of five years were screened for malnutrition, an increase from 71% in 2018-19. A referral system from community to health centre to hospital is in place for the severely underweight.

The MCCH Division supports provision of a package of services for Gender-based Violence cases reporting to its health facilities. Isange One Stop Centres (IOSC) are set up where treatment and counselling was provided to 33,636 cases of which 52% had experienced sexual violence, and 41% physical violence. Just under half (46%) were under 18 years of age. Community sensitization for early presentation at the IOSCs for preventative services against HIV infection and pregnancy is ongoing.

These are the key activities of many interventions to improve maternal, newborn, child, Teenagers and Adolescent sexual reproductive health implemented in year 2020-2021. Coordination and governance mechanisms such as Technical Working Groups, data audits and supportive supervision are part and parcel of the work of the MCCH Division.

This report outlines the main achievements, challenges met during the implementation.
During the financial year 2020/2021, MCCH Division will be guided by valuable lessons from the financial year 2020/2021, additional high impact interventions will beidentified and proposed for implemented in health facilities and the community for maternal, neonatal and child survival with view to continue achieving national and international targets, but also emphasizing on continuum of care of RMNCAH services during the COVID 19 pandemic.

INTRODUCTION

Purpose, target audience and methodology

The purpose of this annual report is to improve health outcomes in children, adolescents, men and women of Rwanda through efficient use of resources by the presentation of the performance of MCCH division for the year 2020/21. The information contained in the report provides the foundation for decision-making for programme implementation and resource (re) allocation.

The primary target audience is Rwanda Biomedical Centre (RBC) leadership as well as the Unit heads of the Maternal, Child and Community Health (MCCH) Division, as key decision-makers. The information contained in this report is also valuable to the Ministry of Health (MoH) and Ministry of Finance and Economic Planning (MFEP). Current and future potential financial development partners and the organisations that support the MCCH Division in programme implementation will also benefit from the information presented.

Data contained in the report comes primarily from the Health Management Information System (HMIS). This is complemented in this year's report by data from the Rwanda Demographic and Health Survey (RDHS) (2019-20). Data for this survey was collected within the same reporting period, however, the RDHS is a household survey using different denominators and indicators than the HMIS so exact comparisons cannot be made. The disaggregation of data between age groups, education levels and wealth quintiles, however, do provide an insight into the populations in which the disease burden is higher and service utilisation lower. This information is invaluable for programme implementation. In general, comparison with between data in the RDHS (2019-20) and HMIS shows a high correlation, indicating the accuracy of routine data.

The report is structured into five key sections: 1. Introduction comprising purpose, target audience, methodology, programme overview and impact of Covid-19, 2. Status of indicators against key activities, 3. Implementation of activities 4. Financial report and 5. Key recommendations.

Program overview

The Government of Rwanda (GoR), through the Ministry of Health and its development partners, is committed to achieving the health related Sustainable Development Goals (SDG), particularly those pertaining to maternal and child health. Both these strategies are in line with the Rwandan Mother, Neonatal, Child and Adolescent Health (RMNCAH) policy as well as both the Family Planning /Adolescent Sexual and Reproductive Health (FP/ASRH) and Maternal, Newborn and Child Health (MNCH) Strategic Plans (2018_2024).

The Maternal, Child, and Community Health (MCCH) Division has a mandate to support implementation, monitor, evaluate and provide direction to all health interventions and initiatives related to maternal and

child health in Rwanda. To facilitate the coordination of all these activities, the Division has three implementing units: Health Facility Program Unit for maternal and child health related activities and interventions in health facilities, Vaccine Preventable Disease Program Unit including routine vaccination, vaccine and vaccine devices supply chain and Community Health Program Unit, with a mandate to increase access to primary health care and improve access in rural areas in Rwanda. Each unit has a specific mandate and objectives within the overall mandate of MCCH division.

Impact of COVID-19 on MNCH service utilisation

The World Health Organisation (WHO) identified a 'severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)', now commonly known as COVID-19, on 11th February 2020. The WHO declared a pandemic on 11th March 2020. The Rwandan government was quick to take measures to mitigate the spread of the virus. These measures included resource (re)allocation, screening of individuals, restriction on their movement within Rwanda and hygiene measures (mask-wearing, social distancing and hand-washing). Travellers into Rwanda were screened and quarantined. Rwanda experienced three waves of higher infection rates.

On 1st July 2020, at the start of this reporting period, the seven-day average was 30 cases, this rose to 140 by 26th August but reduced to below nine by mid- October. The second wave was experienced by the end of January 2021 with rates of 334 (seven-day average). On 1st June the seven-day average was 35, rising to 827 by the end of the Fiscal Year, which proved to be the third and most serious wave that peaked at 1,309 cases on 22nd July (https://github.com/CSSEGISandData/COVID-19)[3].

Mitigation measures, such as restriction on movement, were experienced at different times and for different periods of time in different parts of the country. An assessment by the University of Global Health Equity compared Health Management Information System data on selected MNCH indicators in the months of March and April 2019 and 2020 using population projections as a denominator. The authors concluded that the utilization of 15 MCH services in all four categories (antenatal care (ANC), deliveries, postnatal care (PNC) and vaccinations) significantly declined. Northern and Western Provinces were most affected.

[2] It should be noted that increased access to Covid-19 PCR testing and efficient test and trace strategies may have captured more cases in the third wave.

[3] It should be noted that increased access to Covid-19 PCR testing and efficient test and trace strategies may have captured more cases in the third wave.

PART I: STATUS OF MATERNAL, CHILD AND COMMUNITY HEALTH INDICATORS FY 2020-2021

I.1: MATERNAL, NEWBORN AND CHILD HEALTH

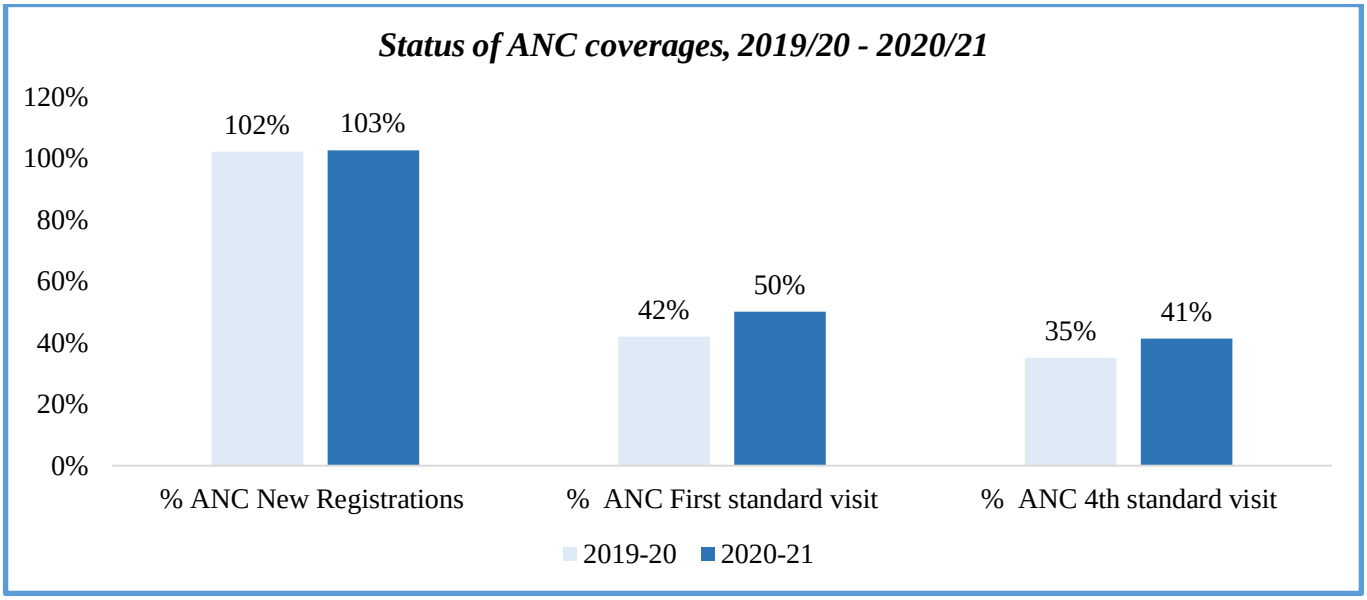
I.1.1 Maternal health indicators

I.1.1.1 Antenatal care

Screening of pregnant women throughout their pregnancies and provision of preventative and curative services at the antenatal care clinics aims to improve pregnancy outcomes for the mother and her child. The Ministry of Health aims for all pregnant women to attend a health centre for the first of four antenatal care (ANC) visits in the first three months of her pregnancy. Figure 1 shows the proportion of expected pregnant women visiting once at any time in her pregnancy, with a first visit within the first 12 weeks of pregnancy and those utilising the ANC at least four times.

The Rwanda Demographic Health Survey RDHS) (2019-20) found 98% women in Rwanda who had a live birth within the past five years had received antenatal services during their last pregnancy. This is consistent with the high coverage rates reported in the Health Management Information System (HMIS). The figures below describe the status of antenatal care service use for 2019/20 to 2020/21.

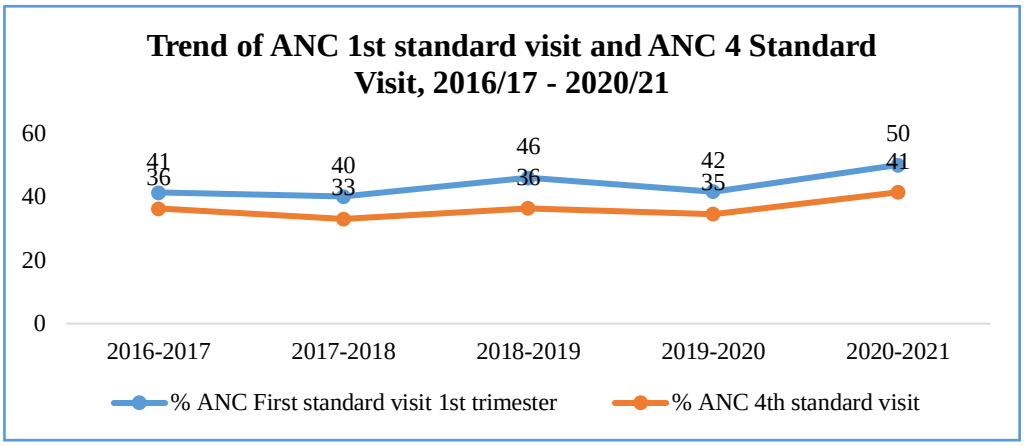
Figure 1: Status of ANC coverages, 2020-2021



While the vast majority of pregnant women make at least one visit during the pregnancy period only half (50%) of these attend during the first three months. Furthermore, only 41% are reported receiving antenatal care four times during their pregnancies in the HMIS[4]. However, there is a 6% increase in both these indicators compared with last year. The RDHS (2019-20) also showed a 3% increase in the proportion of pregnant women attending for four ANC visits since RDHS 2014/15.

[4] Note that this indicator is affected by the use of projections of 2012 census.

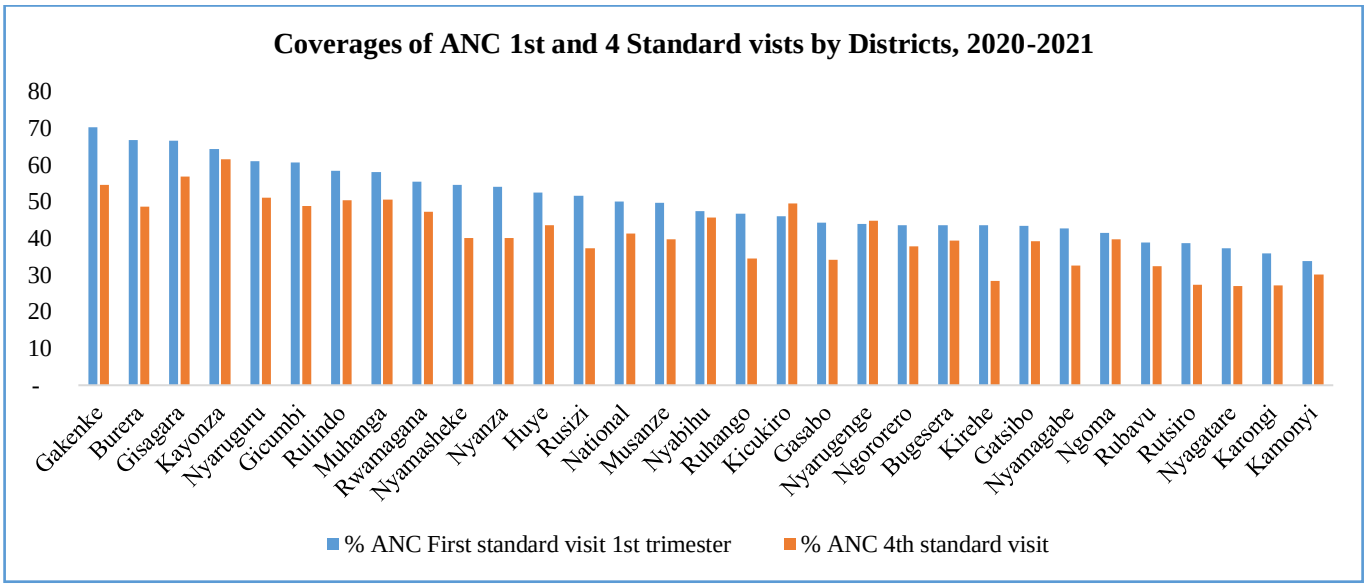
Figure 2: Trend of ANC 1st and 4th ANC standard visits, 2016/17 – 2020/21



The percent of pregnant women initiating a timely ANC 1st visit increased by 9% since 5 years which contributed to the increa of 5% for pregnant women making 4 ANC standard visits from 2016/17 to 2020/21.

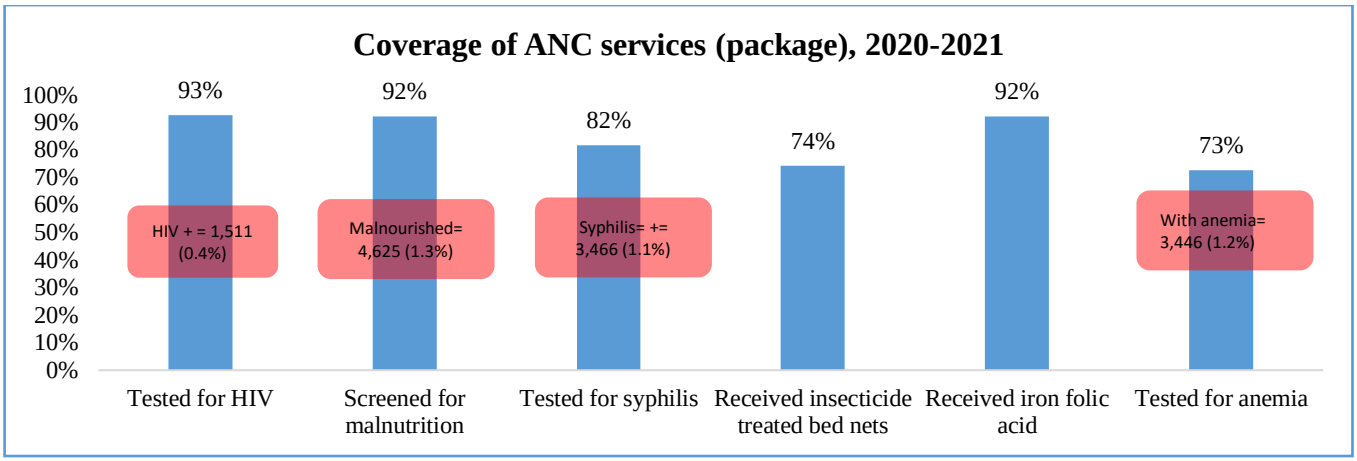
In Figure 3 differences within the Districts of Rwanda can be seen, both in terms of the proportion of expected pregnancies attending within the first 12 weeks of pregnancy and in the proportion of first visits visiting four times.

Figure 3: Coverage of ANC 1st and 4 Standard visits, 2020-2021



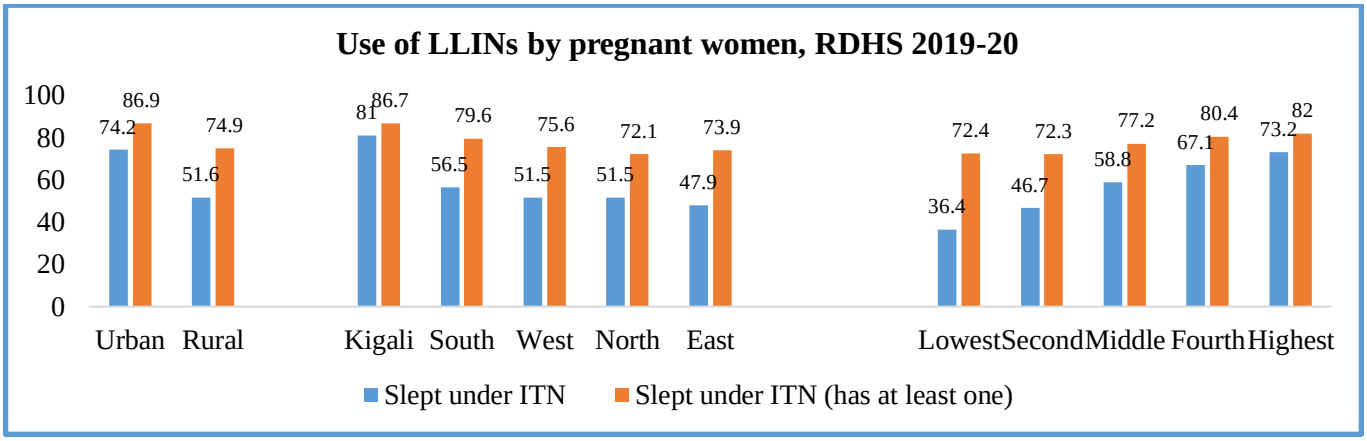
The above graph shows the coverage of ANC 4th standard visit by Districts for 2020-2021 FY: at national level 50% of pregnant women made a timely initiation of ANC visit and 41% managed to do 4 standard visits. The services provided at antenatal clinic are testing for HIV, syphilis and anaemia, provision of long lasting insecticide treated bednets (LLITNs) and iron and folic acid tablets, screening for malnutrition. Figure 4 below shows the proportion of women attending ANC for any visit who received these services.

Figure 4: Coverage of ANC services, 2020-2021



Though pregnant women visit ANC services at least once in pregnancy time course, only 93% were tested for HIV, 92% received iron folic acid, 92% were screened for malnutrition, 82% were tested for syphilis, 73% were tested for anaemia and 74% received an LLIN Services provided to ANC clients varied by District. Over 97% clients were screened for malnutrition and provided iron and folic acid in 25 and 20 Districts respectively. Only Gasabo District reporting under 70%. Over 97% ANC clients were tested for anaemia and syphilis in only two and one District respectively with ten and four reporting testing under 70% clients.

Figure 5: Use of LLINs by pregnant women



While 74% women had access to an LLIN through the ANC clinics the RDHS found use of the nets was higher[5], although lower in the lower wealth quintiles and in rural areas (Figure 7). Malaria in pregnancy and the post partum period has fallen in the last two years by 42% and 36% respectively. There were only two cases of severe malaria in pregnancy for both years and in the post-partum period severe malaria reduced from 27 to 17 cases (see Figure 6).

[5] ITNs are also available through mass distribution campaigns and in the private sector.

