

Maternal, Child and Community Health Division Annual Report 2021-2022

Kigali, August 2022

**Maternal, Child and Community
Health Division Annual Report
2021-2022**

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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 Obstetric 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	Severe Acute Respiratory -Covid-2
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	Diphtheria, Tetanus, Pertussis, Hepatitis B and Haemophilus Influenzae 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-10	International Code of disease (10 th Edition)
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	Measles 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
SBR	Stillbirth rate
SDG	Sustainable Development Goals
SDP	Service Delivery Point
SPIU	Single Project Implementation Unit
SPRP	Stunting Prevention and Reduction 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
WHO

United States Aids
World Health Organization

Foreword

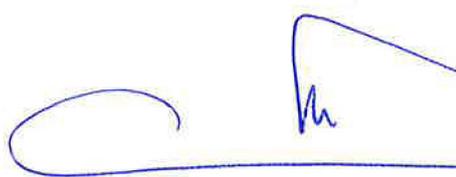
It is my honour and privilege to avail the Maternal, Child and Community Health (MCCH) Annual Report 2021-2022 to all our partners and specifically our MCCH stakeholders. The key achievements presented in the report reflect the performance of MCCH division and partners through its three units: Health Facilities Programs, Community Health Programs and Vaccine Programs Unit. The reporting period corresponds with the third 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 2021-2022 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 2021-2022 would not have been possible without the hard work and dedication of MCCH Division staff, support from partners technical assistants and the support received from colleagues of other divisions of Rwanda Biomedical Centre (RBC) and the Ministry of Health (MoH).

The compilation of the 2021-22 MCCH Annual Report was made possible by the active participation and commitment of staff from the Units of MCCH Division, Single Projects Implementation Unit (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 2022-2023. I guarantee you the support of RBC to ensure coordinated and coherent implementation of these planned activities to realise the Division's objectives.



Prof Claude MAMBO MUVUNYI
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 the goals of the Global Strategy for Women's Children and Adolescent's Health. The Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) Policy and the Family Planning /Adolescent Sexual and Reproductive Health (FP/ASRH) and Maternal, Newborn and Child Health (MNCH) Strategic Plans (2018_2024) are designed for this purpose. Concerted efforts have been made to build on the impressive achievements of last five years and to identify and address issues that lead to maternal and child mortality and . More ambitiously, the strategic plans also look beyond survival to focus on how to ensure that mothers and their new-born and children thrive.

This report presents the status of key MCCH indicators for Financial Year (FY) 2021/2022 and related activities. Key achievements for the year 2021-2022 include an increase of pregnant women attending ANC health services within the first trimester and four standard from 50% and 41% (2020-21) to 51 % and 45% visits, respectively, during pregnancy. The majority of women utilizing these services were screened for malnutrition (93.8%) and HIV (93.1%), and provided with iron and folic acid (93.4%) and Long Lasting Insecticide Treated bednets (LLINs) (80.8%). Stock outs of testing reagents resulted in lower proportion of women tested for syphilis and anaemia at ANC. Women attending ANC receive protection against tetanus to reduce neonatal tetanus. Only four confirmed cases of neonatal tetanus were reported. Of all the ANC attendances 9% were women under the age of 20 years. These achievements were possible through the efforts of the MCCH Division including training and mentorship in the use of ultrasound machines installed for early detection of complications of pregnancy. The mentorship programme also provides mentoring and coaching to health workers in provision of ANC services.

Several interrelated diversions from the trends of the past five to ten years were identified in the year 2021-22. Post partum family planning continued to increase, however, due to continued decline in provision of family planning services by community health workers the contraceptive prevalence rate made only an increase of 1% to 54% from the previous year. There was an increase in the number of deliveries by 4% (25,754), reversing the ten-year decline in number of deliveries. This brought the number of deliveries closer to the Expected Pregnant Women predicted from the 2012 census data (85% in 2020-21 to 89% in 2021-22). The most preferred methods for family planning are Implanon and Jadelle. A new injectable method, Sayana Press was introduced, which was well accepted. In addition to the drive to provide family planning to women in the post-partum period, there was a focus on providing access to family planning to women delivering in faith based health facilities.