Figure 6: Malaria cases in pregnancy and postpartum period,

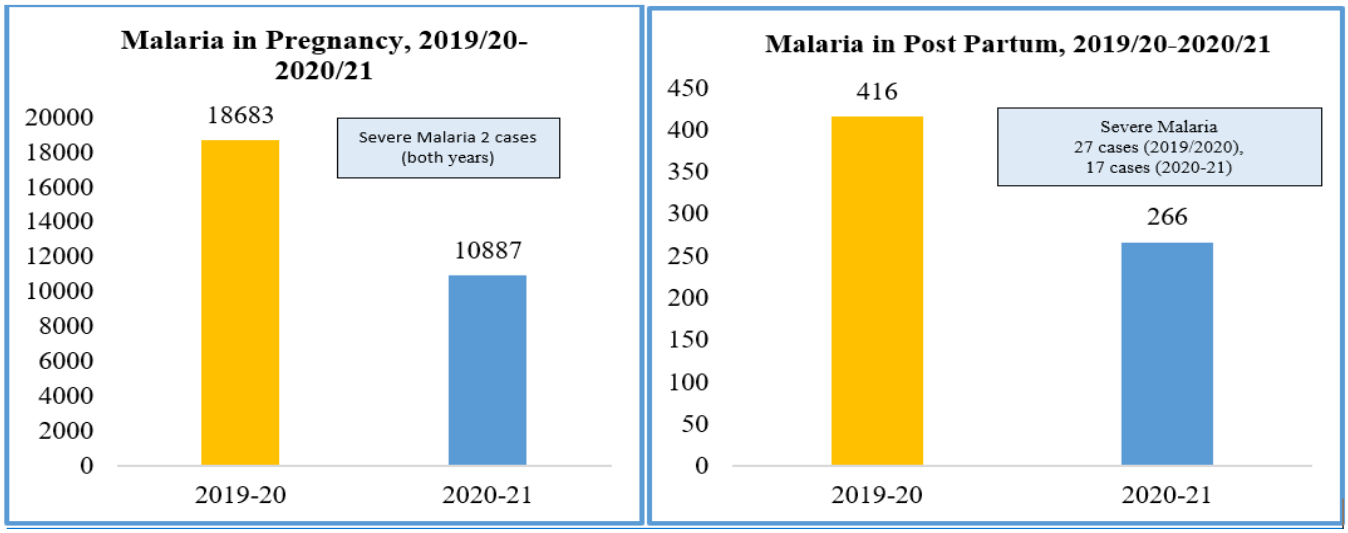
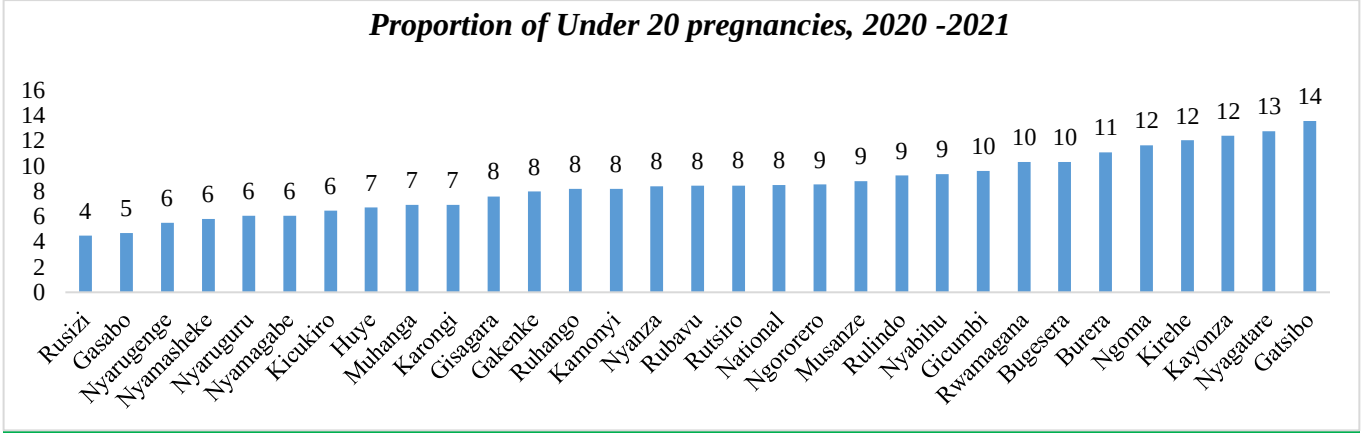


Figure 7: Under 20 pregnancies, 2020-2021



The above graph shows the proportion of under 20 pregnancies registered in ANC services for 2020/2021 which is 8% at national level. The five Districts that reported higher than national proportions of pregnancy in women under 20 years of age were Gatsibo, Nyagatare, Kayonza, Kirehe and Ngoma. The RDHS (2019-20) reported deliveries to women aged 20 years or below to have reduced from 7% to 6%. The majority of women of this age group delivered in a health facility, had an antenatal visit with health provider and received post natal care compared with other age groups. However, fewer in this age group attended ANC four times and their newborns were less likely to be protected against tetanus toxoid (TT) (see Table 1)

Table 1. Key pregnancy and delivery indicators by age group (Source: RDHS 2019-20)

Age	ANC by Health Provider	ANC 4 visits	TT protection for newborn	Delivery by skilled attendant	Health facility delivery	PNC within 48 hours
<20	98.9	43.6	60.2	97.7	96.5	71.4
20-34	97.8	48.5	79.9	96.2	94.2	71
35-49	97.3	44.2	81.8	90.5	88.9	68.2

I.1.1.2 Delivery & Obstetric complications

The national policy calls for all women to deliver in a health centre and those considered at risk for complications in a hospital. The Total Fertility Rate (TFR) has fallen from 4.3 to 4.1 in the last five years (RDHS 2014-15 and 2019-20). ***The national coverage of health facility assisted delivery is 85%*** (n=321,895) of expected pregnancies delivered in a health facility, this has decreased from 98% in 2014-15. However, the proportion of deliveries conducted at home has also decreased. Districts reporting lower health facility assisted deliveriesare Kamonyi (57%), Rutsiro (66%), Nyaruguru (68%), Rwamagana (68%) and Nyanza (68%). In contrast, 5,586 home deliveries were reported by CHWs which correspond to 1.5% of total expected deliveries. 4 districts have registered more than 300 home deliveries: Karongi 379, Bugesera (350), Nyagatare (328) and Nyaruguru (300). Note that the health facility delivery indicator is also affected by the use of projection of 2012 census. As reflected above, the fall in TFR means there are less expected pregnancies than five years ago. Using the estimated pregnancies as a denominator for health facility deliveries there is a difference of 8.1% with the RDHS findings (93% RDHS versus 85% HMIS). If a proxy denominator of BCG is used we find the HMIS data has only a 2% discrepancy (93% RDHS versus 95% HMIS).

Figure 8: Trend of total deliveries (health facility deliveries + home deliveries), 2018/19-2020/21

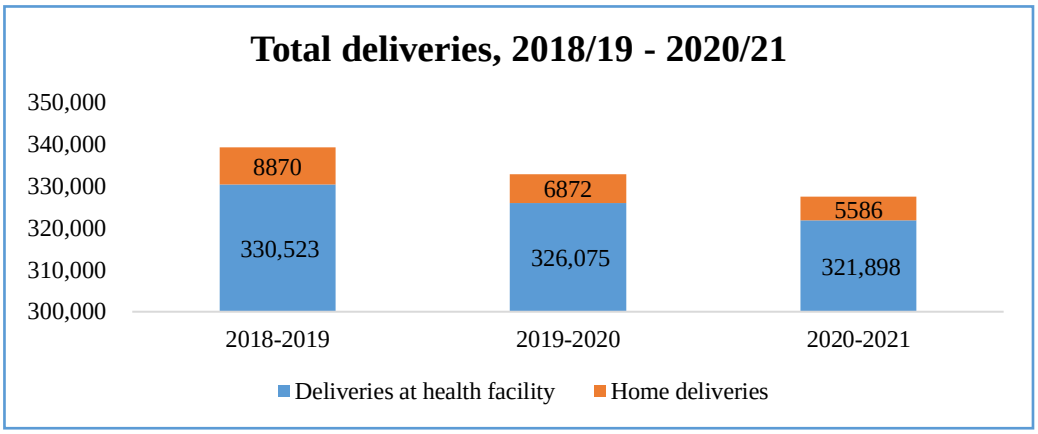


Figure 8 shows how the proportion of home deliveries decreased gradually in three consecutive years. This reduction of deliveries across the country may be explained by the decrease in TFR.

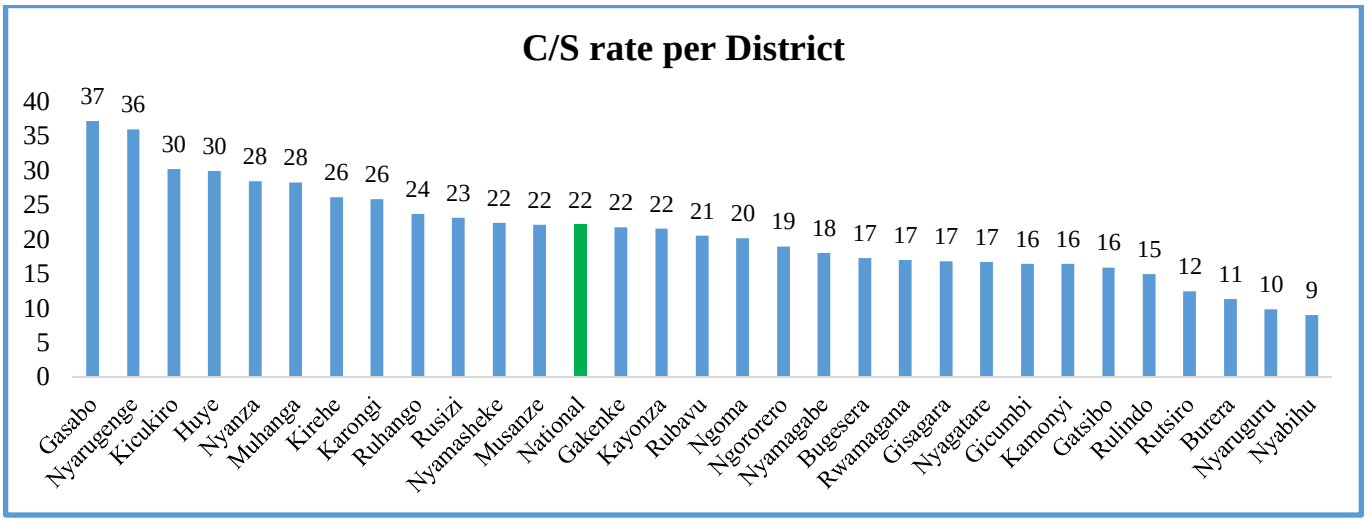
Table 2: Obstetric complications, 2020-2021

Type of cause	Causes	Number of hospitalized cases	Proportional morbidity	Number of deaths	Proportional mortality	CFR
Direct causes	Complications of Abortions all	1804	5.2%	14	5.4%	0.8%
	Ectopic pregnancy	999	2.9%	1	0.4%	0.1%
	Antepartum Haemorrhage	1497	4.3%	5	1.9%	0.3%
	Post-partum hemorrhage	2666	7.7%	56	21.5%	2.1%
	Eclampsia	474	1.4%	12	4.6%	2.5%
	Severe Pre Eclampsia	1998	5.8%	9	3.4%	0.5%
	Post C-Section infection	1975	5.7%	22	8.4%	1.1%

Type of cause	Causes	Number of hospitalized cases	Proportional morbidity	Number of deaths	Proportional mortality	CFR
	Other Postpartum infections	502	1.4%	6	2.3%	1.2%
	Prolonged or Obstructed labor	4197	12.1%	5	1.9%	0.1%
	Uterine rupture	433	1.3%	15	5.7%	3.5%
	Amniotic embolism	14	0.0%	9	3.4%	64.3%
	Complications of anesthesia	17	0.0%	2	0.8%	11.8%
	Direct Obstetrical Complications Other	9148	26.4%	20	7.7%	0.2%
Indirect causes	Anemia Severe <7gm/dl	2027	5.9%	1	0.4%	0.0%
	HIV Opportunistic Infections	256	0.7%	3	1.1%	1.2%
	Pulmonary embolism	77	0.2%	18	6.9%	23.4%
	Pneumonia on pregnancy	199	0.6%	1	0.4%	0.5%
	Malaria in pregnancy	2227	6.4%	2	0.8%	0.1%
	Indirect Obstetrical Complications Other	4127	11.9%	60	23.0%	1.5%
Total		**34,637**		**261**		**0.8%**

Table 2 presents the most common direct and indirect obstetric complications that require hospitalization: in total 34,637 cases of obstetrical complications were recorded in which 261 deaths occurred in health facilities. Among all causes, 74% were related to direct causes and 26% to indirect causes. As for the causes of deaths, 67% are direct causes and 33% are indirect causes. Postpartum hemorrhage, prolonged labor or obstructed labor and malaria in pregnancy are predominant causes of morbidity. While post-partum hemorrhage, postpartum infections and pulmonary embolism are the main causes of death. CFR is 0.8% for all causes whereby amniotic, pulmonary embolism and complications of anesthesia have the highest CFR. There was a 53% reduction in reported hospitalizations from direct and indirect obstetrical complications from 54,716 in 2019-20 to 34,637 in 2020-21. The number of deaths also decreased by 47% from 460 to 261 with a decrease in case fatality from 0.84% to 0.8%. Indirect causes comprised lower proportional mortality than direct causes (0.02% versus 0.5%) but higher case fatality (0.95% versus 0.68%). The majority of deaths from direct obstetrical complications were from post-partum hemorrhage (including post C/S bleeding) and post C/S infection, while the highest case fatality rates were from amniotic embolism, pulmonary embolism and complications of anesthesia.

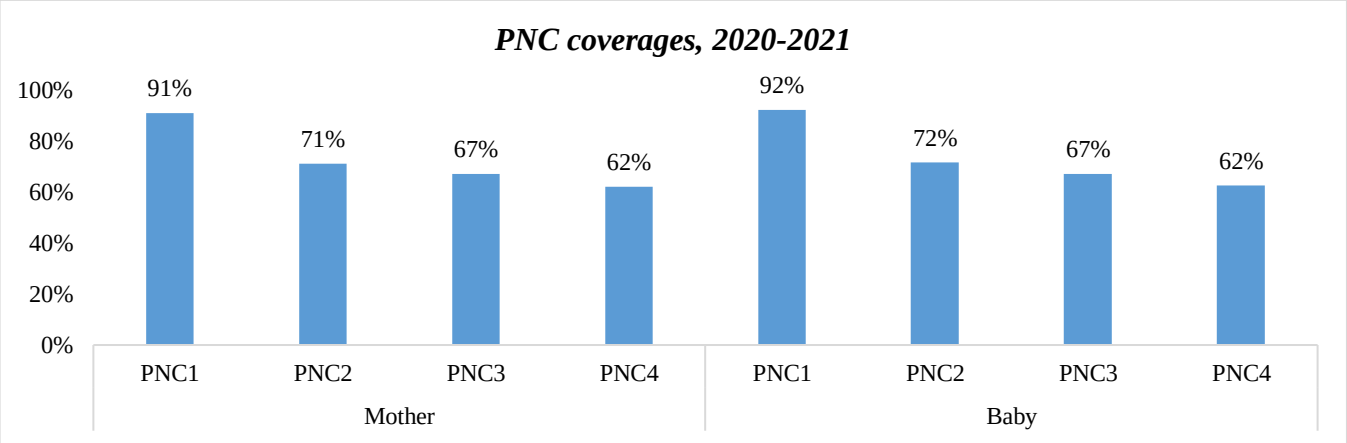
Figure 9: Caesarean sections as a proportion of all deliveries per District and hospital respectively 2019-20



Caesarian Section rates in Rwanda are 22% of all deliveries. The range per District 9% in Nyabihu District and 37% in Gasabo District. Nyarugenge hospital (based in Kigali) performs C/S for 71% patients while the rate is 35% for Muhima District Hospital.

I.1.1.3 Postnatal care (PNC), July 2020 – June 2021

Figure 10: PNC_mother & baby coverage, 2020-2021

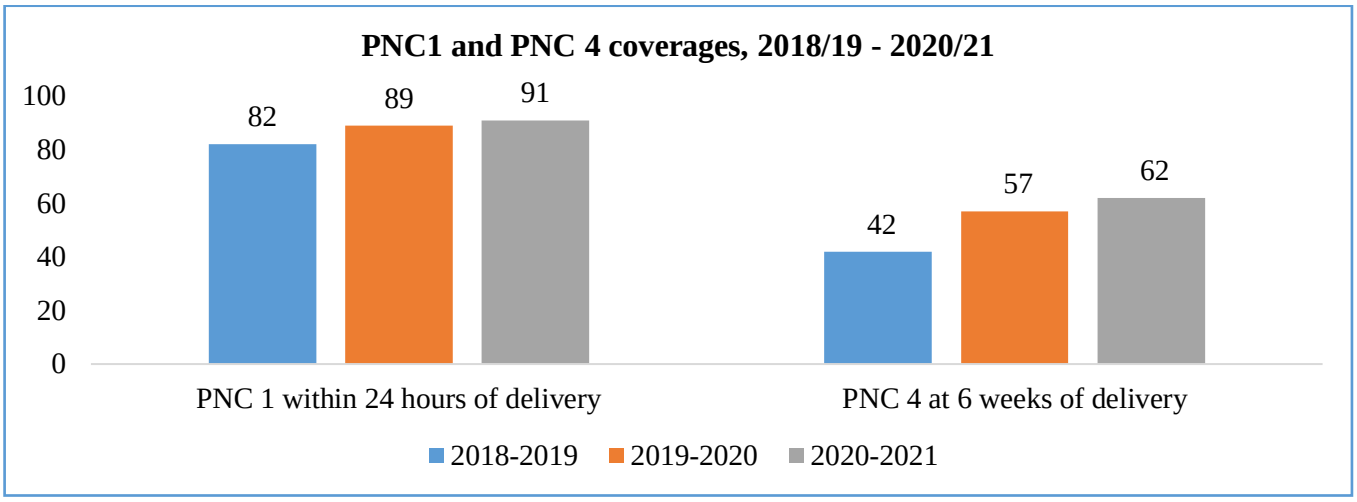


There is noted a high gap between PNC1 and PNC4. There are 9% of mothers and 8%of babies who are not seen before discharge from health facilities after delivery, also when arrived home around 29% are not seen by CHWs at 3rd day of delivery. 5 Districts have low performance of PNC1 coverage: Kirehe (75%), Nyarugenge (78%), Gasabo (81%), Bugesera (86%) and Kicukiro (86%). Districts that report a PNC4 coverage under 50% are Kicukiro (36%), Gasabo (37%), Nyarugenge (45%), Kamonyi (46%), Muhanga (49%) and Bugesera (49%).

Post-natal care (PNC) is recommended in Rwanda for mother and baby within 24 hours of birth and for three additional visits. The majority of women deliver their babies in a health facility so, as expected, the

proportion of mothers and babies who receive the first PNC screening is above 90%. This proportion drops to 62% by the fourth visit an increase in 20% since 2018-19.

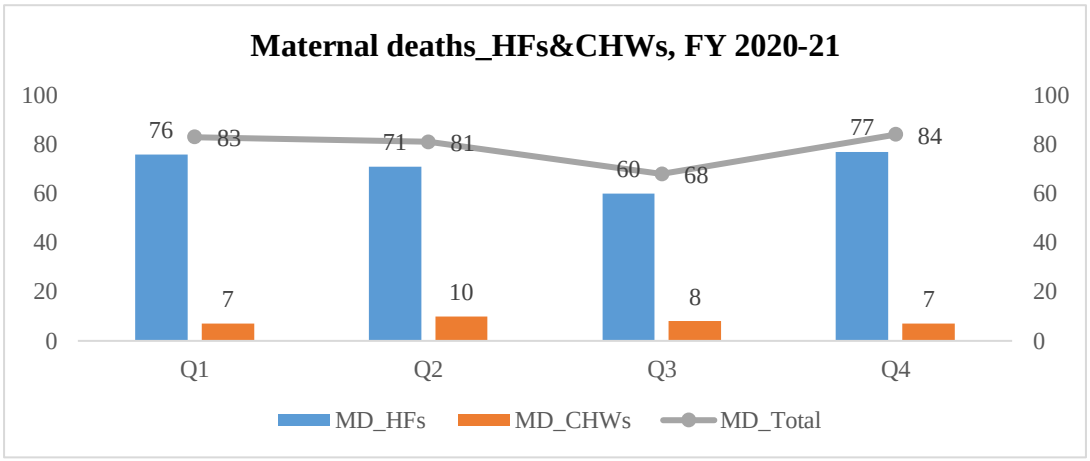
Figure 11: Coverage of PNC1 and PNC 4, 2018/19 – 2020/21



I.1.1.4 Maternal mortality, July 2020 – June 2021

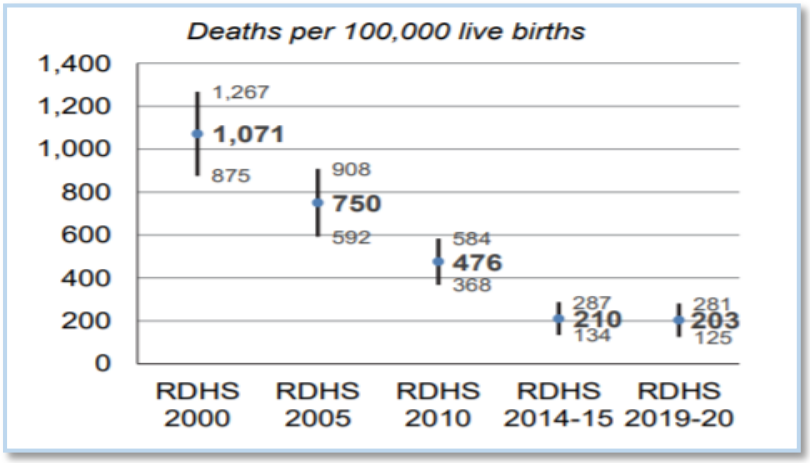
Maternal death: Under the 10th International classification of diseases (ICD-10), maternal death is defined as the death of a woman while pregnant, or within 42 days of the termination of pregnancy, regardless of the duration and site of the pregnancy, from any cause related to, or aggravated by the pregnancy or its management, but not from accidental or incidental causes. **Maternal death surveillance and response (MDSR)** is defined as "a component of the health information system, which permits the identification, the notification, the quantification, and the determination of causes and avoidability of maternal deaths, for a defined time period and geographic location, with the goal of orienting the measures necessary for its prevention".

Figure 12: Maternal deaths (HF based & Community maternal deaths), 2020- 2021



A maternal death is the death of a woman during pregnancy and until 42 days after the end of the pregnancy. In 2020 -2021, 316 maternal were recorded countrywide through HMIS (284 among them by health facilities and 32 by CHWs in the the community) while the number of reported maternal deaths through MPCDSR is 268 (245 among them by health facilities (86%) and 25 (78%) as deaths occurred in the the community). The institutional maternal mortality rate is at 88.4/100,000 Live Births.

Figure 13: Maternal mortality ratio (MMR) according to RDHS 2019-2020

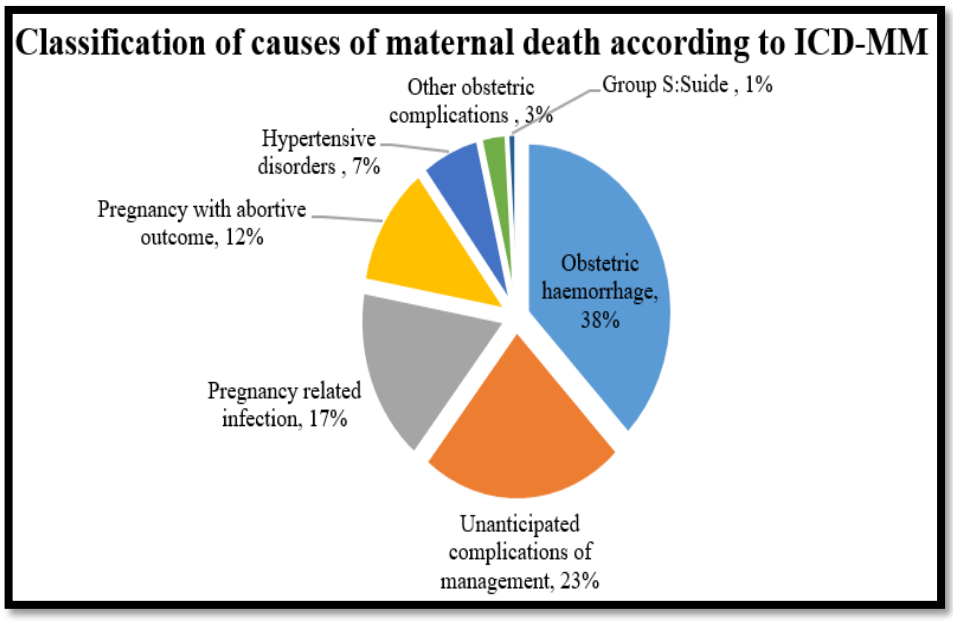


The preliminary results of RDHS 2019-20 showed a decline in MMR in Rwanda from 1071 in 2000 to 203 in 2019-20. A decline from 210 to 203 in the past five years was also reported. .

Figure 14: Causes of maternal deaths according to CEMD, 2020- 2021

Health facility based maternal perinatal and child deaths audit has the challenge of using an internal evaluation methodology which can be considered as routine, leading to a poor quality of deaths. Thus, a Confidential Enquiry into those deaths is recommended.It deeply studies cause and factors contributing to deaths and detect areas of deficiency in clinical practice and devise recommendations to resolve them. This cross-sectional survey was conducted in all hospitals using a death review form designed to apply the WHO ICD-10 to classify deaths that occurred during pregnancy, childbirth, and puerperium period. In total, 269 maternal deaths were reviewed.

Results from the review showed that the post-partum hemorrhage accounted for 67% of all deaths with 63% of deaths occurring within 24 hours. Of the women who died, 51% had delivered by csection while 15% of the deaths happened before onset of labor. Seventy nine percent (79%) of deaths were due to direct obstetrical complications. The ICD-10 classification of maternal deaths revealed that the leading causes of maternal deaths were obstetric hemorrhage (38%), followed by unanticipated obstetrical complications, including complications of obstetric surgery (23%), infections (17%), abortive outcomes (12%), and hypertensive disorders (7%). Of all reviewed deaths, 87% were preventable. Predominant deaths (79%) were related to delays in decision making within health facilities. Ingobyi will use the recommendations from this survey to support hospitals to prevent and manage obstetric complications.



Of the maternal deaths reviewed 74% were due to direct causes primarily obstetric hemorrhage (38%), unanticipated complications of management (23%), pregnancy and delivery related infections (17%) pregnancy with abortive outcomes (12%) and hypertensive disorders (7%). Three delays model analysis shows that third delay (delay within the health facilities) is more contributing to maternal death. This delay was identified as more contributing for 79% od reviewed maternal deaths. A breakdown of the factors associated with third delay indicates that mismanagement (82%),inadequate follow up after admission (54%) ,misdiagnosis (49%) insufficient assessment (36%) and delay to refer (36%) are main leading avoidable factors .

I.1.2 Neonatal health indicators (including perinatal)

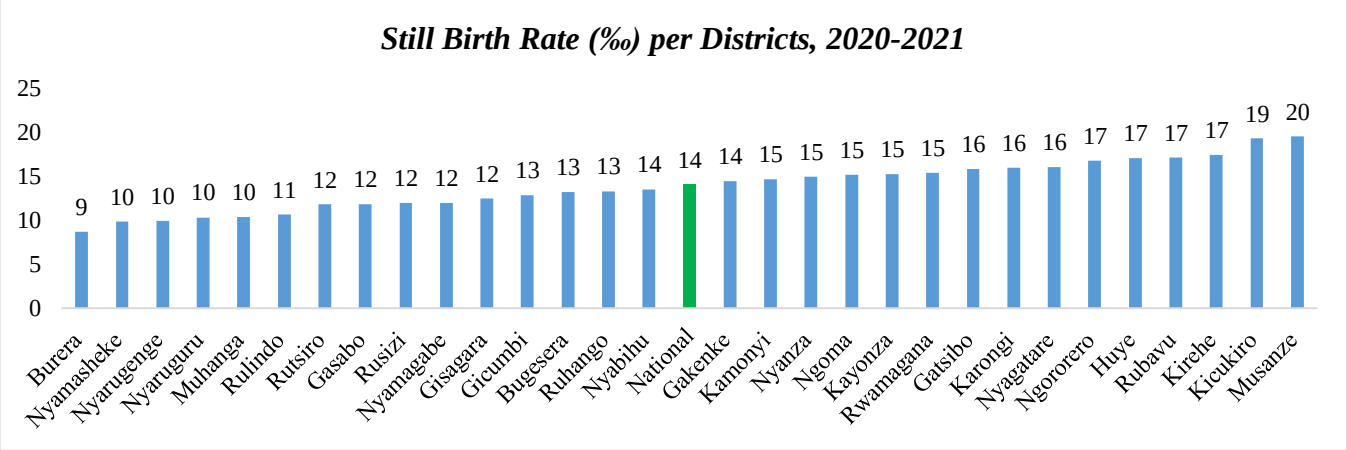
This section provides updated results against indicators in the neonatal period and still births. The neonatal period is from birth to 28 days of life. In this section we include the perinatal period that includes still births as well as early neonatal deaths that occur within seven days of birth. Still births that are categorised as 'still birth fresh' are intrauterine deaths that occurs during labour or delivery. 'Still births macerated' are intrauterine deaths that occur before the onset of labour.

Table 3: Newborn indicators (HMIS), July 2020 – June 2021

	2020-2021
Total births	325,902
Live births	321,320 (99%)
Newborns breastfed within 1 hour of delivery	303,327 (95%)
Congenital malformations	1,401 (0.4%)
Low Birth Weight	19,975 (6.2%)
Premature newborns (alive, 22-37 weeks)	10,636 (3.3%)
Death at birth	782 (0.2%)
Live newborns who didn't cry/breath at birth	12,912 (4%)
Live Newborns who didn't cry/breath at birth and were resuscitated successfully	9,086 (71%)
Low birth weight_2000 gr admitted to KMC	5,747 (77%)

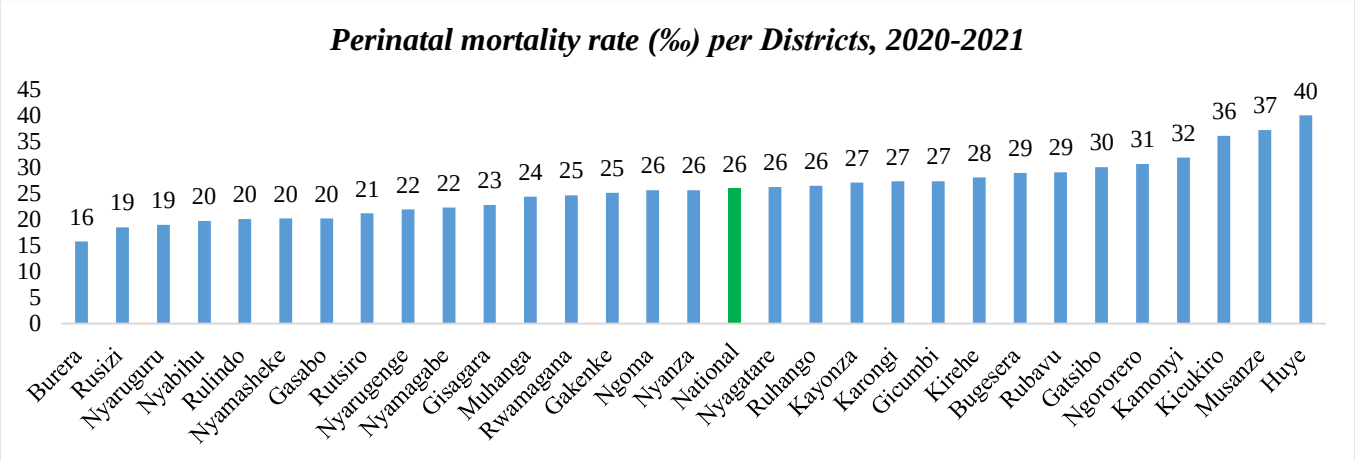
Total births registered in 2020-2021 year were 325,902 for 12 months, 99% of them were live births. In total 4,582(1%) still births were registered and 41% of them were still birth fresh; A among all live births 0.3% born with congenital malformation and 6.2% were low birth weight, while 3.3% were premature babies. Mothers breasfeeded their babies within the first hour at the rate of 95%. In addition, 4% of live births did not cry/breath at birth but 71% of them were successfully resuscitated.

Figure 15: Still birth rate per Districts, 2020-2021



The above graph presents the stillbirth rate (SBR) from July 2020 to June 2021 which is at 14/1000, 14 districts noted high Still birth rate which is 15‰ and above: Kamonyi, Ngoma, Nyanza, Kayonza Rwamagana, Gatsibo, Karongi, Nyagatare, Ngororero, Huye, Rubavu, Kirehe, Kicukiro and Musanze. It is highly needed to take measures to minimise at best this rate. The quality of ANC during pregnancy course period and intrapartum care have an impact on the SBR.

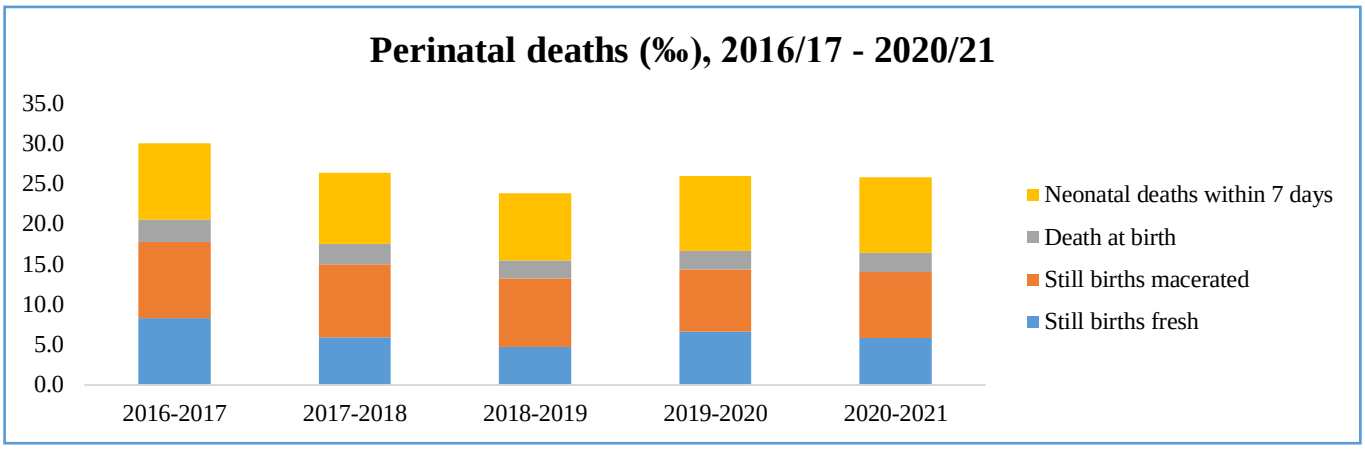
Figure 16: Perinatal mortality per District, July 2020 – June 2021



The above graph presents the perinatal mortality from July 2020 to June 2021 is at 26/‰ at national level. 6 Districts have high perinatal mortality rate 30‰ and above: these are Gatsibo, Ngororero, Kamonyi, Kicukiro, Musanze and Huye Districts. It is highly needed to take measures to minimise at best this rate.

The more a SBR is high the more it si likely to have a high perinatal mortality rate (PMR). For the Districts with low SBR but with high PMR, they face a challenge of management of newborn within 0-7 days of life.

Figure 17: Five year perinatal mortality, 2016/17 – 2020/21



Both still birth and perinatal mortality rates decreased since 2015/16 to 2020/21 to respectively from 18.5‰ in 2015/16 to 14.1‰ in 2020/21 and from 31.3‰ in 2015/16 to 25.8‰ in 2020/21. More efforts and strategies are needed to reduce the number of still births and early neonatal deaths in general.

I.1.3.3 Neonatal morbidity and mortality, 2020-2021

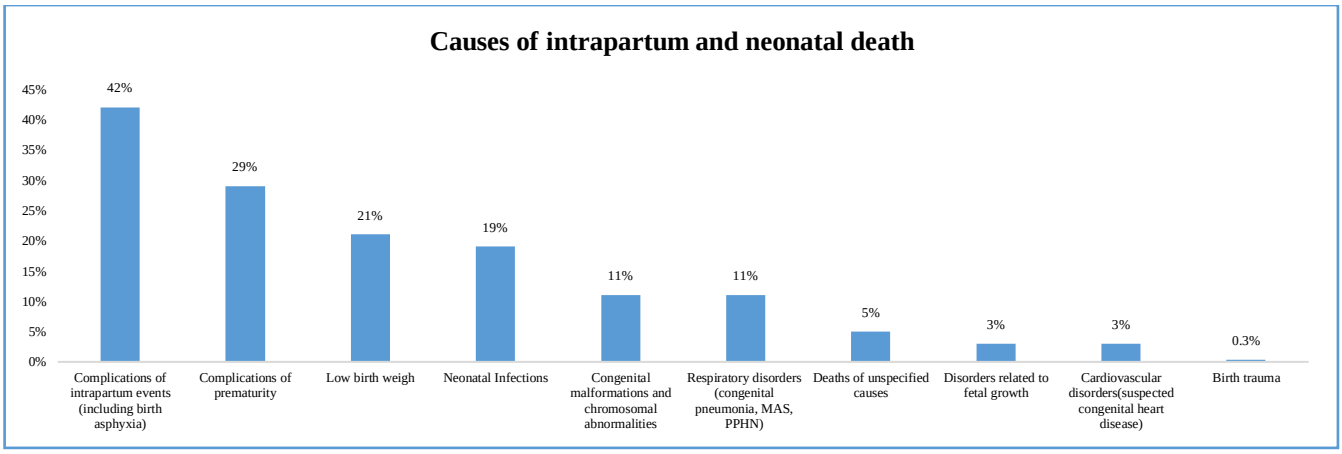
Table 4: Top causes of neonatal morbidity and mortality (HMIS), July 2020 – June 2021

	Hospitalized cases	Proportional morbidity	Neonatal deaths	Proportional mortality	NCFR
Asphyxia	5,573	14.5%	1051	31.7%	18.9%
Prematurity_22 to 37 weeks	8,838	23.0%	1507	45.5%	17.1%
Congenital malformation	1,319	3.4%	336	10.1%	25.5%
Neonatal infections	22,669	59.0%	421	12.7%	1.9%
Total cases	38,399		3,315		8.6%

Prematurity, neonatal infections and asphyxia are the leading causes of neonatal morbidity and mortality; whereas asphyxia, prematurity and congenital malformations have the highest CFR. Among those neonatal infections, sepsis takes a first place with more cases and deaths.

Figure 18: Causes of intrapartum and neonatal deaths according to death audit (CEPD)

In June 2021, Rwanda Biomedical Centre through MCCH Division conducted first confidential enquiry into perinatal death. This cross-sectional survey was conducted in all hospitals using adapted WHO application of ICD-10 PM in classification of causes of perinatal deaths tools. In total 1995 perinatal deaths including 478 antepartum deaths(24%),443 intrapartum death(22%) and 1074 neonatal death (54%) has been reviewed.

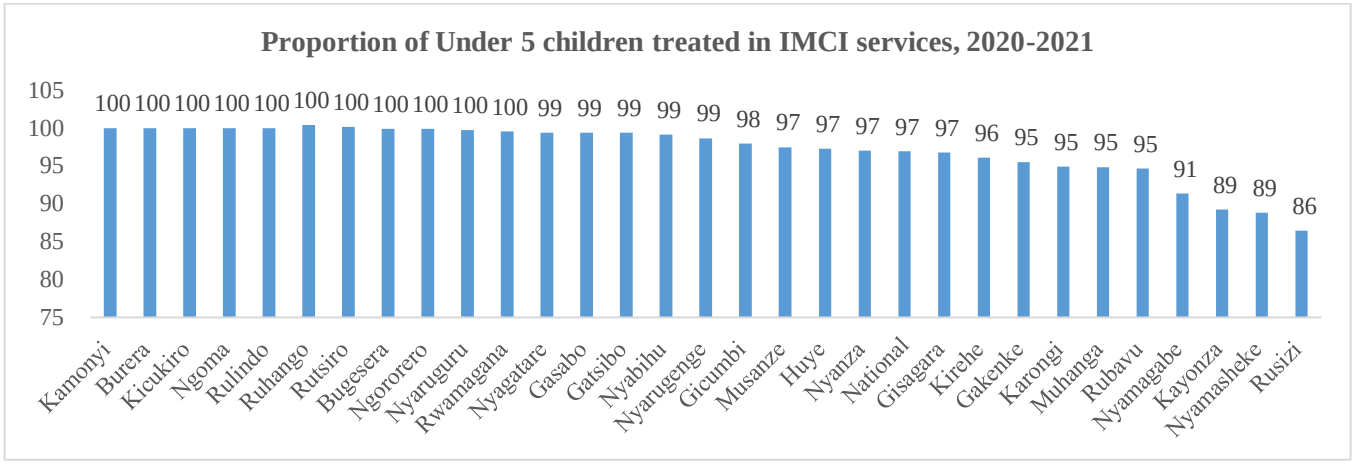


The figure above shows the causes of intrapartum and neonatal deaths in 2020-2021. Results show that prematurity and low birth weight(50%, complications of intrapartum events including birth asphyxia (42%), neonatal infections (19%) and congenital abnormalities (11%) are leading causes of intrapartum (Fresh stillbirths) and neonatal deaths and there are quality issues regarding administration of corticosteroids to mothers , aminophylline/cafeine to newborn in case of delivery before 34 weeks as per recommendation, administration of prophylactic antibiotics in case of Prolonged PROM and PPROM and glycemia taking at admission in neonatology service. Those gaps should be targeted by clinical mentorship of neonatalogy services.

I.1.3 Child health indicators

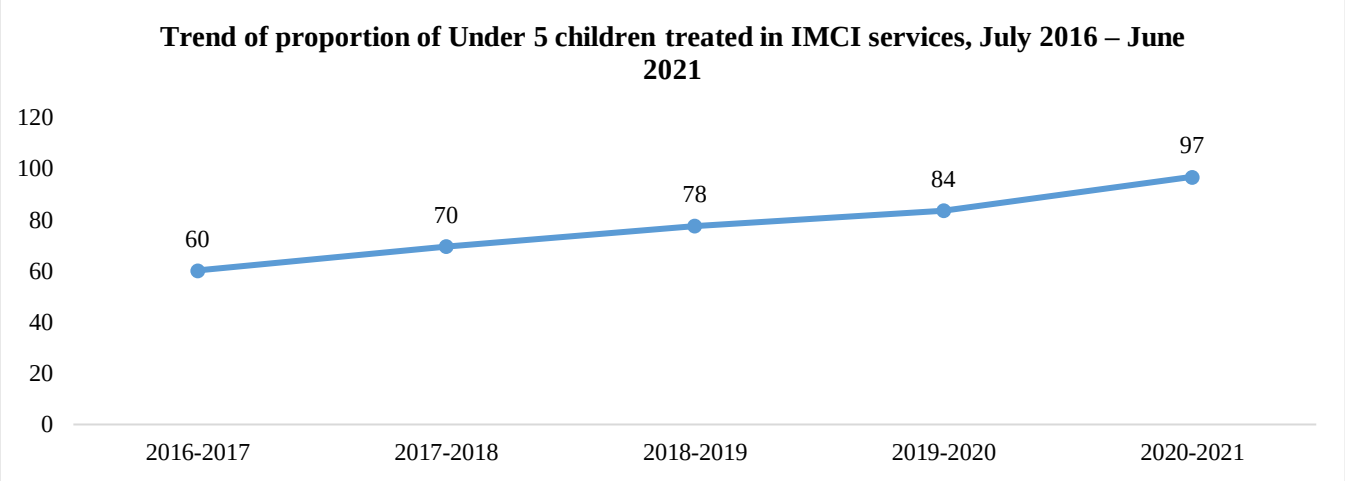
In this section we present data against indicators related to service utilization, disease burden and mortality of children under five years of age. Childhood vaccines will be described in the following section.