A second trend that was reversed was the decline in maternal mortality and the maternal mortality ratio. There was an increase in maternal deaths in health facilities from 261 (81.2 per 100,000 live births) in 2020-21 to 322 (92.2 per 100,000 live births) in 2021-22. The quality of care during labour and delivery, particularly during and after Caesarian Section (C/S), remain a challenge. The rate of C/S of all deliveries increased to 24% of all deliveries with rates of over 60% in some hospitals. Case fatality rates for post C/S infection is 1.2% of 1780 cases, 11.9% for amniotic embolism and 17.4% for pulmonary embolism of 46 cases. Rwanda has a well-developed Maternal, Perinatal and Child Death Surveillance and Response (MPCDSR) strategy and near miss audits as well as trainings and mentoring on correct use of ICD-10 definitions and conducting near miss and death audits.

Following delivery, Post Natal Care (PNC) 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 fourth for mothers. As expected the proportion for post natal services for the newborn are similar.

There was, however, a decrease in perinatal mortality over the past five years, including from 2020-21 in all categories. Fresh still births fell from 5.8% to 5.4%, macerated still births from 8.2% to 7.9%, death within 30 minutes from 2.4% to 2.1% and neonatal deaths from 9.3 to 7.7%. Asphyxia, prematurity and congenital malformation are linked to neonatal deaths. Procurement of essential equipment and mentoring programmes were key activities in the past year to improve perinatal outcomes.

The majority of children under five years old attending a health facility are treated using the Integrated Management of Childhood Illness tools (96%). Respiratory diseases (25.9%), pneumonia (18.2% and diarrhoea (17.7%) are the most common diagnoses. In the community 63% of children with fever are received and treated compared to only 23% for respiratory infections and 16% for diarrhoea.

Rwanda provides a comprehensive vaccine schedule for children under the age of five years that is well utilized. The rates of vaccination coverage are influenced by the projected census data. A 'drop-out' is noted between first and subsequent doses. For example, Pentavalent doses 1 and 3 (90% to 88%) and between the two doses of Measles/Rubella (MR) as per schedule (85% to 80%). A catch-up campaign to vaccinate children with IPV to reduce the transmission of polio through the oral 'live' vaccine. During these campaigns and Mother Child Health (MCH) week 79% children identified were vaccinated with IPV. Vaccination against Human Papilloma Virus (HPV) reached 78% girls aged 12 years. The vaccine is given to reduce the risk of developing cervical cancer in later life.

In addition to the routine vaccines the MCCH Division was responsible for Covid19 vaccinations. By the end of June 2022, a total number of 9,130,139 (100.7%) people had received 1st dose of COVID19 vaccine; a total number of 8,755,611 (96.6%) people had received second dose of COVID19 vaccine and 5,042,098 (55.6%) people had received a booster dose. These coverages are calculated using target population of 12 years and above. Coverages by general population are as follows: first dose is 70%, second dose is 67.1% and third dose is 38.6%.

The Mother and Child Health week was conducted in November 2021 and May 2022 with very good results: 93% children were given for vitamin A and 97% de-worming medication, while nutritional screening for the three anthropometric measurements (Measurement of Upper Arm Circumference (MUAC), Weight for age and Height for age) was conducted on 92%, 91% and 69% children aged 6-59 months respectively. For malnutrition prevalence, the same report showed the following results: in children aged 6-23 months, the rate for stunting is 32%, for underweight is 7.1% and for wasting is 6.6%, acute malnutrition identified by MUAC is 3.4%. In addition, 1,801 (0.3%) were found with oedema and 3,718 children aged 5-6 years were vaccinated for IPV. A total of 11,062 clients received family planning methods including 6,183 for condoms, 4,360 for depo-provera, 2,174 for implanon, 1,695 for microgynon, 71 for IUD and 16 for permanent methods. 2,782 adolescents girls were screened/tested for anemia in Bugesera, Rusizi and Nyamagabe Districts.

The MCCH Division also 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 38,066 cases of which 51% had experienced sexual violence, and 40% physical violence. Just under half (44%) were under 18 years of age. Community sensitization for early presentation at the IOSCs for preventative services against HIV infection and pregnancy is ongoing.

Efforts were made during the FY 2021-22 to improve data quality and use. Weekly data use meetings with individual programme units, training and monitoring of the World Health Organisation (WHO) outlier tool, attention to selected indicators and both nationwide and ad hoc data quality assessments were conducted. However, interpretation of the trends of the results should consider that some of the denominators are estimated from projections of the 2012 population census. Deliveries (facility and home based) were lower than projected expected pregnancies. This will be resolved in the next FY when new population data is available.

These are the key activities of many interventions to improve maternal, newborn, child, Teenagers and Adolescent sexual reproductive health implemented in year 2021-2022. 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. The MCCH Division has taken a renewed focus on generation and use of data in planning and programme implementation. Both formal and action research continue to add to the evidence based. This report outlines the main achievements, challenges met during the implementation.

During the financial year 2022/2023, MCCH Division will be guided by valuable lessons from the financial year 2021/2022, additional high impact interventions will be identified 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.

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 2021/22. 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 of health facilities and community. The denominator used for ‘coverage’ comes from the 2012 population census estimated projections. During the financial year 2022-23 we are expecting revised population data from the 2022 census.

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, 3. Implementation of activities 4. Financial report and 5. Key recommendations and priorities for next year

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 (SDGs), particularly those pertaining to maternal and child health. The Rwandan Mother, Neonatal, Child and Adolescent Health (RMNCAH) policy, Family Planning /Adolescent Sexual and Reproductive Health (FP/ASRH) and Maternal, Newborn and Child Health (MNCH) Strategic Plans (2018_2024) are designed to meet the SDG and Rwandan targets.

The Rwanda Biomedical Centre (RBC) is the implementing agency for the Ministry of Health. The RBC’s 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 (VPD) 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 year 2021-22 was dominated by the continuing Covid-19 pandemic. In July and January two ‘waves’ of high caseloads were recorded. The vaccination campaign was successful in meeting the target of 40% population coverage by December 31st 2021 and 67% by June 30th 2022. These efforts employed both existing staff and additional staff employed for the campaigns. The system was highly digitalised, requiring the time of existing data managers.

PART I: STATUS OF MATERNAL, CHILD AND COMMUNITY HEALTH INDICATORS FY 2021-2022

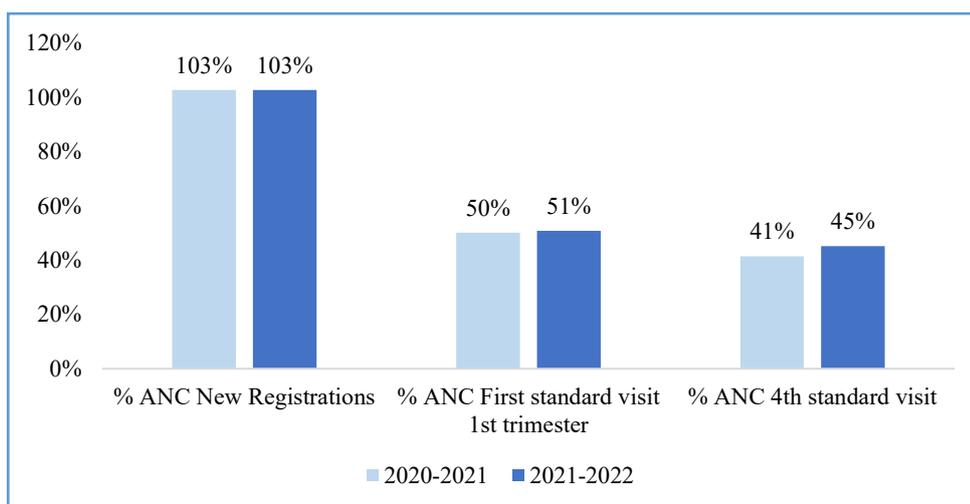
I.1: MATERNAL, NEWBORN AND CHILD HEALTH

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.

Figure 1: Proportion of expected pregnant women (census projections) receiving any ANC, during the first trimester and four times during the pregnancy 2021-2022