Figure 19: Proportion of Under 5 children treated in IMCI services, July 2020 to June 2021



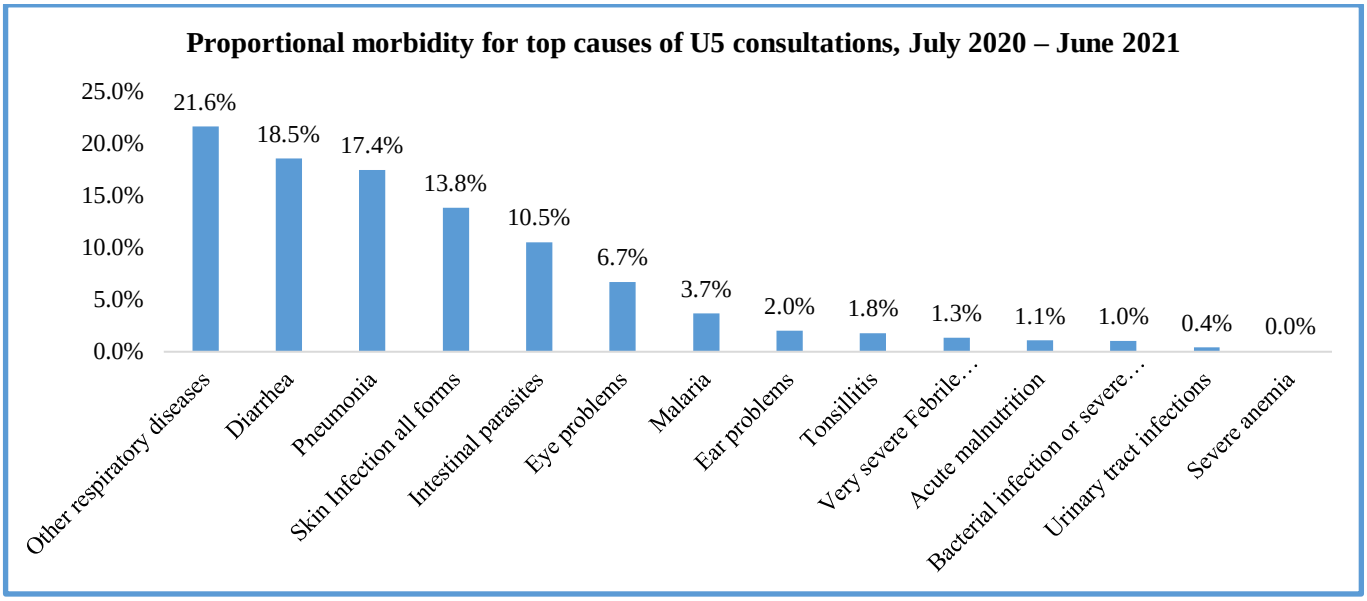
Among all under 5 children received and treated in health facilities (1,746,253), 97% were seen and treated according in IMCI services across the country. However, three Districts have a rate less than 90%: Rusizi, Nyamasheke and Kayonza. Most of those districts with low performance, they faced a challenge of lacking trainings, lack of partners and high staf turn over in charge of IMCI.

Figure 20: Trend of proportion of Under 5 children attending a health facility treated with IMCI services, July 2016 – June 2021



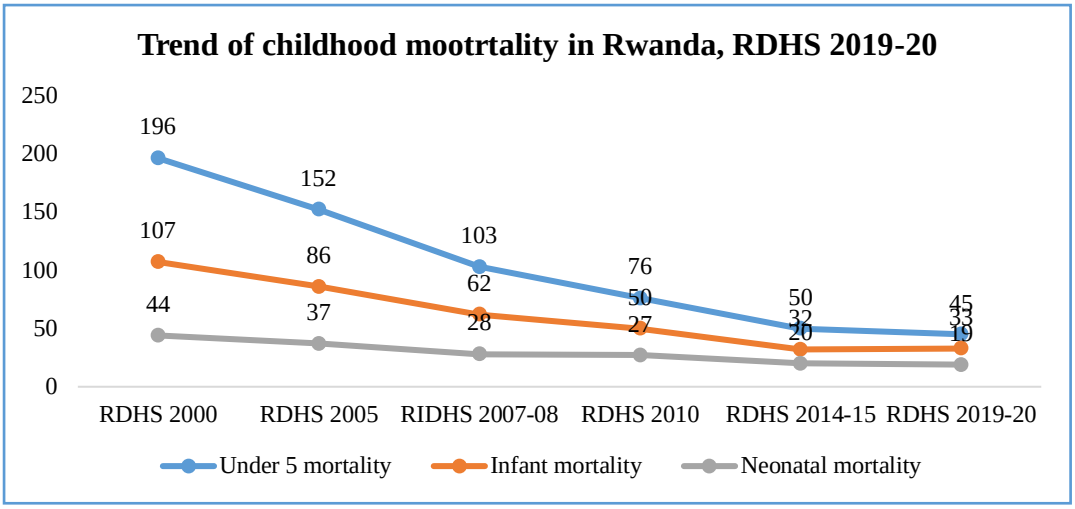
The above figure shows that the proportion of under 5 children who attended a health facility and were treated withn IMCI services across the country kept on increasing within 5 consecutive years. It increased from 60% in 2016-2017 to 97% from 2016-17 to 2020-2021.

Figure 21: Causes of morbidity in U5 children (IMCI)_ July 2020 – June 2021



Respiratory diseases, diarrhoea diseases, skin infections, intestinal parasites and malaria are the leading causes of morbidity in under five children while respiratory diseases (49%) is the first cause of hospitalization followed by diarrheal diseases (24%), sepsis (6%), malaria and diseases of intestine (4%). Pneumonia (15%), sepsis (14%), problems of bone and joints (9%) and diarrheal diseases (8%) are reported to be the leading causes of death (excluding neonatal deaths) for under five children.

Figure 22: Childhood mortality, RDHS 2019-2020



Mortality of children between the ages of 1 and 5 years has decreased steadily over the past fifteen years while infant and neonatal mortality have stagnated or risen slightly in the past five years.

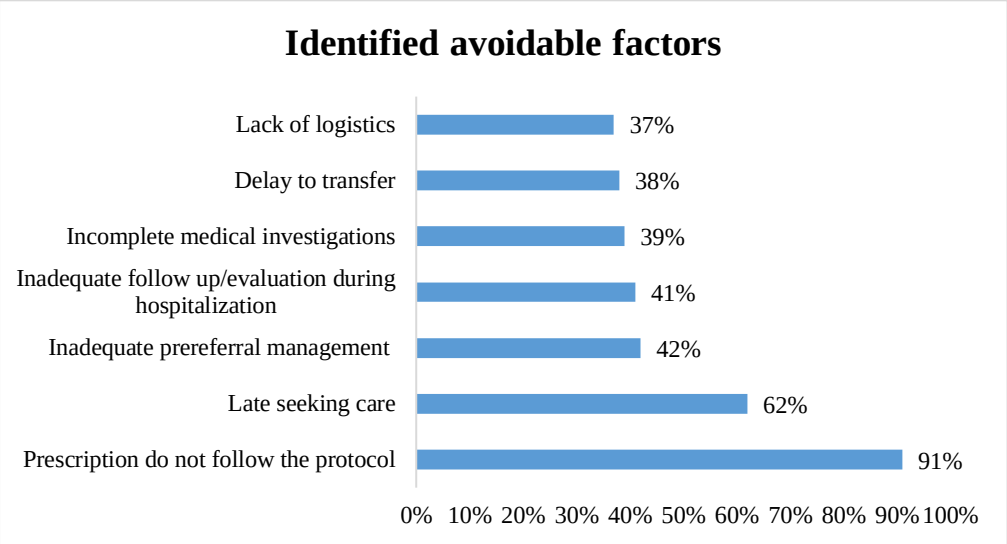
Table 5: Case fatality rates in Under 5 moratlity_2020-2021

	Hospital cases	Deaths	CFR
Appendicitis	7	3	43%
Hepatitis	30	12	40%
Tetanus	8	2	25%
HIV AIDS related opportunistic Infection	61	12	20%
Diseases of the stomach or the duodenum	455	87	19%
Cirrhosis of the liver	36	5	14%
Diseases of the genitourinary system	254	32	13%
Cancer all	469	40	9%
Bone and Joint problems	1726	100	6%
Acute Malnutrition	1154	54	5%
Sexual transmitted diseases	219	10	5%
Sepsis	3665	154	4%
Tuberculosis	282	10	4%
Burns	1116	26	2%
Diseases of intestine	2283	53	2%
Malaria	2597	41	2%
Diarrheal diseases	14399	90	1%
Skin Diseases	1217	7	1%
Respiratory diseases	29745	169	1%

The highest case fatality rate is seen for appendicitis (43%), hepatitis (40%), tetanus (25%), HIV and opportunistic infections (20%). In total 378 under five deaths (neonatal excluded) were reviewed audited by hospital death audit committees to review factors related to those deaths and put aside the causes of those causes that leads to plan mitigation measures to avoid same conditions to happen to other cases. Analysis of under five deaths shows that 50% of under five deaths occur within 48 hours after admission ,17% among them with within six hours.

Figure 23: Identified avoidable factors

445 under five deaths occurred in 2020 have been analyzed and results show that 87% were admitted referred from upper level health facilities;69% by health centers and 21% by District hospitals,3% by private clinics. 48% of under-five deaths occurred before 48 hours after admission and five leading causes of deaths are respectively pneumonia, septicemia, malnutrition cardiopathy and malaria.62% od deceased children were admitted in unconscious state that may justify late seeking care.



In addition analysis showed that 77% of deaths were qualified as avoidable and figure above show that adherence to protocol, late seeking care inadequate prereferral management and inadequate follow after admission have been respectively identified as main contributory/avoidable factors. There is a need to conduct confidential enquiry into under-five deaths to access Cleary clinical management , contributory and causes of death and propose strategies to eliminate preventable deaths.

I.1.4 Status of CBMNH and CCM indicators

Table 6: Community based maternal health indicators, 2020/2021

	2020-2021
Number of pregnant women newly identified by ASM confirmed pregnant	280,518
Number of women within 4 months of pregnancy referred by ASM to ANC	220,722
Number of currently pregnant women	1,016,134
Number of women referred to health center for PMTCT	250,706
Home deliveries	5,676
Number of women who delivered at home and received mizoporositol to prevent Post Partum Hemorrhage	2,437
% of women who delivered at home and received mizoporositol to prevent Post Partum Hemorrhage	43%
Number of women accompanied to postnatal visit within 24 hours of home delivery	5,122
% of women accompanied to postnatal visit within 24 hours of home delivery	90%
Pregnant women accompanied to HC by CHW for deliveries	204,798
Number of mothers identified with danger signs upon the visit by the Community Health Worker	1,441
Number of mothers referred to the health center for danger signs in post partum period after receiving home visits	1,139

	2020-2021
Number of mothers referred to the health center after miscarriage	3,262
Number of pregnant and breastfeeding women screened for malnutrition using MUAC	3,245,690
Number of pregnant women with MUAC < 21cm	7,962
Number of breastfeeding women with MUAC < 21cm	5,007
% of women (pregnant+ breastfeeding) with MUAC < 21cm	0.4%

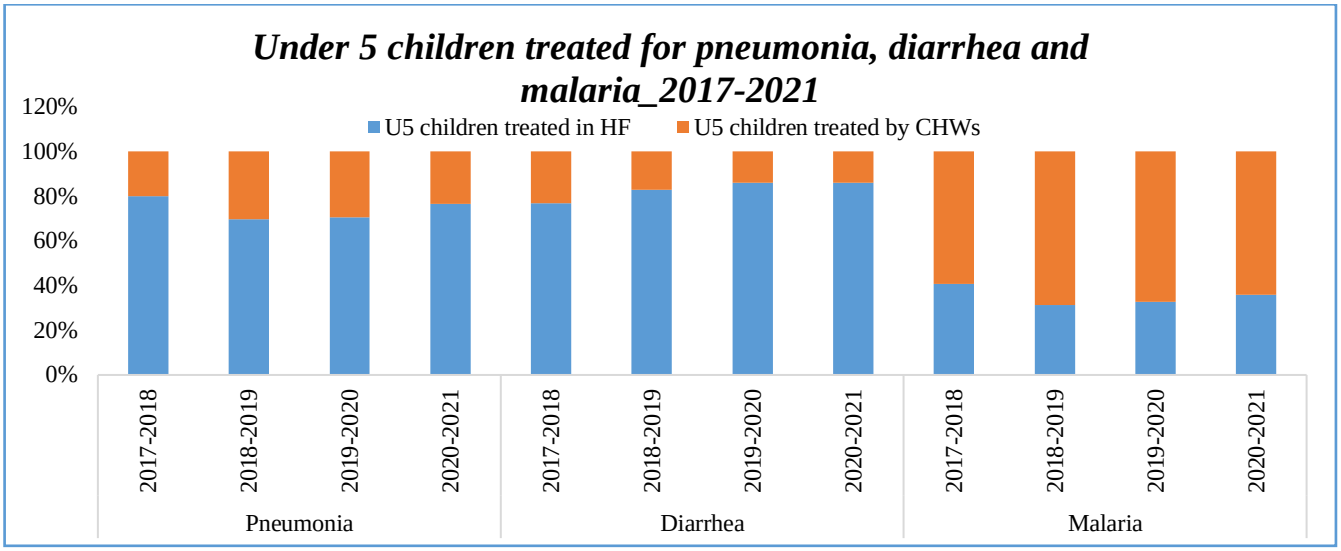
CHWs identified 280,518 new pregnant women; 204,798 pregnant women were accompanied by CHWs to HC for delivery; 5,676 home deliveries were reported and among them 43% received misoprostol; 90% were accompanied for PNC within 24 hours after home delivery; 5,007 (0.4%) women were identified with MUAC < 21 cm.

Table 7: Community based newborn health indicators, 2020/2021

	2020-2021
All live births (including home and facility based deliveries)	249,310
Number of newborns accompanied at the health center within 24 hours after home delivery	5,342
% of newborns accompanied at the health center within 24 hours after home delivery	94%
Number of newborns who received home visits on the third day after birth	230,876
% of newborns who received home visits on the third day after birth	93%
Number of newborns who received home visits between 7 and 14 days after birth	216,368
% of newborns who received home visits between 7 and 14 days after birth	87%
Number of newborns who received home visits on 28th day after birth	34,235
Number of newborns identified with danger signs upon the visit by the Community Health Worker	2,804
Number of newborns referred to the health facilty for danger signs	2,648
% of newborns referred to the health facilty for danger signs	94%
Number of children under Kangaroo mother care in the village	2,055
Number of children < 2 months referred to a health facility due to danger signs	30,636

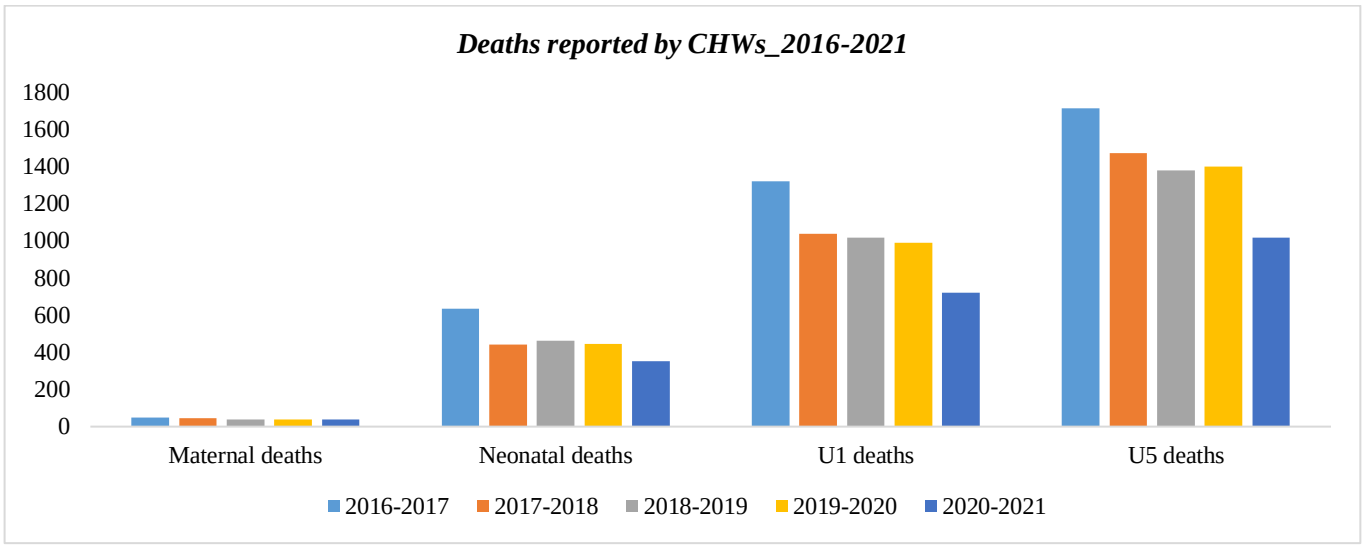
94% all home newborns were accompanied to HC for PNC; 93% of new-borns were visited by CHWs on the 3rd day after birth; 87% of new-borns were visited between 7th and 14th day after birth, 94% of newborns with danger signs were referred to HF. During 2020/21 FY, CHWs received 914,179 adults and children: 91% were received for malaria (74% were adults and children > 5 years for fever, 26% were children 6-59 months for malaria), 5% for pneumonia and 3% for diarrhoea. Among all those cases received, 1,529,297 (58%) were treated at community level, others were referred to health centres for further investigations. Malaria treatment was given to 51% of children and adults received with fever, 85% were treated for diarrhoea and 82% received pneumonia treatment.

Figure 24: Under 5 childern treated for pneumonia, diarrhea and malaria, 2017-2021



All CHWs are trained and equipped to provide screening and treatment for malaria, diarhoea and pneumonia for children under the age of five in their catchment areas. These are the most common causes of morbidity in children in this age group. However, the majority of visits for IMCI are at the Health Centre or Health Post (Figure 23) for pneumonia and diarrhea. For malaria, many children are seen and treated by CHWs though it is still low compared to national policy.

Figure 25: Deaths occurred in community 2016-2021



Although there is decrease in number of deaths occurring in community in five-year period, these numbers are still too high and much effort should be put in assessing the reason of death so that measures should be taken at all levels.

I.2 VACCINATION

Childhood vaccines have contributed to the reduction in mortality of children under five years of age in Rwanda. The current vaccine programme includes vaccines to pregnant women to protect the baby at birth and to babies in the first year of life. The vaccine schedule is shown in Table 8:

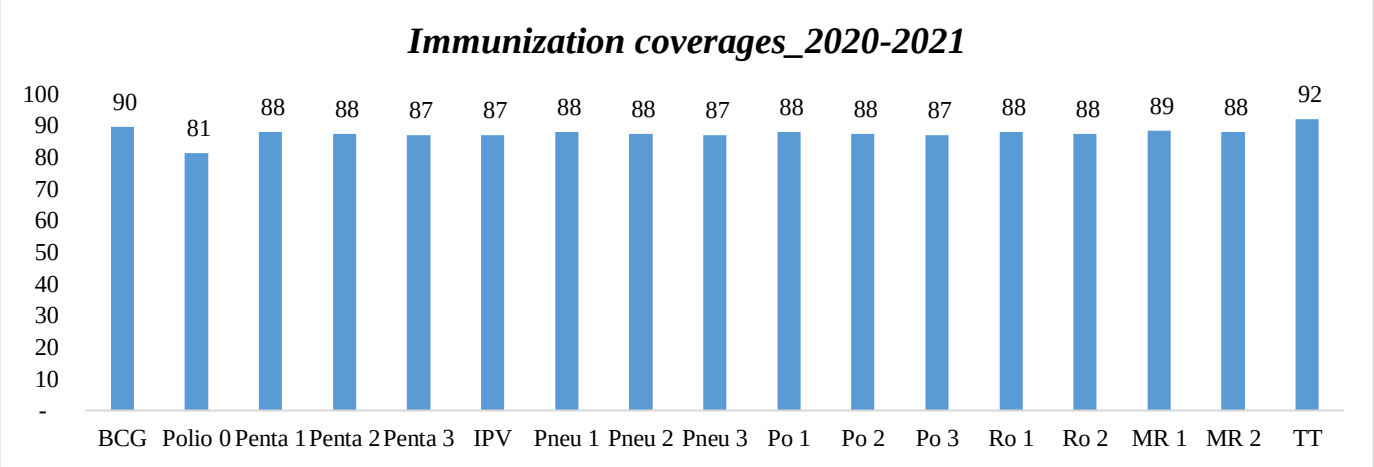
Table 8: Rwanda routine immunization schedule

Vaccine	Total doses	Age and interval
BCG (against tuberculosis)	1	Birth
Trivalent Oral Polio Vaccine (tOPV)	4	Birth, 6, 10, 14 weeks
Inactivated Polio Vaccine (IPV)	1	14 weeks
Diptheria, Tetanus, Pertussis, Hepatitis B and Haemophilus INfluenczae type B (DTP-HepB-Hib)	3	6, 10, 14 weeks
Pneumococcal Conjugate Vaccine (PVC13)	3	6, 10, 14 weeks
Rotavirus vaccine (Rotarix)*	2	6, 10 weeks
Measles-rubella (MR vaccine)	1	9 months
Tetanus Toxoid (TT) (pregnant women)	5	First contact, 1, 6, 12, 12 months (interval)
Human Papillomavirus (HPV)	2	2 doses of HPV for each cohort of girls 12years old (6 months interval)

*Rwanda shifted from Rotateq to Rotarix in April 2017

I.2.1 Status of routine vaccination indicators

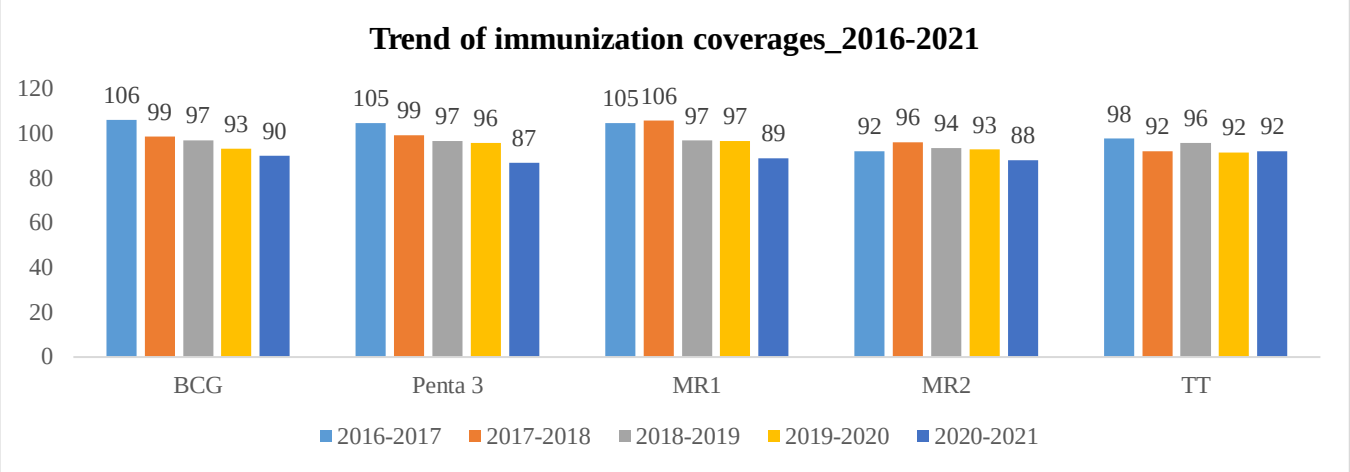
Figure 26: Immunization coverage rate, July 2020 – June 2021



This graph presents the coverages of immunization in 2020/21: 90% children received BCG, 81% received polio 0, 88% children have been vaccinated for penta 1, 88% children have been vaccinated for penta 2,

87% children have been vaccinated for penta 3, 89% were vaccinated for MR1 at 9 months of age, 88% were vaccinated for MR2 at 15 months of age and 92% pregnant women received TT vaccine.

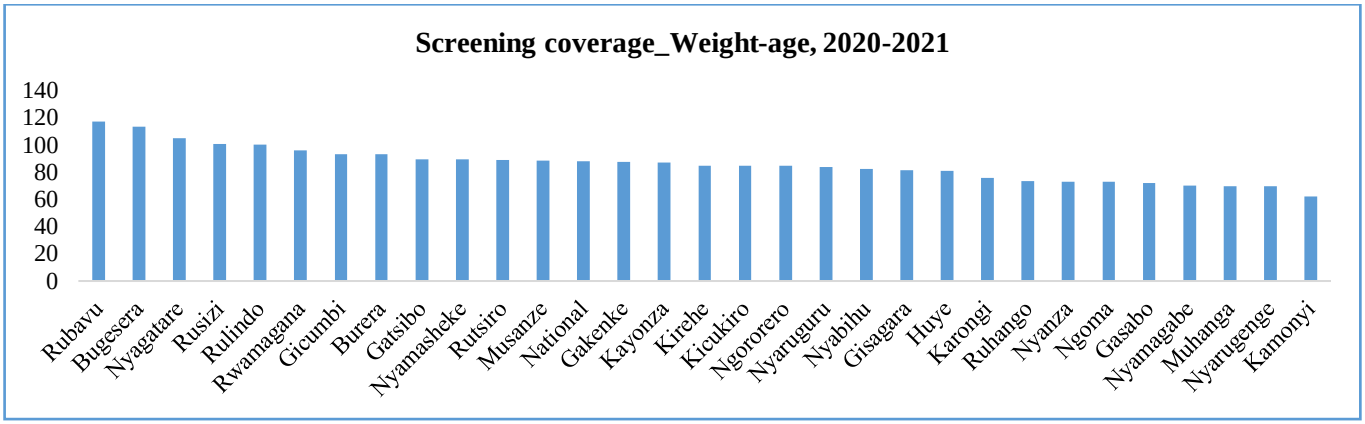
Figure 27: Trend of Immunization coverage rates, 2016-2021



Over the past five year, BCG declined from 106% to 90%, penta 3 decreased from 105% to 87%, MR1 slightly declined from 105% to 89%, MR2 decreased from 92% to 88%, TT coverage decreased from 98% to 92%. Further deep investigations are highly needed to know the root causes of the decreased coverages. NB. This indicator is also concerned by the 2012 population census projection.

I.3 NUTRITION

Figure 28: Growth monitoring in under five children, 2020-2021



By end of June 2021 , the screening for nutritional status of under 5 using weight for age is 88%. The global under weight is at 0.3%. Six districts have a global acute malnutrition above or equaling to 1.0%: Nyamagabe (2%), Gakenke (1%), Gisagara (1%), Karongi (1%), Muhanga (1%) and Rusizi (1%). There is particular problem or challenge in cities where children are screened to the low level as in rural districts and this is highly linked to life conditions of towns. The trend of coverage trend increased from 75% to 88% in 2020-2021.

I.4 FAMILY PLANNING & REPRODUCTIVE HEALTH

The Total Fertility Rate (TFR) in Rwanda decreased from 6.1 to 4.1 between 2005 and 2019-10 (RDHS) (Figure 18). Harnessing the benefits of the Demographic Dividend, decreasing the dependency ratio on an educated workforce to gain national economic prosperity, relies on a falling TFR. This decrease was a result of a desire for less children, with 48.8% women expressing a desire for no more children compared with 47.2% in 2014-15 (RDHS) and a reduction in the unmet need for family planning. However, fertility in rural areas remained unchanged in the past five years. The difference between urban and rural areas in 2019-20 was 3.4 and 4.3 respectively

Figure 29: Total Fertility Rate (TFR) in Rwanda, RDHS 2019-20

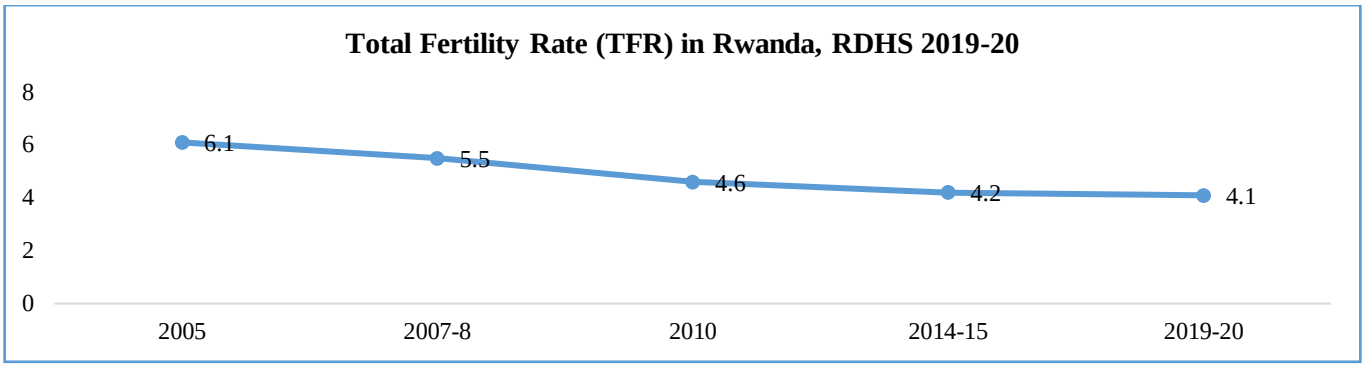
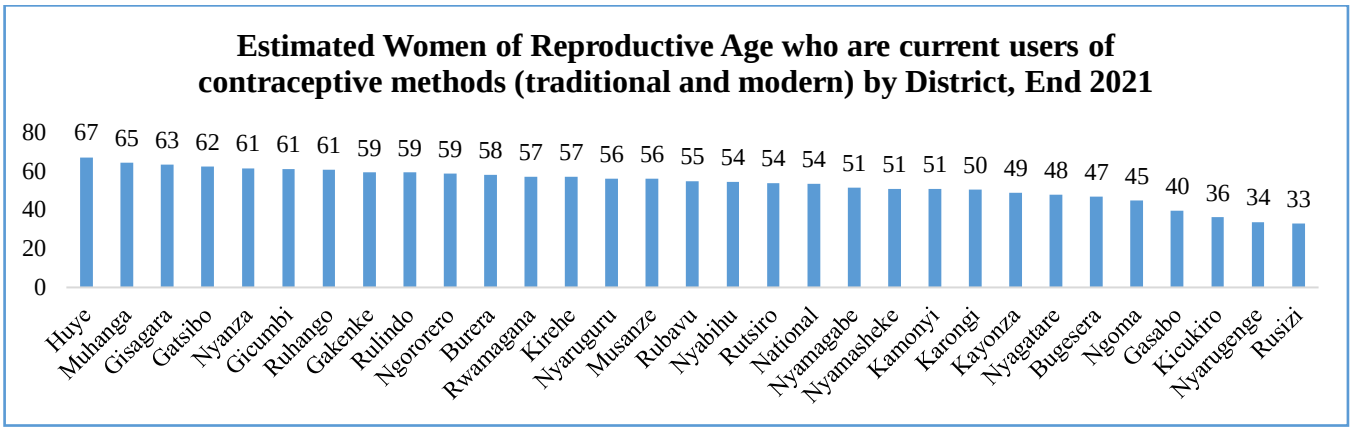
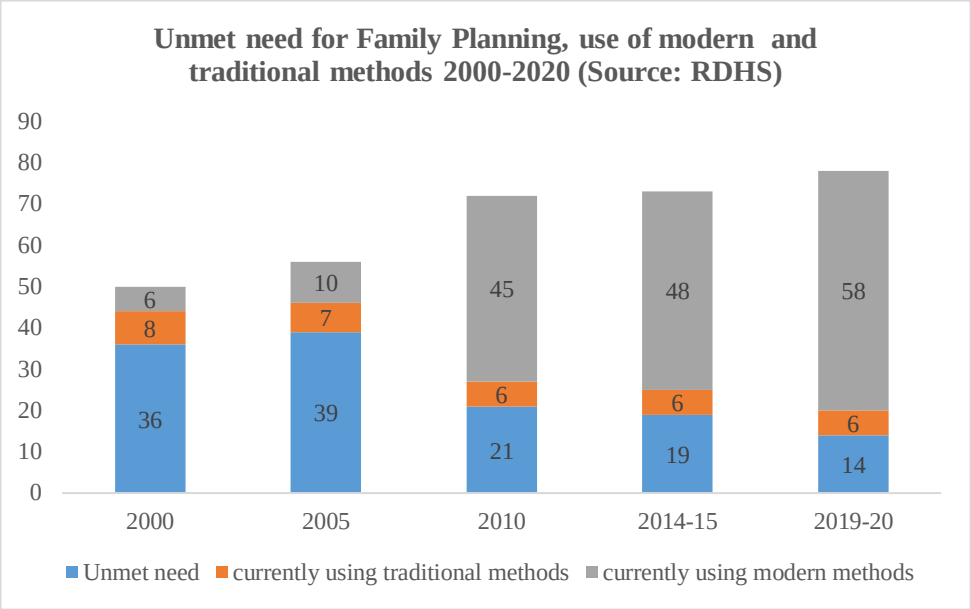


Figure 30: Contraceptive Prevalence rate (all methods) by District_HMIS 2020-2021



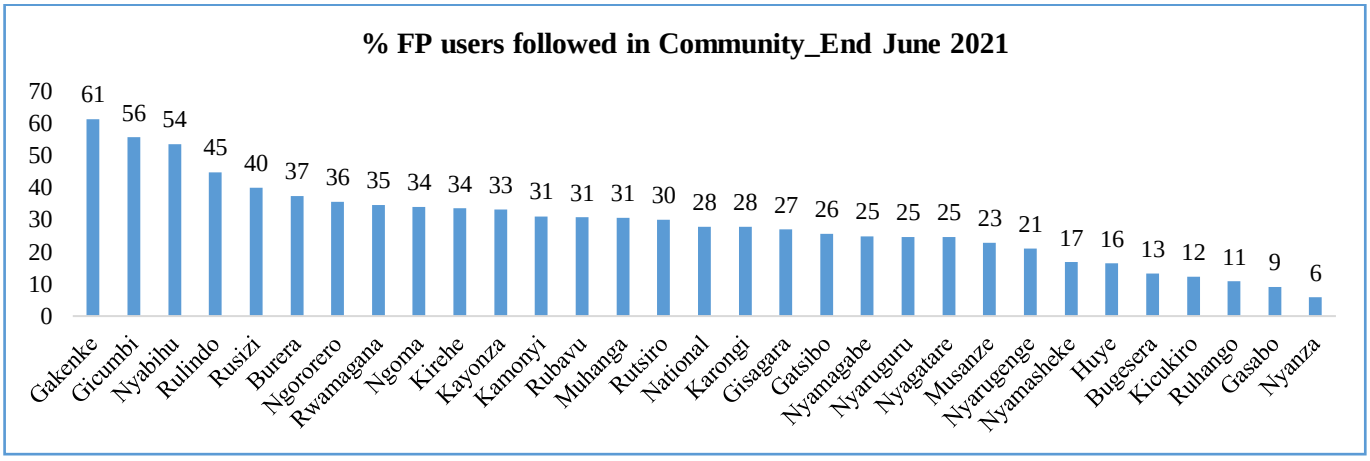
The contraceptive prevalence rate was at 54% for all methods combined and 53% for modern contraceptive. Three Districts; Rusizi (33%), Nyarugenge (34%) and Kicukiro (36%) have a contraceptive prevalence below 40% and 7 Districts: Huye (67%), Muhanga (65%), Gisagara (63%), Gatsibo (62%), Nyanza, Gicumbi and Ruhango with 61% have a contraceptive prevalence of ≥ 60%. Low reporting rate of private health facilities in cities, insufficient awareness of population are the main causes of low FP utilization in those Districts, some health facilties do not provide family planning services especially in Rusizi Districts.

Figure 31: Unmet need for Family Planning, use of modern and traditional methods 2000-2020 (Source: RDHS 2019/20)



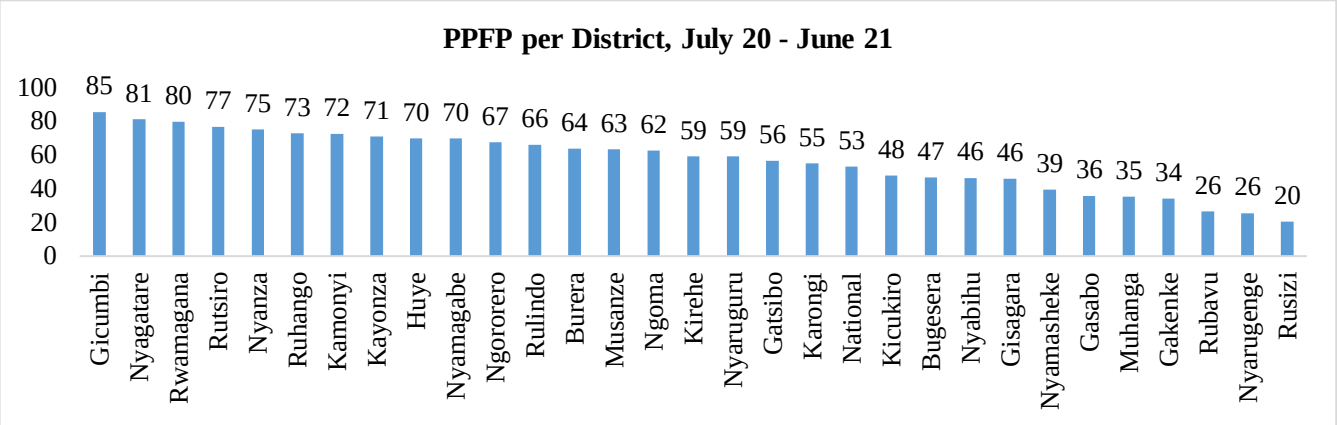
In addition to creating demand for family planning by encouraging delay in childbearing, spacing of pregnancies and limiting the number of children per family, providing access to effective family planning methods to those who want to limit or delay childbearing is key to further reducing TFR. Rwanda has made great strides in both increasing demand and providing access to modern family planning methods. Women using modern methods has increased from 6% to 58% women aged 15-49 between 2000 and 2020. At the same time unmet need has decreased from 35% to 14% in the same time period and the use of traditional methods remains low at 6% (Figure 28).

Figure 32: Community Based Provision of FP, 2020-2021



28% of FP_users are followed by CHWs. The contribution of CHWs is high and appreciable at Gakenke (61%), Gicumbi (56%) and Nyabihu (54%) and very low in Gasabo (9%), Ruhango (11%) and Nyanza (6%). CHWs are under utilized in those districts where the CBP is low.

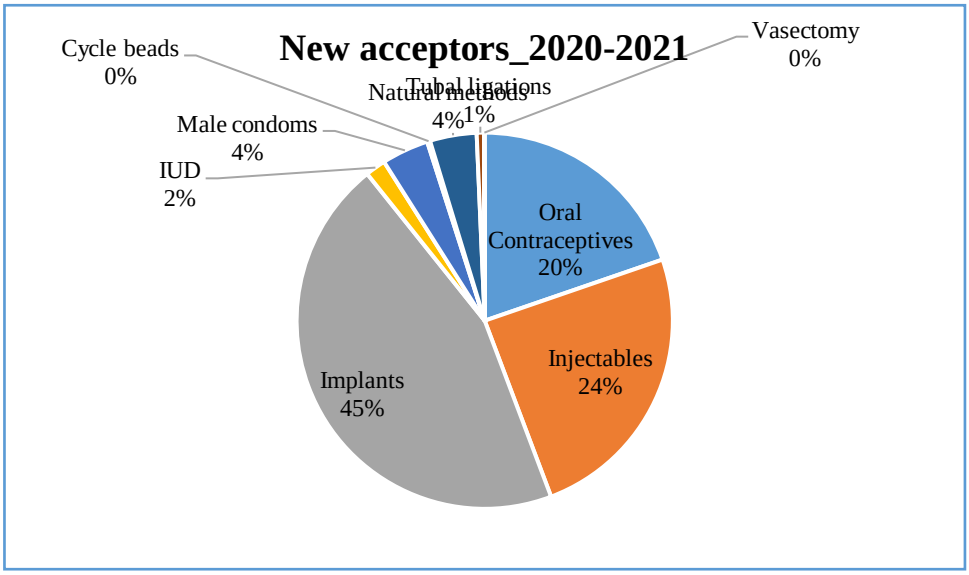
Figure 33: PPFP per District, July 2020 - June 2021



Of the women who gave birth in a health facility 53% received a FP method before discharge. PPFP is highly impacted by the mobilization performed during ANC visits and in intra and postpartum education of mothers. Possible causes of low performance in PPFP for different districts are thatfaith based health facilities do not provide FP services with modern methods andlow reporting rate of private health facilities partculary in Kigali City. The contraceptive prevalence (modern and traditional methods) increased from 36% to 54%, PPFP increased from 32% to 53%, CBP halted from 59% to 28%.

Contraceptive methods suitable for women in the post-partum period differ from FP users at the end of month. Impants (Implanon 39%) and Jadelle (21%)) and the progesterone only oral contraceptive pill (30%) are the most common methods provided to women at post-partum while DepoProvera (35%) Implants (Implanon 24%/ Jadelle 13%) and the combined oral contraceptive pill (16%) are the most used among FP users at the end of month.

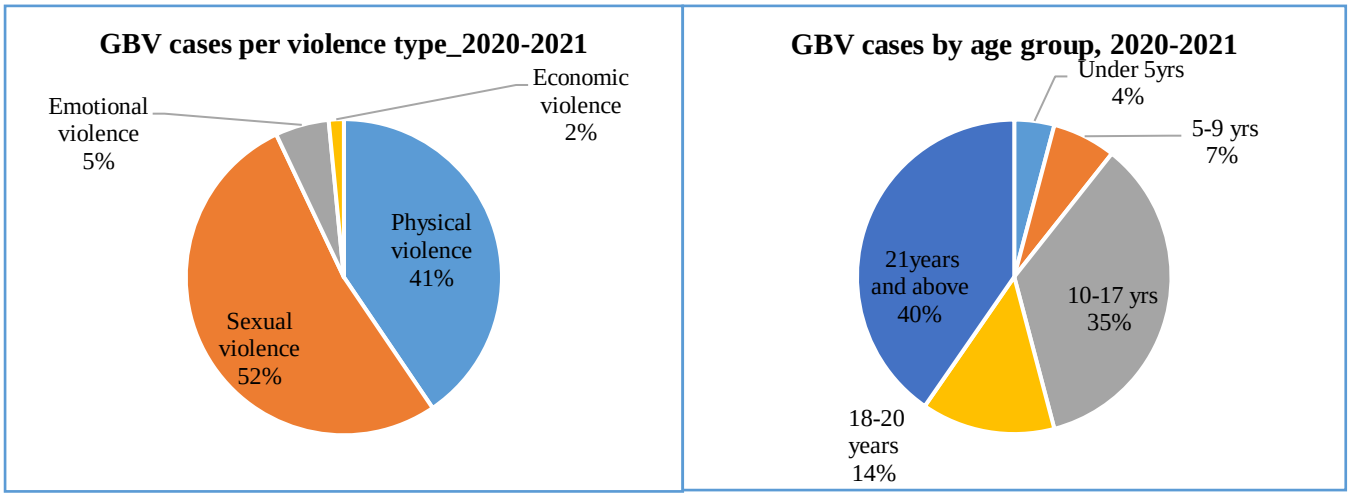
Figure 34: FP new acceptors_2020-2021



290,690 new acceptors were reported by health facilities. Among them 45% received implants, 24% injectables, 20% pills and 4% use natural methods (LAM and auto observations), 1% opted for tubal ligations.