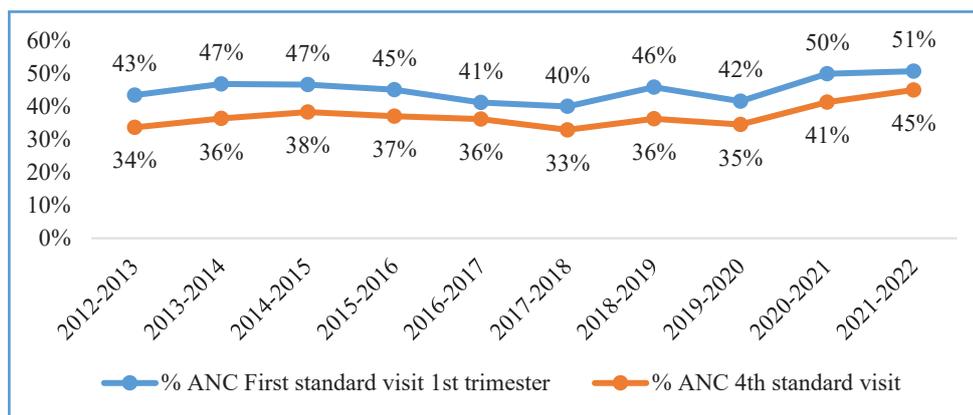


While the vast majority of pregnant women receive ANC care at least once during their pregnancy only half (51%) of these receive ANC within the first three months. This leads to fewer

ANC visits during the entire pregnancy. Only 45% had at least four standard visits. However, there is an increase in both indicators since the previous year (1% increase for early ANC and 4% increase in four visits).

The pattern over the last ten years also shows a small but steady increase reaching the highest in this reporting period. The ten-year trend for ANC fourth standard visit follows the same pattern with 45% expected pregnant women receiving antenatal care four times during their pregnancies an increase of 11% over the past ten years (see Figure 2).

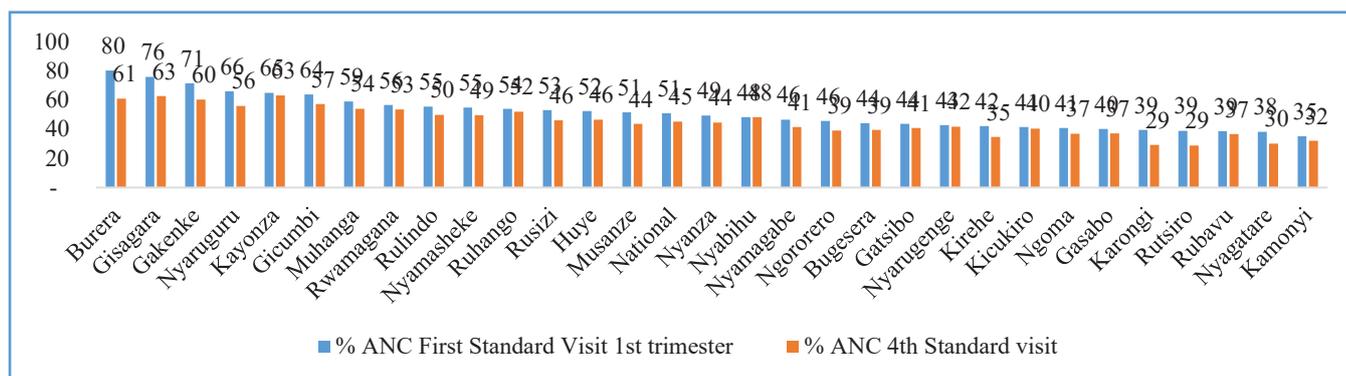
Figure 2: ANC 1st visit within the first trimester and 4 Standard visits of all projected Expected Pregnant Women (census projection), 2012/13 – 2021/22



A wide range of coverage rates of first ANC within first trimester and four standard visits can be seen between the Districts of Rwanda, from 80% in Burera to

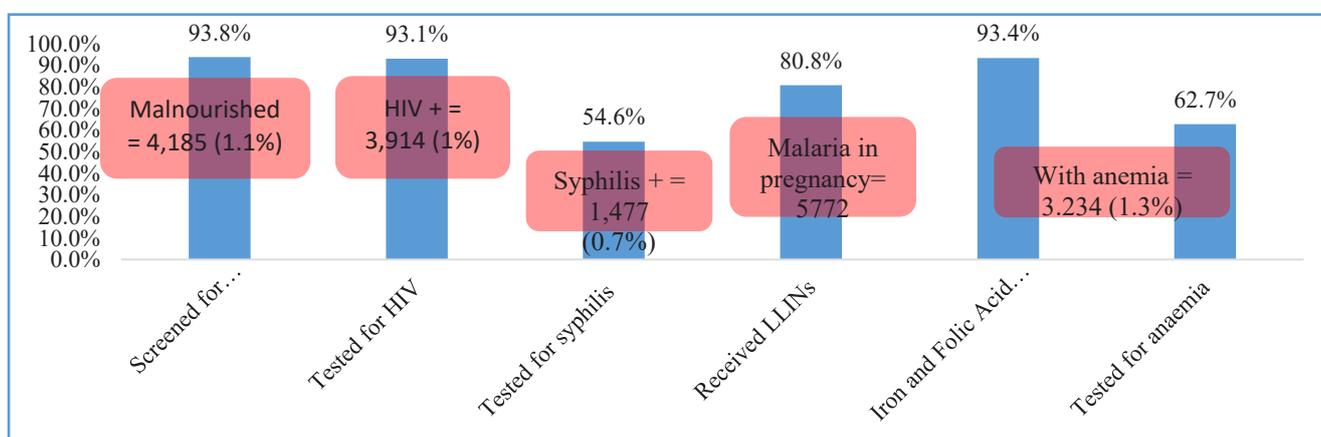
only 35% in Kamonyi (see figure 3).