I.5 GENDER BASED VIOLENCE AND LEGAL ABORTION

Figure 35: GBV cases reported by type and age group, 2020/2021

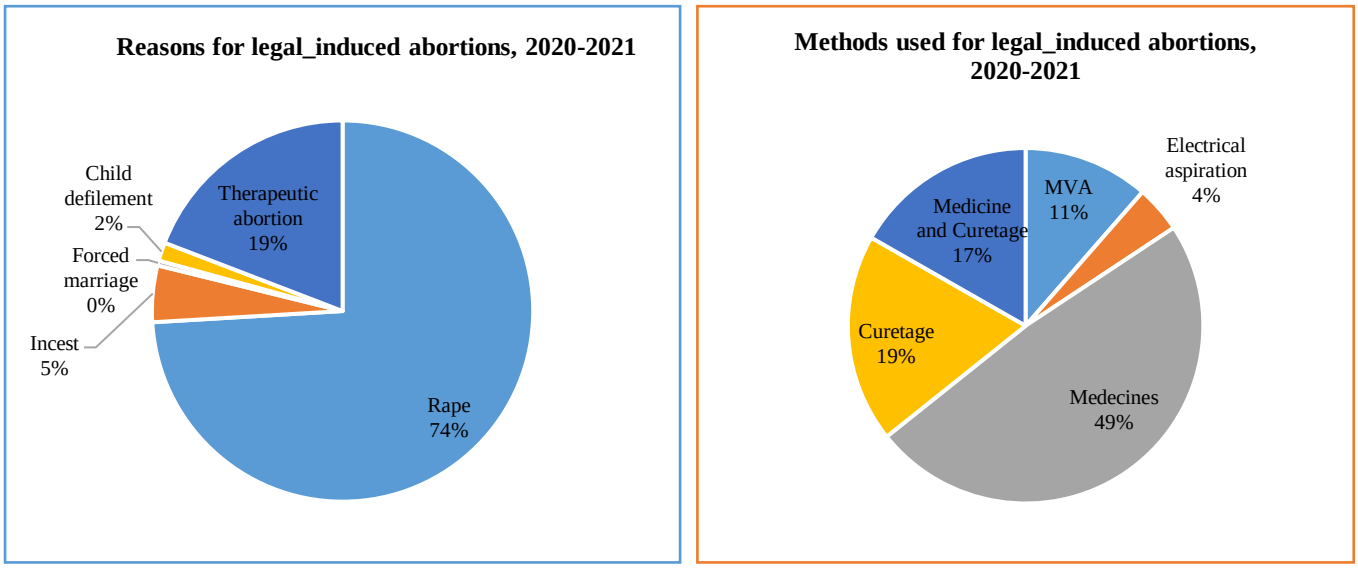


33,636 total GBV victims reported, 52% were victims of sexual violence, 41% physical violence victims and 46% were aged under 18 years.

Table 9: Other GBV important informations_July 2020 to June 2021

	2020-2021
Total GBV victims	33,636
GBV victims with symptoms of physical violence	40.5%
GBV victims with symptoms of sexual violence	52.4%
GBV Victims with economic violence	5.5%
GBV Victims with emotional violence	1.5%
Female GBV victims	88.3%
Male GBV victims	11.7%
GBV victims referred to this facility by RIB	55.7%
GBV victims referred to this facility by community health workers	7.4%
GBV Victims pregnant 4 weeks after exposure	2,406
GBV victim Deaths	43
GBV victims with irreversible disabilities due to GBV	70
GBV victims HIV+ seroconversion 3 months after exposure	72
GBV victims received emergency contraception within 72 hours	2,912
GBV victims received post exposure HIV prophylaxis within 48 hours	3,825
GBV victims referred for care to higher level health facility	3,395

Figure 36: Reasons for legal abortions and Methods used to perform legal abortion, 2020-2021



A number of 960 abortions were legally induced. The main reason for seeking safe abortion was rape at 74%, 19% for therapeutic abortion and 1% for child defilement. Medicines and curettage were the common methods used.

I.6 STRATEGIC INFORMATION

I.6.1 Routine data systems

All Maternal and Child health programs are reported through DHIS and use standards data collection tools. The completeness and timeliness during the reported period was 90 % and 84% respectively. Data are collected from registers at level of service delivery point mainly by health centres and entered into the DHIS2 platform by data managers. Data at community level are collected by CHWs and the compilation is made by the health centre staff, who enter the data in DHIS2.

Monthly review and validation of data is conducted at the level of district hospitals with all head of health centres. The central level organizes data quality assessments in parallel with integrated supportive supervision twice a year where some of MCH indicators are part of the focus area and the indicators are changing every year according to the identified data issues. In addition, the program teams conduct supportive supervision visits in line with the findings from the internal analysis of entered data to improve quality of data.

The national DQA assessment was conducted in December 2020 with the key MCH indicators being #total deliveries at HF and #total deliveries in community and BCG vaccine. The findings showed that implementation of the recommendations of the revsious ISS/DQA remain a problem in many areas. The monitoring and evaluation (M&E) component of the ISS identified several deficit such as quality data and its use were compromised in a few District Hospitals and Health Centres due to structural issues such as inadequate M&E staff, not all modules of the Open MRS correctly used (and only 56% Open MRS in HCs)

and untrained doctors in MCCOD in a few DHs. Procedures not being followed included regular DQA according to SOPs at all levels, underuse of the data amendment mechanism and lack of attention to correct reporting and certification of death. Use of data through analysis of Rapid SMs at all levels and review of death certificates at DHs was reported as inadequate in some health facilities. Divergence for between entry in registers and DHIS for HF deliveries was 0.15% in DHs and 0.17% in HCs for total deliveries and 2.12% for BCG (only at HC level). However, divergence of 12.28 was found for # home deliveries. The primary causes of divergence were counting errors (45%) and lack of data verification (39%). Other causes were misunderstanding of indicators (13%), typos (3%) and missing registers (1%). Recommendations included actions from central to facility level and were similar to previous years. These included for District Administration to prioritise implementation of recommendations and hire M&E staff, MoH/RBC to speed up implementation of Open MRS in all HCs and strengthen its use in DHs and more attention following a death (reporting, certifying, conducting and using verbal autopsy)

Most of the data are still collected using traditional data collection tools which makes high the running cost of different programmes and errors in entering data in DHIS2. The process of developing Electronic Medical Record for all MCH programs is in process. All modules were developed and tested in health centres situated in Muhima hospital catchment area. For now, adaptation is done according to the feedback made by the technical team. To ensure proper understanding of indicators definition, a process of reviewing the current metadata dictionary as well as development of HMIS and C-HMIS job aids is in process

I.6.2 Surveillance and research

All maternal, neonatal and child deaths are subject of audit/review in the framework of Maternal, Perinatal and Child Death Surveillance and Response (MPCDSR) both at health facility and community level. Data are analysis by local death committees as well as by the national maternal, perinatal and child death surveillance and response committee.

Surveillance of adverse event related to immunization is being actively done: health facilities report the cases and severe cases are reviewed by the national committee of adverse event following immunization.

Researches conducted

1. **2020 Health Facility and Community assessment of reproductive health and family planning commodities and services in rwanda**

The Government of Rwanda is currently implementing programs to address maternal and neonatal morbidity and mortality, which has resulted in a steady decrease in maternal and neonatal mortality rates. Specifically, the maternal mortality rate has decreased tremendously from 1071 maternal deaths per 100,000 live births in 2000 to 203 deaths per 100,000 live births in 2019–20. Furthermore, neonatal

mortality has decreased from 44 neonatal deaths per 1000 live births in 2000 to 19 deaths per 1000 live births in 2019–20. Even though Rwanda has made tremendous progress in improving maternal and child health, the maternal mortality rate remains high. The third Sustainable Development Goal states that maternal mortality should be reduced to less than 70 per 100,000 live births, and neonatal mortality should be reduced to 12 per 1000 live births or less. To ensure that Rwanda achieves this goal, there is a need to ensure universal access to sexual and reproductive healthcare services, including family planning services; information and education services; high-quality essential healthcare services; and safe, effective, affordable, and high-quality essential medicines. Moreover, there is a need to integrate reproductive healthcare services into national strategies and programmes.

The 2020 Service Delivery Point (SDP) survey aims to determine the availability of reproductive health commodities and identify gaps in the provision of reproductive health services in order to measure and track the results of reproductive health commodity security/family planning interventions.

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2. The assessment of the quality of youth corners and other related youth friendly services at the health centers and expectations of young people and the community

Rwanda faces several pressing challenges related to adolescent sexual and reproductive health (ASRH), including early sexual activity, high rates of teenage pregnancy, and low levels of contraceptive use among youth. BARAME Project is one of health sector interventions financed by Enabel (Belgian Development Agency) through bilateral cooperation between the Federal Government of Belgium and the Government of Rwanda (GoR) which focuses on improving Sexual and Reproductive Health and Household access to

health care. The project is being implemented in seven districts of Rwanda, namely Gakenke, Gisagara, Karongi, Nyamasheke, Nyarugenge, Rulindo, and Rusizi.

The objective of this study was to assess the quality status of Youth Friendly Services (YFS) offered to young people at the Youth Corner (YC) and identify the adolescents'/community expectations, and experience vis-à-vis these YCs and YFS.

The study revealed that 7 out of 129 visited Health centers (HCs), provide "Good ASRH services", 85 provide "acceptable ASRH services", 16 YCs provide poor ASRH services, and 21 HC do not have YCs. Overall 65% of HCPs working in YCs have not been trained on the policy of privacy and confidentiality. 58% HCPs said that they don't have ordinogram/algorithm or protocol for ASRH. 20% HCPs reported that the working hours in the YC are not convenient for adolescents. 17% of HCPs reported that they didn't offer services to adolescents within the last 12 months because of malfunctioning/unavailable equipment and while 22% owing to the recent stock-out. The qualitative data revealed that key barriers include fear of being stigmatized or discriminated against; Long waiting time; Lack of youth friendly services offered at youth corner; Lack of convenient time to seek for ASRH services and Lack of facility infrastructure and supplies in delivering SRH services. While facilitating factors are having information about ASRH services; individual's perception about ASRH services; professional confidentiality; making friendly services available all the time; friendly services and friendly service providers (quality of service provision); making ASRH services free of charge. HCPs reported different types of ASRH services delivered at youth corners including, provision of information about reproductive health, prevention of unintended pregnancies, providing family planning methods, encouraging them to use condoms, taking care of those who are pregnant, treating those who got STIs and VCT services. Challenges were inadequate accessibility of contraceptives and condoms; insufficient Page viii of 89 number of staff to provide the youth friendly services at YC; lack of community-based health insurance among the youth and to keep youth in full confidentiality and to not inform parents/guardians. the respondents highlighted that the youth are willing to have contraceptive but they are fearing what people may say when they see them at YCs.

Despite a lot of efforts from the GoR to improve access to ASRH services, there are still challenges hindering the quality of YFS offered to young people at the YC. This assessment recommends putting in place innovative strategies aimed to disseminate at wide scale the laws, policies protocols and guidelines related to the provision and for utilization of YFS at YC level. These strategies should be targeting young people in and out school through mass mobilization for community awareness about ASRHR, integration of YFCs into routine work of health centers, youth mobilization through peer education programmes and SRH clubs.

PART II: IMPLEMENTED ACTIVITIES UNDER MCCH DIVISION 2020-2021

2.1. Maternal, Newborn and Child Health

1. Capacity building of healthcare providers on maternal and newborn health, related interventions

Health care providers (HCP) from health facilities of Gisagara, Nyarugenge, Nyamasheke, Karongi, Gakenke and Rulindo were oriented on new EmONC, PNC guidelines and national neonatal protocol (n=146). HCP from all hospitals were trained on safe abortion and post abortion care (n=180); 51 HCP from 3 Districts (Nyanza, Nyabihu and Kayonza) were trained on IMCI; 19 health care providers (midwives and nurses) were trained on Emergency obstetrics and neonatal care (EmONC). A total of 114 HCP were trained on the new ANC guidelines considering 8 contacts. 193 HCP from health centers were trained on conducting verbal autopsy of maternal and under five deaths occur in the community. 135 HCP attended the workshop on conducting near miss audit and peer review of maternal, perinatal and child deaths. Conduct supportive supervisions to ensure implementation of death audit recommendations: 29 hospitals were visited with a focus on functionality of deaths audit committee according to MPCDSR committee guidelines, classification of causes of maternal and perinatal deaths using ICD-MM and ICD-PM WHO classification. 17 trainers were trained on comprehensive post abortion care. HCP from Karongi and Rusizi Districts were received a basic training on ultrasound (n=162). A refresher training on EmONC mentorship was organised and benefited by 21 national trainers from different health facilities. IMCI/ICATT trainings were organised and conducted successfully: 51 HCP were trained. A training on ETAT+ was attended by 110 nurses and Medical doctors working in Pediatric services and Emergency have been trained.

2. ***Developing protocol, guidelines and other training tools:*** ANC training materials & ANC tools in line with new ANC guidelines considering 8 contacts was updated in a workshop that was attended by 32 participants. In the same line, ANC facilitator training maternal was finalised. A workshop to finalize the MCH handbook was finalized and will replace the majority of MCH training tools was organized and attended by 32 participants. An English version of IMCI chart booklet and registers was developed and apporved.

3. ***Ditribution of medical equipment and other tools:*** 64 CPAP machines, 50 incubators, 59 Ultrasounds, 42 infant warmers, 9 ventilators, 20 Oxygen concentrators and 40 Flow Spliter for Oxygen concentrators were distributed to hospitals. 1000 kits of the combination mifepristone and misoprostol used in abortion services provision were distributed to hospitals. 3000 ANC guidelines, 3000 national neonatal protocols, 999 IMCI registers, 122000 partograms, 61000 PNC files and

61000 ANC/PNC individual card, 131,000 FP consultation and FP individual files and 1470 FP registers

4. Assessment, M&E activities related to MNCH: during FY 2020-2021 different activities were implemented to ensure the continuity of MNCH services in health facities. 3 main activities were conducted: 1. EmONC need assessment in health facilities aiming at evaluating the capacity of health facilities attending deliveries on a regular basis to provide quality care to women and newborns in the case of complications related to the pregnancy, childbirth or during the postpartum period. 2. Second national confidential enquiry into maternal deaths and first national confidential enquiry into perinatal deaths using WHO ICD-10 Maternal Mortality. 3. Continuous and regular follow up of maternal, perinatal and child death surveillance and response through death audits reports monitoring: 243 maternal deaths were notified by health facilities. 4. Supportive supervision in 23 hospitals to ensure implementation of death audit recommendations. 5. Peer review meetings on MPCDSR and malaria death audits aiming at strengthening capacity of members of Death audit committee at District, Provincial and Referral hospital level to implement strengthened Maternal, Perinatal MPCDSR with a focus on conducting critical analysis to identify really causes of maternal and child deaths and suggest actionable recommendations to improve maternal health care. 6. Workshop with national maternal death surveillance committee to review summary reports of maternal deaths occurred in health facilities of deaths happened in 2020 and to propose recommendations and strategies to avoid future similar deaths. 7. MPCDSR workshop for review of cases monitoring of performance, strengthen quality and timeliness of the "response" component, this activity aimed to strengthen capacity of members of Death audit committee at District, Provincial and Referral hospital level to implement strengthened MPCDSR with a focus on conducting critical analysis to identify really causes of maternal, perinatal and child deaths and suggest actionable recommendations to improve maternal, perinatal and child health care. 8. Workshop for additional MPCDSR committee members on deaths audit data collection using new updated form considering ICD-10 MM. 9. National Confidential Enquiry into Maternal deaths using WHO ICD-10 Maternal Mortality. 10. Mentorship field visits on EMONC were organised and conducted in 32 hospitals across the country.

2.2 Vaccine preventable diseases program

During the reporting period, much efforts was focussed on COVID19 vaccine deployement activities.

1. ***Prepare, Organize and implement COVID-19 vaccination related activities***

Development of national deployment and vaccination plan for COVID-19 vaccine: Rwanda is planning to vaccinate 7,832,799 people (equivalent to 60% of the population) by the end of 2022. The 1st year (2021) target priority population for vaccination includes health and social workers; security

organs; elderly people (65 years old and above) ; people living with chronic conditions; people living in specific high density settings such as prisons and refugees camps and other frontline workers that may be identified as being at high risk of the disease. By the end 0f 2022, Rwanda is intending to reach the African Union target of 60 % of the total population.

Establishment of COVID 19 Vaccination Committees: in order to respond to this unprecedented pandemic, different committees at each level were established for decision-making framework. These include: National COVID-19 vaccine readiness and delivery Task Force, Interagency Coordination Committee (ICC), National Immunization Technical Advisory Group (NITAG), National Immunization Technical Working Group (NITWG) and its sub-committees and National Immunization Logistics Working Group.

Enumeration of frontline workers for COVID 19 vaccination and identification of vaccination team: under the coordination of DG of hospital, each hospital was requested to identify 2 vaccination teams and each member form this team was required to complete WHO *COVID-19 vaccination training for health worker* on line course and get the certificate.

Development of national guidelines for covid-19 vaccination: with the purpose of guiding the smooth deployment of COVID-19 vaccines at all levels of immunization system, it was necessary to develop technical guidelines and standards operating procedures. The guide covers the following elements: Leadership and coordination, Planning of vaccination sessions, Vaccination site set – up & People flow, COVID-19 vaccine supply, storage and logistics, Preparation and administration of the vaccine, Surveillance of Adverse Events Following Immunization (AEFIs) and reporting, Waste management, Data management.

Training of RBC staff and hospital teams on COVID-19 vaccination: to build knowledge capacity on vaccine storage, vaccine management and administration. The training covered the following areas: Vaccine cold chain supply and storage, Covid-19 vaccines, Roles and responsibilities for the vaccination team at district level and central level supervisors, Organization & requirements of the vaccination site and AEFIS. This training was followed by preparation meeting with hospitals. A team of 5 staff from hospital (DG, a medical doctor in charge of observation after vaccination, a staff in charge of COVID-19, nurse in charge of vaccination and a staff in charge of safety surveillance) were also trained.

COVID-19 Vaccination implementation countrywide: COVID-19 Vaccination implementation is ongoing in collaboration with local leaders' and Rwanda Nation Police partnership and central staff from MoH and RBC have supervised the implementation of this Covid-19 vaccination.

Vaccine safety monitoring and management of AEFI and injection safety: Following reports of COVID-19 VACCINES AEFIs, it was necessary to conduct investigation Rubavu and Gicumbi districts targeting selected cases in order to know more about the arising AEFIs. After the

investigation, it was found no circumstances or procedure or operational aspects around the vaccination witch were beyond stipulated measure, no cluster was identified.

2. **Routine imminization capacity building activities:** ***Training for preventive maintenance of new cold chain equipment received from CCEOP:*** 510 participants from health centres countrywide attended the training. ***Training on electronic vaccine logistics management system using DHIS2 for health center vaccinators:*** 1009 nurses form health centers have trained out of 1014 nurses were expected to be trained.

3. Supply chain for vaccines cold chain management

During the period from of July to June 2021 following activities were successfully performed:

CCEOP Implementation where the main objective was to increase the storage capacity of vaccines at hospital and replacement of obsolete refrigerators and freezer at health facilities. The whole number of cold chain equipment to be received for first and second batch is 638 CCE.

Supervision of new cold chain equipment received from CCEOP project: The main objective of this supervision was to confirm if the requested cold chain equipment is the one supplied and installed at health facilities.

Training of health center vaccination focal personnel and Hospital Biomedical equipment technicians on preventive maintenance for new cold chain equipment received from CCEOP. Biomedical technicians and staff from central level were facilitators. And training on effective use of temperature monitoring for EPI Supervisors.

Continuous temperature monitoring at Central Vaccines Store and during transportation of vaccine to district level is to document the level of freezing damage and exposure to heat damage in the cold chain, to identify specific problem areas and to determine the most appropriate interventions required for warranty. During this period all fridge Tag and beyond wireless system showing normal temperature range between +2 °c to +8 °c of storage in cold rooms, between -25 °c to 15 °c in freeze room and deep freezers. And between -85 °c to 65 °c in UCC equipment for Pfizer vaccine. No alarms and freezing observed (no temperature excursion observed).

Implementation of System redesign, the efforts are to contribute effective Distribution and stock management. This is in addition to its added benefit of cost effectiveness, extending the reach of the supply chain and contributing to addressing inequity in vaccine distribution and improving system efficiencies.

4. **EPI Monitoring and evaluation activities:**

Maternal, Child and Community Health data quality review was conducted with an aim to improve the quality of MCCH data including management of vaccines through data quality audit, assessment of the performance of use of immunization e-tracker system therefore improve the accuracy of MCCH data. The following indicators were verified: HF's Deliveries, Women Transferred during

birth/delivery labor, Women transferred during ANC consultation, Total Live births, Home deliveries (CHWs' reports), BCG and PENTA3. During this exercise, 16 Districts were visited.

Conducted supportive supervision on immunization program: The main objective of this supportive supervision is to improve the quality of vaccination program. Key findings from the supervision are: Discrepancies between the doses in refrigerators and doses recorded in vaccine stock register; No vaccine contingency response plan availed at more health centers; No Maintenance plan and no documentary evidence that the maintenance is being followed or visual evidence that the maintenance is taking place in more health facilities; Vaccine inventory practice is not done correctly as it should be done and Vaccine stock register is not well filled and Multi dose vial policy is not respected (observed more confusion).

Interagency Coordinating Committee (icc) meetings: under the chairship of chaired by Honorable Minister of Health, 2 meetings took place. Attended these meetings partners coming from different NGO, organization like WHO, UNICEF, Rwanda Rotary international, USAID, BUFMAR, EPI Committees (NITAG, NCC) Rwanda Red Cross, Urunana DC, SPIU and MCCH staff.

Assessment of the functionality of immunization e-tracker system in health facilities: health facilities in Northern and Wesetrn Provinces were visited with the purpose to evaluate the performance of immunization e-tracker. Key findings from this trip are summarized as : disabled many accounts for vaccinators due to long time of inactivity, internet connectivity issues for some Health facilities, Incompleteness for more than 3 months has been observed for many HFs, Outliers are found for many health facilities, where the number of children per a given Antigen in the etracker is higher than the cases reported in HMIS monthly reports. From the findings, recommendations were given out to HFs for improvement.

2.3 Community health

During the reporting period, the program implemented the following key activities:

1. **Continuous capacity building of health care providers and CHWs through:**

HCP and CHWs were trained on community health package: a total of 483 HCP and 61,399 CHWs were trained with a funding support from partners. HCP (Titulaires and IMCI Nurses) from health centres were capacitated on nutrition intervention and community health package, this was benefited by 393 HCP. A training on mentorship of community health was organised with a focus to build the capacity of health center-based providers in community health mentorship. Participants were 1494 HCs staff including CEHOs and clinical nurses from 16 districts.

C-EHOs from Nyagatare, Muhanga, Kamonyi, Gicumbi, Kicukiro, Gatsibo, Ngoma, Rwamagana and Bugesera districts were trained on Malaria and HBM, this training was attended by a total of 87

health professionals. The training of C-EHOs was followed by a training of CHWs that was benefited by 4390 CHWs from Nyagatare, Bugesera, Ngoma, Gasabo,Kicukiro, Nyanza, Huye, Rubavu, Rutsiro, Ngororero, Nyabihu, Musanze, Nyaruguru, Nyamagabe, Ruhango, Kamonyi, Muhanga, Gicumbi, Gatsibo and Rwamagana. The training of C-EHOs on e-learning system was conducted countrywide focusing on CBMNH content and was also conducted to CHWs from the districts of Rutsiro and Ngoma were 36 CHWs were trained in each district.

C-EHOs and Midwives from Health centers of Gakoma and Kibilizi District Hospitals on how to conduct verbal autopsy of maternal and under five deaths occurred in the community, a total of 34 participants have been trained (32 from HC and 2 community supervisors in 2 hospitals).

2. **Mentorship and supervision activities**:

The supportive supervision reviewed the activities and services applied to treatment and management of severe acute malnutrition among malnourished children under five years old at hospital, health centers level and follow up of nutrition status of the children in community. Also, the supervision aimed at strengthening the capacity of health care providers and community health workers at health facility level to care for children with severe acute malnutrition and community level respectively, and documenting strength and weakness which will be used for future capacity building interventions.

Supportive supervision to CHWs was conducted in collaboration with CHW supervisors from Hospital and C-EHOs and CHWs from 42 HC catchment area were supervised on community Health package

3. **Distribution of CHWs' tools**

During FY 2020-2021, CHWs received different tools and equipments to ensure they have ann necessarie to well perform their activities. CHWs received 2776 boots, 137 Weighing scales were distributed, PPEs (22,957 surgical masks, 63,336 local made masks, 37454 Cartons and 21,112 bottles of Hand sanitizers) distributed to CHWs, 21,106 FP register at community level, 16,298 monthly report booklets, 13,313 registers for records of women & girls in childbearing age, 6923 follow up sheet for pregnant women &mother and new born in postnatal, 3,854 Counselling cards for ASM, 80,749 Store cards, 18,270 referral forms.

4. Workshops and meetings

A workshop aiming at reviewing the community health worker's guidelines was conducted and 40 participants attended the workshop. The workshop resulted in developing 14 program training

manuals and curriculum. A review of community health indicators and reporting forms was conducted through a workshop. The indicators falling into different programs were revised by 20 participants from MOH, RBC, Ingobyi Activity and hospitals. These programs are : Maternal & New Born Health, Integrated Community Case management (ICCM), Nutrition/ECD, Community Based Provision Family Planning(CBP/FP), Mental health, Non communicable disease(NCDs), First Aid and Emergency response to epidemics,

A workshop to integrate infographics in the community health training manuals was conducted and attended by 40 participants from MOH, RBC, UNICEF and hospitals. Workshop to prepare master training of community health package was attende by 40 participants from MOH, RBC and partners. Workshop to validate Digitalization systems: All currently digital solutions being used in Rwanda were reviewed basing on advantages and disadvantages, flexibility and adaptability in Health Facilities and all participants discussed and agreed on the point of Rwanda currently having a big number of digital systems which have to be customized into one mother systems.

Orientation workshop for health care providers in the 13 SPRP supported districts on community health mentorship: The main objective of this workshop was to review all digital solutions used in Rwanda including Rapidsms/Rapidpro,Open clinic,EMR among others and see how they can be integrated into one master digital solution that can be a solution in easing medical services but also help in client satisfactory. Also a workshop to validate WHO verbal autopsy tool to be used in the Rwandan context: The main purpose of the workshop was to review the existing verbal autopsy tools used, verbal autopsy committee members and how basically verbal autopsy is conducted in Rwanda and then review the standard WHO verbal autopsy tool and how it can be adopted to the Rwandan context.

Supply plan review and Implementation of Procurement &supply Plan: the purpose of this activity was to review the ongoing procurement plan of health commodities, to provide a 12 month's forecast of program health commodities and develop a new/ or revised budgeted supply plan for health commodities to be procured. On a monthly basis the implementation of the supply plan is monitored to make sure commodities are delivered as planned. Its ensure that all commodities are delivered on time and maybe push when there are challenges, sometimes advocacy is made when technician cannot solve them.

Inventory Sport Check is regularly conducted for the purpose to provide reliable evidence on whether the donated programme supplies are adequately managed and safeguarded by the Ips, provide other insights into the health of the supply chain (i.e. strengths, weaknesses, and trends across sampled facilities), provide 'on-the-spot' training to address weaknesses at the facility level, substantiate the

need for additional resources to support supply chain strengthening as part of applications to the UNFPA Supplies Phase III Technical Envelope.

Coordination meetings were organized and conducted targeting CHWs in 17 Districts including Musanze, Nyabihu, Ngororero, Rubavu, Huye, Nyamagabe, Nyanza, Nyaruguru, Ruhango, Gasabo, Kicukiro, Muhanga, Kamonyi, Gicumbi, Ngoma, Nyagatare.These meetings focused on discussing different indicators related to ICCM, CBMNH, Nutrition and CBP/FP, 41130 CHWs were reached during coordination meeting from 273 HC catchment areas.

2.4 Family Planning and ASRH

2.4.1 Family planning

During the FY 2020/21 FP/PPFP clinical mentorship visits were conducted by 43 district-based mentors in 145 health facilities. In total 168 mentees were reached during this period in Gisagara, Gakenke, Karongi, Nyamasheke, Nyarugenge, Rusizi and Rulindo districts. National mentors visited 43 districts-based mentors (nurses and midwives) to support them in way of conducting mentorship. In addition, a meeting was organized with 71 Head of health, Data Managers and FP focal points of health facilities to discuss on the quality of FP service provision and FP data specially in their respective health facilities. In order to support medical doctors in provision of family planning permanent methods under local anaesthesia a clinical mentorship in family planning permanent methods was conducted Nyamasheke District, from this mentorship 2 medical doctors were validated and can now perform tubal ligation under local anaesthesia without assistance.

HCPs and CHWs from different health facilities benefited trainngs on provision of FP methods: 34 health care providers were trained on FP permanent methods, 338 health care providers from all Districts were trained DMPA sub cutaneas, 768 community health workers on family planning in Nyarugenge District after training of 22 trainers.

2.4.2 Adolescent health

- ✓ Conducting ASRH supervision in 268 HCS of districts of Huye, Nyanza, Ngororero, Kamonyi, Nyarugenge, Gasaba, Kicukiro, Bugesera, Kayonza, Kirehe, Gicumbi, Burera, Musanze and Rubavu.
- ✓ Workshop to develop adolescent health training manual based on WHO guidelines: participated in this workshop the representatives of DGs of hospitals, ASRH national trainers and mentors and representatives of ASRH partners.
- ✓ ASRH quarterly meeting with ASRH focal points from hospitals for experience sharing and learning: The main objective of the ASRH Quarterly meetings was to discuss the ASRH current

situation in Rwanda, strengths, weaknesses and challenges. Assess other needs at site for better youth friendly services and sharing experience and best practices in ASRH program.

2.5 Gender Based Violence

Gender Based violence sub Program Conducted the following activities: Training of clinical psychologists, mental health and social worker on Mental health and psychosocial support for gender based violence victims, to equip them with a fundamental understanding of trauma, its effects on individuals who suffer gender-based violence, and how to deal with these effects through psychosocial care and support in 7 districts supported by BARAME project. Supervision of 6 IOSC supported by OXFAM to assess quality of services offered to SGBV victims (victim files, staffing, collaboration between multidisciplinary team, meetings with victims and follow-up of legal case. Conduct GBV mentorship in districts supported by BARAME Project to contribute to the improvement of quality of the clinical care offered to GBV victims at IOSC, by strengthening the IOSC multi-disciplinary team members in GBV case management. Visited IOSC are Gakoma, Kibilizi, Nemba, Ruli, Muhima, Kinihira, Rutongo, Kibuye, Kirinda, Mugonero, Bushenge, Kibogora, Mibilizi, and Gihundwe. National GBV Steering Committee Meetings were organised to assess implementation status of previous resolutions and to deliberate on findings from assessment of IOSC and health centers on GBV service delivery as well as to discuss on IOSC Program Sustainability plan.

PART III. FINANCING OF THE MNCH AND ASRH/FP STRATEGIC PLANS

III.1. Domestic and external sources of funds (GoR and DP contributions)

During 2020-2021, the total budget allocated to activities under MCCH Division was 8,402,118,420 Frs, 37.9%% of this budget is from domestic funds which includes 35.8% of ordinary budget and 2.1% of own revenues. DP contribution is estimated at 62.1%.

Table 10: MCCH budget allocation according to source of funds and Funding source for program expenditures

Funding source	Planned budget	Proportion of Source of funds	Budget spent	Budget Execution Rate
Barame Project	606,870,623	7.2%	594,850,238	98%
END Fund	5,420,000	0.1%	-	0%
GAVI	257,627,902	3.1%	166,166,531	64%
Ordinary budget	3,007,964,367	35.8%	2,987,264,461	99%
Own revenues	172,511,711	2.1%	115,982,459	67%
RBF-Enabel MCCH	2,254,089,133	26.8%	2,596,056,003	115%
UNFPA	231,267,019	2.8%	154,639,720	67%
UNICEF	360,766,054	4.3%	350,870,292	97%
WHO	212,053,411	2.5%	172,121,134	81%
World Bank - SPRP	1,293,548,200	15.4%	1,019,342,994	79%
Total	8,402,118,420	100.0%	8,157,293,832	97%

The contribution of some partners through direct implementation is not captured in this table as well as cost covered by the government related to HR (payment of salaries) and investment in infrastructure. All activities related to construction, equipment and consultancy for MCCH are captured in SPIU budget.

III.2 RESULTS BASED FINANCING_ RBF ENABEL SUPPORT

1. SPECIFIC OBJECTIVE OF THE PROGRAM

To ensure that all women, new-born, children, adolescents and men have universal access to quality integrated RMNCAH (Reproductive, Maternal, New-born, Child and Adolescent Health) and/or FP/ASRH (Family Planning & Adolescent Sexual Reproductive Health) services.

Table 11: Disbursements made to RBF Enabel Account during FY 2020_2021

	Disbursed amount in Euros	Period
Instalment 3	2,662,646	11th September 2020
Instalment 4	1,632,655	18 May 2021

Total	**4,395,201**	

Table 12: RBF ENABEL budget and expenditure per MTEF chapter for the year ended 30 June 2021

MTEF Chapter	Budget in EUR	Expenditures in EUR	Variance in EUR	Performance in %
22 Use of goods and services	1 627 375.91	1 651 786,72	-24 410,8	101.5%
23 Acquisition of fixed assets	2 090 130.46	1 981 988.82	108 141.6	94.83%
26 Grants	397 552.47	446 030.85	(48478.4)	112.19%
28 Other expenditures	559 641.87	899372.02	(339 730.2)	160.70%
Total	**4 674 700.71**	**4 979 178.41**	**(304 477.69)**	**106.51%**

As per the table above for FY 2020-2021, Enabel is contributing to RBF Enabel expenditures the total budget of EUR 4 674 700.71 with Expenditures by budget activities of EUR 4 979 178.41 representing 106.51 % of total budget planned for Fiscal year 2020-2021.

The execution rate of 106.51% in derived from Budget overspending using cash balance fy 2019-2020, equivalent to (304 477.69 EUR).

Table 13: Reproductive, Maternal, Neonatal, Child and Adolescent Health –RBF Enabel Annual Budget Execution rate FY 2020/2021

RBF- Enabel Annual budget Execution rate FY 2020/2021					
BNR Exchange rate, annual average 2020/2021 =1155,154165					
Planned activities	**Approved budget in EUR**	**Commitment in EUR**	**Budget Balance in EUR**	**Budget execution rate**	**Comments on budget execution rate**
RBF-Enabel MCCH	**4,674,700.71**	**4,979,178.41**	**(304,478)**	**106.51%**	
Administrative And Support Services	2,623,368.85	2,731,810.84	(8,442)	100.31%	
Increase Family planning uptake in Catholic church affiliated health facilities	7,308.09	129,852.80	122,545	1176.84 %	The activity was implemented using balance of last FY, through overspending request after Minecofin's approval.
Support COVID-19 preparedness and response activities	77 838,77	77 838,77	0	100%	This activity was successfully implemented
Community (including Schools and Universities) outreach theatres and Production & broadcast of FP/ASRH and MNH information to address barriers to FP/ASRH	295 491,52	361 555,24	-66 064	122.36%	The activity was implemented using balance of last FY, through overspending request after Minecofin's approval.

RBF- Enabel Annual budget Execution rate FY 2020/2021					
BNR Exchange rate, annual average 2020/2021 =1155,154165					
Planned activities	**Approved budget in EUR**	**Commitment in EUR**	**Budget Balance in EUR**	**Budget execution rate**	**Comments on budget execution rate**
Conduct monthly coordination meeting	254 653,63	404 862,04	-150 208	158.99%	The activity was implemented using balance of last FY, through overspending request after Minecofin's approval.
Construct and equip 20 new health posts per year	117 733,20	117 733,20	0	100%	This activity was successfully implemented
Nyarugenge District for gap funding for the addendum 3 to the construction contract of Nyarugenge DH	0,00	48 478,38	(-48 478)		Delayed construction works due to COVID 19.
Organise regular meetings with implementing institutions	12 985,28	12 985,28	0	100%	This activity was successfully implemented
Organise technical and steering committee meetings	6 980,45	6 980,45	0	100%	This activity was successfully implemented
Pay salaries to SPIU project staff	80 197,05	80 070,45	127	99.84%	This activity was successfully implemented
Procure office equipments	2 337,35	2 337,35	0	100%	This activity was successfully implemented
Provide communication airtimes	4 103,35	4 103,35	0	100%	This activity was successfully implemented

RBF- Enabel Annual budget Execution rate FY 2020/2021					
BNR Exchange rate, annual average 2020/2021 =1155,154165					
Planned activities	**Approved budget in EUR**	**Commitment in EUR**	**Budget Balance in EUR**	**Budget execution rate**	**Comments on budget execution rate**
Supervision of construction works of health posts and maternity wards	0,34	0	0	0	The activity was not implemented due to delayed Health Post sites assessment caused by lockdown/due to COVID 19
Supervision of project activities	6 406,07	6 406,07	0	100%	This activity was successfully implemented
Support COVID-19 preparedness and response activities	961 623,76	956 021,21	5 603	99.42%	This activity was successfully implemented
Support to C-PBF focusing on indicators not financed in current model	351 224,12	351 224,12	0	100%	This activity was successfully implemented
Support to HF PBF focusing on indicators not financed in current model	46 328,35	46 328,35	0	100%	This activity was successfully implemented
Youth corners and youth centres equipment(including university dispensaries)	498 157,50	125 033,78	373 124	25.10%	Due to delays in delivery of specialized equipment, the invoice was not paid during FY 20/21.
COMMUNITY HEALTH	**332 022,73**	**365 209,02**	**-33 186**	**110%**	
Procure Community (ICCM) Drugs and Consumables	39 611,35	72 884,22	-33 273	183%	The activity was implemented using balance of last FY, through overspending request after Minecofin's approval.

RBF- Enabel Annual budget Execution rate FY 2020/2021					
BNR Exchange rate, annual average 2020/2021 =1155,154165					
Planned activities	**Approved budget in EUR**	**Commitment in EUR**	**Budget Balance in EUR**	**Budget execution rate**	**Comments on budget execution rate**
Digitalization of CHWs' reporting system (Printing of M&E Tools for CHWs	173 137,06	173 137,06	0	100%	This activity was successfully implemented
Support the use of rapid SMS by increasing the time of CUG	119 274,31	119 187,74	87	99.93%	This activity was successfully implemented
FAMILY PLANNING	**81 991,39**	**82 873,54**	**-882**	**101.08%**	
Procure FP Drugs and Consumables	81 991,39	82 873,54	(-882)	101.08%	The activity was implemented using balance of last FY, through overspending request after Minecofin's approval.
MATERNAL AND CHILD HEALTH IMPROVEMENT	**1 537 317,75**	**1 799 285,00**	**-261 967**	**117.04%**	
Mentorship of health providers/health professionals (including teachers and youth clubs) at all levels to offer youth friendly services in and out of schools	65 415,34	62 400,51	3 015	95.39%	This activity was successfully implemented
Procure equipment for maternity and neonatology units in health facilities	1 471 902,41	1 736 884,49	(-264 982)	118%	The activity was implemented using balance of last FY, through overspending request after Minecofin's approval.

Key achievement registered during FY 20/21 under RBF Enabel Project: RBF Enabel

Under this project, the following are tremendous achievements:

1. **Procurement of Medical, ICT equipment**

- Procured 293 computers were procured using RISA Contracted frameworks and were provided to Hospitals for EMR operationalization.
- Youth centers scattered in all Districts were supported with ICT equipment, as it was a request from Ministry of Youth and ICT purposely to deliver ASRH/FP services
- 19 ultrasounds machines were procured and distributed to Health Facilities
- RBC procured 50 mobile infant incubators and 42 infant radiant warmer for health centers
- procured 52 CPAP machine were delivered for health facilities
- 40 Ambulances were purchased using Enabel Contract Frameworks and were officially provided to Hospitals (Procured through Regie Mechanism but using Enabel RBF funds after grant amendment, official launch held to RBC to deliver 40 Ambulances to Hospitals Director Generals on 24th September 2020. (fy 20/21)
- 15 laundry machines were procured to health facilities

2. **Construction Works**

- As it was planned under RBC/SPIU Procurement Plan, RBC transferred list of tenders to Rwanda Housing Authority which are now under procurement process.
- Construction works of Health Posts for 16 assessed sites
- Construction works of Maternity Ward at Kibagabaga Hospital
- Construction works of Maternity Ward at Muhima Hospital
- Supported in completion of Shagasha Health Center (In Rusizi District)

3. **Support to Civil Society Organizations (CSOs)**

- Since October 2020, the project is supporting **NGOs (FVA (Faith Victory Association) and Access to Health** to implement activities in line with RBF Enabel main objective which is to ensure that all women, new-born, children, adolescents, and men have universal access to quality integrated RMNCAH (Reproductive, Maternal, New-born, Child, and Adolescent Health) and/or FP/ASRH&R (Family Planning & Adolescent Sexual Reproductive Health & Rights) services. Addition to this, in May 2021, **CARITAS Rwanda** was single sourced to deliver Family Planning Services in all Catholic co-managed Health Facilities and Community Catchment areas.

Key achievement of above two NGOs started in October 2020

Faith Victory Association (FVA):

- Kick-off meetings conducted in all 30 Districts to introduce RMNCH project being implemented by FVA.
- 300 youth trained in 30 districts to help them to train other youth in community
- 2248 booklet with SRHR information were produced and distributed to youth in 30 districts
- FVA produced 6499 posters,180 banners and 7320 fact sheets to be pinned and distributed in health facilities, schools, youth center and bus stops.
- Through the project implementation, FVA have reached in 668 health facilities,1054 CHWs, 32 youth center, 45 local leaders and 50 schools

No	Set indicators	Target	Achievement	Comments
1	# of developed multi media tools to raise awareness on RMNCAH/FP/ASRH services	16797	16797	all planned multi media developed include :6499 poster,7320 fact sheet,180 banners,Sheets,54 billboards and 2248 brochures and the developed items were distrubuted and pined to different strategic palces such as health facilities, schools, youth center,bus stops and main raods.
2	# of radio talk shows conducted to disseminate messages on RMNCAH services	20	20	Community radio stations and nation radio were used to disseminate different messages in regard with RMNCAH services. Due to COVID19 measure, the activities that were planned to meet physicaly were implemented through radio talk shows.the activity are followed: Orient religious Leaders and Local Leaders on RMNCAH/PF on how to Support communities and CHWs perfomance ,Organize Provincial debate in city halls to xplore collaboration with churches to promote health RH practices for adolescents,Conduct the campaign on To work with existing school clubs/Universities in disseminating SRHR/FP messages prevention of teen pregnacy and fight against SGBV in the community,
3	# of youth ToT trained on FP/ASRH in districts to train otheir Peers	300	300	youth coming from 30 districts were trained and each district provided 10 youth to become a
4	# of TV shows conducted to	2	2	all 2 TV shows were successfully conducted at RTV to disseminate RMNCAH

No	Set indicators	Target	Achievement	Comments
	disseminate RMNCAH			/FP/ASRH this activity conducted in partnership with religious leaders
5	# of youth centers supported	30	30	youth centers were supported with brachures Each youth center received 74 brachures
6	# of local leaders reached through orientation meeting	150	150	150 leaders were reached during the project orientation(kick off), where 5 local leaders from 30 dsitrict.

Access to Health:

Access to health facilitated the smooth implementation of CHWs Quarterly Meeting and here below are key indicators with positive outcomes.