Figure 3: ANC 1st visit within the first trimester and four Standard visits of all Expected Pregnant Women (EPW) by District, 2021-2022



The services provided at ANC 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 shows the proportion of women attending ANC for any visit who received these services.

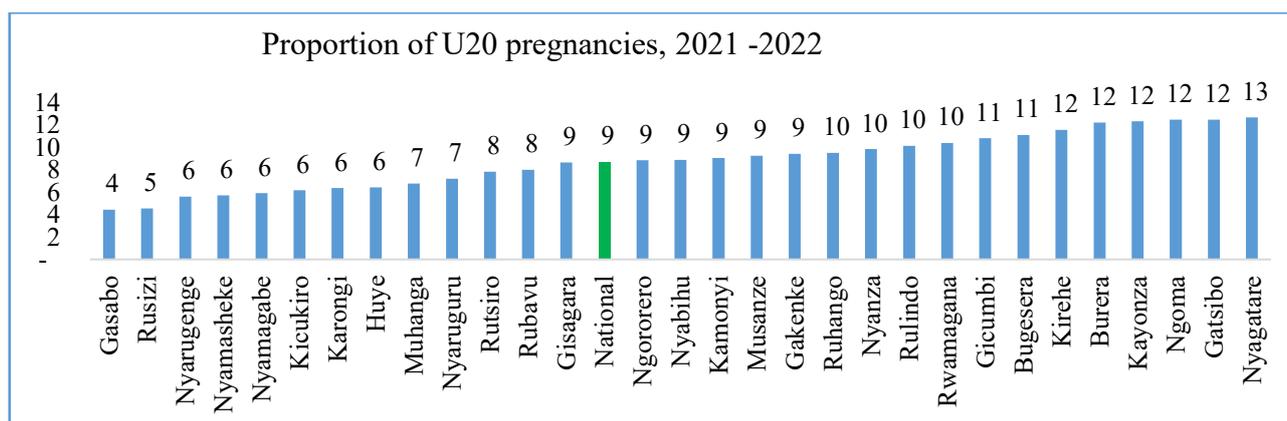
Figure 4: Coverage of ANC services, 2021-2022



Though pregnant women visit ANC services *at least once* during pregnancy, only 93% were tested for HIV with 1% testing positive. Of all women attending ANC at least once during the pregnancy 93% received iron and folic acid supplements. Malnutrition was identified in 1.1% women of the 94% screened. These are consistent with the previous reporting period. There was, however, an increase in the proportion of pregnant women receiving LLITNs from 74% to 81%. While testing for malaria is no longer routine during ANC, 5,772 cases of malaria were confirmed during curative consultations in the health facilities in pregnant women. There was a 10% decrease in the proportion of women receiving ANC who were tested for anaemia and a decrease from 82% to 55% tested for syphilis (positivity rate 0.7%), primarily due to stock outs of reagents.

The proportion of under 20 year old women registered in ANC services for 2021/2022 of ANC registrations of all ages in Rwanda was 9%. Twelve Districts reported higher than national proportion (see figure 5) ¹.