- 96.6% of Districts organized quarterly coordination meeting
- 92.% of CHWs attended the quarterly coordination meeting

The above high rate of attendance, resulted in improving key MCCH indicators at Community level including the following:

- Availability of updated M&E tools
- Completeness and accuracy of the tools
- Availability of drugs and supply (insisted on withdraw of nearly expired drugs and all expiries)
- Home deliveries (verified reported versus the hard copy)
- U5 death in community (verified reported versus the hard copy)
- Maternal death (verified reported versus the hard copy)
- Number of women who delivered at home and received misoprostol to prevent Post-Partum Haemorrhage (check the misoprostol stock card vs reported)
- Number of new FP clients initiated at HF and being referred to the CHW in this month (compare the register vs the reported)
- Number of FP clients continuing in the CBP program in this month (compare the register vs the reported)
- No of children screened for malnutrition (compare MUAC, W/A and H/A) NB: always consult MCCH to give you HMIS data before to compare with the verified
- Percentage of implementation of recommendation from the previous Coordination meeting

4. Support to PBF

- The Project supported to Health Facilities and Community PBF focusing on indicators not financed in current model (Payment of Q1, Q3, Q3 were paid under FY 20/21)

- **Supported Mentorship sessions carried out by Mental Health Division** Conducted Mentorship of health provider's/health professionals (including teachers and youth clubs) at all levels to offer youth friendly services in and out of schools.
- **Support the use of rapid SMS by increasing the time of CUG of CHWs** MTN invoices issued for Q1, Q2, Q3 were paid during FY 20/21

Key challenge

- Pending construction works of Kibagabaga and Muhima Maternity Wards as well as Health Posts for 16 assessed sites by Rwanda Housing Authority.

PART IV. GOVERNANCE MECHANISMS

The health sector in Rwanda is organized by level of care provided with a high burden of disease addressed at community level. Rwanda's health sector is managed and coordinated through a mechanism of stakeholders.

IV.1. National coordination on RMNCAH

All interventions as well as principles guidance are directed by the Reproductive, Maternal, Neonatal, Child and Adolescent Health policy with its 2 strategic plans: Family Planning and Adolescent Sexual Reproductive Health and Maternal, Neonatal and Child Health strategic plans

The Ministry of Health (MoH) is responsible for central functions such as policy and priority setting, financial management, budget execution, and audits. The Department of Maternal, Child and Community Health of the Rwanda Biomedical Centre (RBC) is responsible for implementation of most of the RMNCAH programmes in collaboration with divisions under the department of HIV/AIDS, Disease Prevention and Control, the Rwanda Health Communication Centre, the Research, Innovation and data science division.

Key guidance that require multi sectoral responses are approved by the Social Cluster Ministries: including Ministry of Health (MoH), Local Government (MINALOC), Ministry of Agriculture and Animal Resources (MINAGRI), Ministry of Gender and Family Promotion (MIGEPROF), Ministry of Education (MINEDUC), Ministry of Youth and Culture(MYC), MININFRA (Ministry of Infrastructure) and the Ministry of Disaster Management and Refugee Affairs (MIDIMAR).

Key technical priorities and interventions are jointly prepared and implemented by MCCH division in collaboration with partners through the Reproductive, Maternal, Neonatal, Child

and Adolescent Health Technical Working Group. Various sub programs have a deep discussion on sub TWG (FP, Safe motherhood, child health, ASRH and neonatal) prior to the approval by RMNCAH TWG.

The community health TWG is another area of importance which guide on the same way RMNCAH interventions at community level.

Development partners provide technical and financial support to build local capacity in delivering quality RMNCAH prevention and treatment interventions; scale-up appropriately trained midwives and neonatologists in the numbers and skills mix required; mobilise resources to support RMNCAH programme implementation: and facilitate research and continuous quality improvement of RMNCAH services through evidence-informed programming and planning and documenting and disseminating lessons of good practice.

The Joint Health Sector Review: MoH, Rwanda Biomedical Centre and Development Partners (DP), civil society organisations (CSOs) and the private sector are regular informed, monitor key indicators and follow implementation of agreed interventions and report to the Health Sector Working Group (HSWG): which is under the overall leadership of MINECOFIN and chaired by the MoH with co-chair from Development Partners.

For all decision made regarding the vaccination program, the final approval is given by the Interagency Coordination Committee chaired by the Minister of Health and co chaired by WHO. ICC brings together all key partners intervening in immunization and the civil society organizations.

The provision of RMNCAH promotion, prevention and treatment services extends beyond the mandate of the MoH/RBC and require coordination, financing and monitoring between different sectors (especially those ministries in the Social Cluster), civil society organisations (CSOs), and the private sector and development partners and health facilities.

IV.2. Decentralised / district level leadership and coordination

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

IV.3. Civil society organisations

Civil Society Organisations (CSOs) scale-up health promotion, social mobilisation and outreach services, and provide technical assistance, financial and material support to beneficiaries based on the priorities and needs identified in the RMNCAH joint plans at district, health centre and community level. They undertake research on RMNCAH programme improvements, build capacity of community teams and provide feedback on all activities to the RMNCAH TW.

IV.4. Private sector

Private sector invest in RMNCAH as a corporate social responsibility. Private sector health care facilities and pharmacies promote affordable RMNCAH commodities and services and carry out research and innovation on agreed RMNCAH priorities. All private sector RMNCAH promotion, prevention and treatment services are in accordance with the highest standards of quality as defined by the MoH.

PART V. CHALLENGES, RECOMMENDATIONS AND KEY PRIORITIES

During the reporting period fiscal year ended in June 2021; Maternal, Child and Community Health division was affected by challenges which impacted the smooth implementation of activities planned for the same period, especially the COVID19 pandemic.

V.1 CHALLENGES and RECOMMENDATIONS

#	Challenge	Recommendations
1	Stock out of some products, delays in shipments due to global shortage especially for implanon and microgynon	✓ Continue to work with logistic team for tracking the stock out and push for shipment on time
2	Low coverages/high morbidity and mortality for MCCH indicators in some Districts	✓ Conduct operational research in some districts ✓ Intensify awareness activities in some of those disrticts
3	The time allocated for the GBV training was very limited and did not allow enough practical session, which are very important All hospitals are not trained on GBV because some hospitals did not sent all required staffs to the training	✓ Re-organize such training in a practical manner which would be held at operational IOSCs for practical enhancement ✓ Personnel working in hospital IOSCs are called to ensure the following, including but not limited to: Teamwork, Continuing and enhancing the discussions, Enhance community awareness on GBV and child abuse, Enhancing linkages with relevant agencies.
5	It was a challenge to disseminate findings of the above conducted studies and to finalize the curriculum, training manuals and start training community health workers due to COVID-19	✓ Use online meetings and workshops for fine-tuning these documents and start master training once the pandemic will be controlled
6	It was also a critical challenge to ensure continuity of Community health services but the Ministry of Health in collaboration with partners equipped CHWs with Personal Protective Equipments (PPEs) and CHWs are providing an important support in management of COVID 19.	✓ Provide enough PPEs to CHWs to ensre the continuum of care

#	Challenge	Recommendations
7	Activities not timely implemented or suspended due to Covid-19 pandemic	✓ Make an advocay to carry over those activities for the current fiscal year (2021-2022)
8	Vacant positions in MCCH which resulted in workload for some staff; shortage and turnover of trained staff in RMNCAH in most of health facilities	✓ Organise regular onsite trainings and mentorships ✓ Make an advocacy to MOH and RBC leaders for a prompt recruitment and replacement of departed staff
9	Decline in coverage for some indicators: possibly due to the denominator used from 2012 population census and impact of COVID 19	✓ Work closely with Disrticts to have a common agreement on indices and proportions to be used
10	Delay in deaths audit (All cases occurred in 2020 were not yet audited and/or entered in the database) in almost of supervised hospitals due to lack of ownership of death audit committees	✓ To critically analyze the perinatal data on daily/weekly basis not waiting until they are overwhelmingly high to ensure recommendations are timely implemented to prevent similar deaths ✓ Improve ownership of death audit by hospitals leaders trained (Director of nursing and clinical director) ✓ MPCDSR Committee members to conduct regularly the death audit after death occurred and responsible of service to fill the form with the initial information, then the deep analysis will continue directly on cause of deaths, delays and contributing factors and keys actions during the session without losing time in completeness of general information
11	A shortage of health professionals especially in remote areas, also health facilities experienced a high turnover of trained staff which resulted in poor quality of service and lack of follow up of clients who stopped especially those managed by CHWs.	✓ Continue advocacy for permanent staff at secondary health post for continuity of FP services

#	Challenge	Recommendations
12	Delayed funding from partners resulting in lack of implementation of some activities	✓ Make continuous advocay with insistence to all partners to avail their commitments on time
13	Inappropriate medical equipment maintenance/ lack of capacity and maintenance plan in most of health facilities	✓ Procure appropriate medical equipment ✓ All health facilities to prepare and execute the maintenance plan for all medical equipment to their disposition ✓ RBC to conduct regular mentorship for maintenance of medical equipment
14	Lack of appropriate/sub-standard infrastructure dedicated to MNCH interventions in different health facilities	✓ Make an advocay to MOH and or partners to renovate existing or build new infrastructures in health facilities where needed
15	CHWs are under utilized provision, mobilization and education of population	✓ Make an effort to maximumly involve CHWs in performance of family planning activities: participation in FP health education and provision of FP services ✓ Conduct regular training of new elected CHWs
16	Reporting rate of private health facilities is till a challenge especially for FP	✓ Close monitoring of private hospitals in regards of reporting in HMIS platform

V.2 KEY PRIORITIES FOR 2021-2020

For the year 2021-2022, MCCH Divsision priorities are summarized as follows:

- Dissemination and Implementation of new guidelines and protocols: ANC, EmONC, neonatal
- Conduct Cascade training of CHWs on Comprehensive package including ASRH,CBP/FP and GBV interventions
- Procure of ICCM commodities (Misoprostal,UPT,Zn and ORS) & Procure FP Drugs and Consumables

- Capacity building for both CHWs supervisors at Hospital, Health centers and CHWs
- Printing of FP tools (FP consultations files, FP individual cards, FP registers, FP image boxes) and ASRH tools
- Working on community Health Reform (service delivery and supervision)
- Capacity building of health providers for high quality YFS: conduct training of Health Care Providers in 3 target districts on quality Youth Friendly Services (at least 2 staff per Health Care Centre)
- Conduct cascade training on Sayana Press
- Development of new cMYP: cMYP 2022 – 2025
- Development of a business case for CHP which will help to analyse the financial needs, funding flows of the community health program in Rwanda and provide a clear analysis of Community Health program financing needs and gaps
- Conduct a bi-annual SRMNCAH data quality review
- Introduction of new family planning commodities: Sayana press , hormonal IUD

In addition to key priorities listed here, MCCH has an entire action plan to be implemented in 2021-2022 which will be revised and add other activities from stated recommendations.

CONCLUSION

In the year 2020-21 the MCCH Division has supported the progress towards meeting Rwanda's ambitious goals of economic prosperity and health for women, children and adolescents as a human right. The decline in the Total Fertility Rate moves Rwanda in the right direction to harness the Demographic Dividend by reducing the dependency ratio.

Successful new strategies such as post-partum family planning have complemented continued efforts to improve access to contraceptives that families want and to increase demand for family planning. While these efforts continue to be supported, particular focus on reducing teenage pregnancies would add to the overall success. The achievements in improving health outcomes as a human right are also evident in the reduction in maternal and child mortality. Provision of comprehensive care from pregnancy to childbirth continues to reach the vast majority of pregnant women.

Thereafter, in FY 2020-21 their children continued to be provided with vaccines against infectious diseases and treatment for the most common and serious childhood illness as close to the home as possible. Further efforts to improve the quality of care during labour and delivery, reducing unnecessary surgical interventions, will build on the gains of the last year.

The MCCH division remains committed to contribute to the RBC vision of healthy people in a wealthy nation through achieving SDGs, HSSP IV and Rwanda Vision 2050 targets.

ANNEXES

Annex 1: MCCH Staff FY 2020-2021

#	Names	Position
1	Dr SAYINZOGA Felix	Division Manager
2	SIBOMANA Hassan	Director of Vaccine Programs Unit
3	Dr BIKORIMANA Ferdinand	Ag Director of Health Facilities Programs Unit
4	MUKAMANA Beatrice	Ag Director Community Programs Unit
5	HAKIZIMANA Jean de Dieu	AEFI Surveillance and Monitoring Officer
6	IRAGUHA Gisele	Vaccine Stock Management Officer
7	MINGA NSENGIYUMVA Fabien	International Vaccination Officer
8	MUHOZA Jered	Cold Chain Senior Officer
9	MUKANYANDWI Irene	SIAs and New Vaccine Officer
10	NGILIMANA Gad	Cold Chain and Maintenance Engineer
11	NSHIMIYIMANA Laurence	International Vaccination Officer
12	RWAGITARE Eraste	Vaccine Program Officer
13	RWASANGABO KANOBAYITA Anicet	Vaccine Distributor
14	MUDAHERANWA Evodie	Vaccine Supply Chain Officer
15	NZARAMBA Emmanuel	Routine Immunization Officer
16	MUREKATETE Odette	Cashier
17	TUYISHIME Yvette	Immunization Field Staff
18	HABARUREMA Nicodeme	Nutrition M&E Officer
19	KARAMAGE Eliphaz	Adolescent Health Officer
20	KAYITARE Evariste	Community Health Program M&E Officer
21	NGENZI WANE Olivier	In Charge of Commodities Senior Officer
22	NKURUNZIZA Appolinaire	Nutrition Officer
23	SERUCACA Joel	Community Family Planning Officer
24	NTAGANDA Justin	Nutrition Technical Assistant
25	KARANGWA Eugene	Child and Maternal Death Audit Officer
26	MUTONI Merab	SGBV Officer
27	NDARUHUTSE Victor	Monitoring and Evaluation Officer
28	NYAMWASA Augustin	MCH Mentorship Officer
29	RUBAYITA Jean Claude	SGBV M&E Officer

30	UMUTESI Sharon	Maternal and Newborn Health Senior Officer
31	Dr BUCYANA Tatien	MCH Technical Advisor
32	MUKAKABANDA Suzanne	FP Quality of Care Specialist
33	MUKASHYAKA Clarisse	Avenir Health M&E Officer
34	KANYAMANZA Eugene	Focal Point PAC and Safe Abortion
35	BURANGA UMULISA Assumpta	CHWs Training Officer
36	UMUTONI GAGA Alice	Program Liaison

Annex 2: MCCH Partners _ FY 2020-2021

Partner	Program of intervention	District(s) where they intervene
WHO	MNH, MPCDSR, ASRH, Immunization, Family Planning	Contrywide
GAVI	Immunization	Countrywide
RBF-ENABEL	RMNCAH	Countrywide
UNFPA	MPCDSR, Family Planning, ASRH, Mentorship	Contrywide for MPCDSR, Nyamasheke, Karongi, Rusizi
UNICEF	Immunization, Nutrition, Child Health and Mentorship	Countrywide (Targeted activities) for Immunization. Rutsiro, Rusizi, Rubavu, Nyaruguru, Nyamasheke, Ngororero, Karongi, Gicumbi, Burera, Gakenke, Musanze, Nyagatare, Gatsibo, Nyarugenge, Nyanza, Kicukiro, Kayonza (Gahini), Gasabo, Bugesera.
USAID_Ingobyi Activity	MNH, Child Health, Community Health, GBV, ASRH, Family Planning, Mentorship	Gasabo, Kicukiro, Kamonyi, Gicumbi, Muhanga, Ngoma, Gatsibo, Nyagatare, Bugesera, Rwamagana, Rubavu, Ngororero, Rutsiro, Musanze, Nyabihu, Ruhango, Huye, Nyamagabe, Nyaruguru, Nyanza
ENABEL_Barame Project	MPCDSR, GBV, Community Health, ASRH, Child Health, Mentorship, Family Planning, Data quality	Nyamasheke, Karongi, Gisagara, Gakenke, Rulindo, Rusizi, Nyarugenge

Partner	Program of intervention	District(s) where they intervene
PIH	MNH, Child Health, Community Health, ASRH, Family Planning, Mentorship	Kirehe, Burera and Kayonza
World Bank_SPRP	Nutrition	Ruhango, Gakenke, Karongi, Rusizi, Kayonza, Nyabihu, Ngororero, Rutsiro, Nyamagabe, Nyaruguru, Rubavu, Bugesera & Huye
Access to Health	Community Health	Countrywide
Rwanda Paediatric Association	Mentorship	Countrywide
RAM_50.000 HBD	Mentorship	Bugesera, Burera, Gasabo, Karongi, Kayonza, Kicukiro, Kirehe, Ngororero, Nyamasheke, Nyanza, Nyarugenge, Rubavu, Rutsiro and Rusizi
ADRA Rwanda	Child health, Nutrition and mentorship	Nyabihu
CARITAS	Nutrition	Ruhango
Garden for health	Nutrition	Musanze
CRS_Gikuriro Project	Nutrition	Ngoma, Kayonza, Nyarugenge, Kicukiro
Girl Effect	ASRH	Nyamagabe, Huye, Ruhango, Kamonyi, Muhanga, Nyabihu & Gakenke
HDI	ASRH	National level for advocacy program, Nyarugenge, Kicukiro, Gasabo, Huye, Nyanza, Muhanga &Nyaruguru
HDP	ASRH	Ruhango & Nyamagabe

Partner	Program of intervention	District(s) where they intervene
Health Builders	MNH, Child Health, ICCM, ASRH, Mentorship	Rulindo, Rwamagana, Nyabihu
Humanity& Inclusion	Child Health, Mentorship	Ngororero, Rutsiro and Karongi
IHANGANE Project	Nutrition	Gakenke
Imbuto Foundation	ASRH	Nyarugenge, Gicumbi, Nyagatare & Burera
KASHA	ASRH	Gasabo & Huye
Projet Suisse	Nutrition	Karongi, Rutsiro
Save Generations Organization	ASRH	Gasabo & Kamonyi
SFH	ASRH	Gasabo & Nyagatare; All districts for condom distribution
VSO	ASRH	Nyagatare
WFP	Nutrition	Nyaruguru, Nyamagabe
World Vision	Maternal Health, Nutrition, Family Planning and Community Health	Gicumbi, Gatsibo, Kayonza, Gakenke, Gasabo, Kicukiro, Karongi, Rutsiro, Ngororero, Nyamasheke, Rusizi, Huye and Gisagara

Annex 5: RBF-ENABEL Result Framework

Program area	**Indicator**	**Baseline_2017-18**	**Target_2020-21**	**Results achieved_2020-2021**	**Data source**
Maternal and newborn health	•OCI 1: Facility deliveries – percentage of births attended by skilled health professionals – facility based information °HMIS	92%	90%	85%	HMIS_Routine data
Reproductive Health	•OCI 2: mCPR : utilization rate of modern Contraceptives – facility based ° HMIS	47%	49%	53%	HMIS_Routine data
Reproductive Health	•OPI 1: PPFP uptake : Post-Partum Family Planning within the first 6 weeks after delivery : °HMIS : baseline and target to be agreed on	32%	45%	53%	HMIS_Routine data
Reproductive Health	•OPI 2: New acceptors of Family Planning: °HMIS: baseline and target to be agreed on (alternative: New users of FP, but this is a weaker indicator)	14,763	278,556	290,690	HMIS_Routine data
Maternal and newborn health	•OPI 3: PNC1 visit within 24 hours of delivery by neonates: °HMIS: baseline and target to be agreed on	74%	90%	91%	HMIS_Routine data
Maternal and newborn health	•OPI 4: First routine ANC within 1st trimester: °HMIS: baseline and target to be agreed on	40%	43%	50%	HMIS_Routine data

Program area	Indicator	Baseline_2017-18	Target_2020-21	Results achieved_2020-2021	Data source
Maternal and newborn health	•OPI 5: Total of new-born not breathing successfully resuscitated/total of new-born not breathing: °HMIS: baseline and target to be agreed on	58%	70%	71%	HMIS_Routine data

Annex 6: SPRP Result Framework

PDO-level indicators	**Baseline_ 2017-2018 FY**	**Target FY 2018/19**	**Results_ FY 2018/19**	**Target FY 2019/20**	**Results_ FY 2019/20**	**Target FY 2020/21**	**Results_ FY 2020/21**	**Data Source**
Indicator 3: Percentage of women who attended 4 or more ANC visits during their most recent pregnancy	**36%**	**37%**	**37%**	**38%**	**36%**	45%	40%	HMIS
Indicator 4a: Number of children under 5 were beneficiaries of project interventions	-	508,826	515,573	510,326	581,142		657,784	SISCOM
Indicator 4b: Number of women of reproductive age (including pregnant and lactating women) who were beneficiaries of project interventions	-	389,623	395,190	391,623	367,894	530,000	397,667	HMIS
IRI 2: Percentage of CHWs who received a quarterly supportive supervision visit from HC	**40%**	**48%**	**59%**	**56%**	**86%**	64%	91%	Supervision reports
IRI 3: Percentage of pregnant women who attended the first ANC visit during the first trimester	**42%**	**44%**	**46%**	**46%**	**44%**	48%	48%	HMIS
IRI 4: Percentage of pregnant women with anemia	**1.6%**	**1.5%**	**2%**	**1.40%**	**1%**	1.3%	0.7%	HMIS
IRI 6: Percentage of children 6-23 months old receiving micronutrient powders	**18%**	**46%**	**59%**	**36%**	**34%**	54%	40%	HMIS

IRI 7: Percentage of children under five with diarrhea treated with ORS and zinc.	**0%**	**95%**	**93%**	**95%**	**85%**	95%	82%	RapidSMS and HMIS
IRI 10: Percentage of children under 5 with height measured and recorded at health facility	**73%**	**74%**	**72%**	**75%**	**83%**	81%	72%	HMIS
IRI 11: Percentage of CHWs with no stock out of Zinc for diarrhea treatment	**95%**	**95%**	**95%**	**95%**	**93%**	95%	94%	SISCOM
IRI 12: Number of women of reproductive age who are new acceptors of modern contraceptives	-	**125,000**	**124,894**	**125,000**	**100,158**	125,000	125,904	HMIS

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