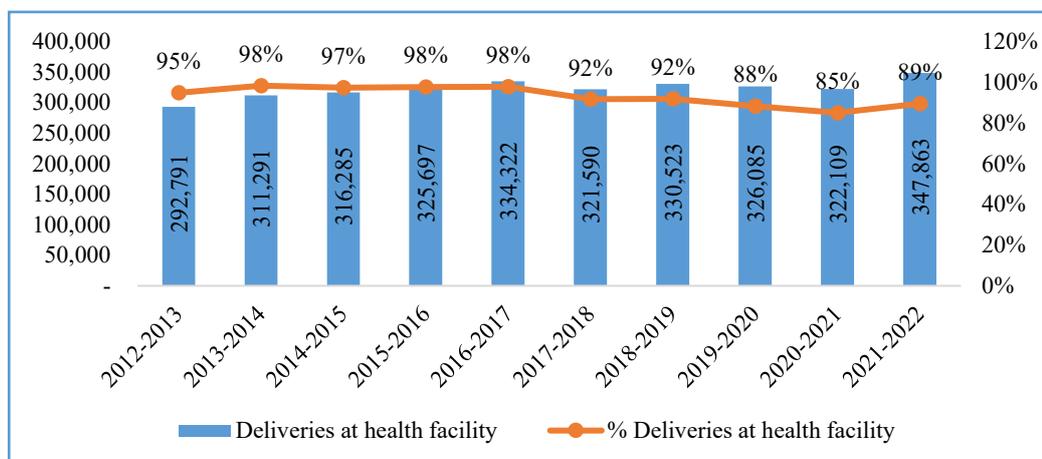
Figure 5: Proportion of under 20 year old pregnant women of ANC registrations (all ages) by District 2021-2022



¹ The proportion of women under 20 within the population who became pregnant in the previous year was not calculated

I.1.1.2 Delivery & Obstetric complications

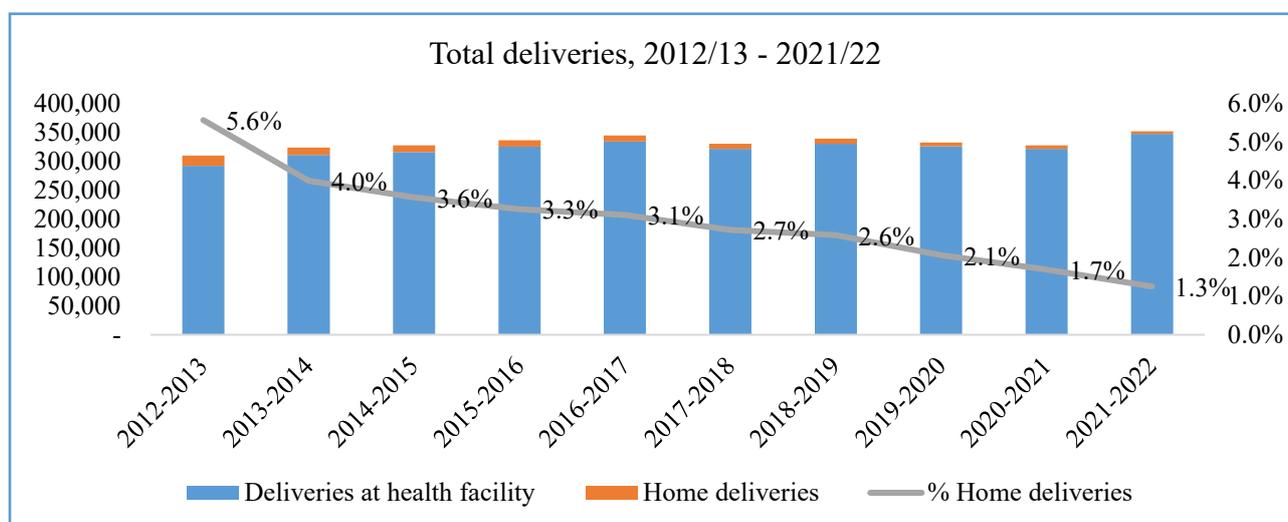
Figure 6: # deliveries and % deliveries of Expected Pregnant women (census projections), 2012/13 – 2021/22



The national policy calls for all women to deliver in a health centre and those considered at risk for complications in a hospital. The

number of deliveries increased by 25,754 thus bringing the number of deliveries closer to the census projections of Expected Pregnant Women (see figure 6). However, the proportion of reported home deliveries fell from 1.7% in 2020-21 to 1.25% in 2021-22² (see figure 7).

Figure 7: Total deliveries (health facility deliveries + home deliveries), 2012/13-2021/22



The ten year trend shows a decrease of home deliveries from 17, 285 (5.6%) in 2012/13 to 4,415 (1.25%) in 2021/22 (see figure 7).

² There is likely some under-reporting of home births that is currently being investigated and data quality strengthened for this indicator.

Table 1: Obstetric complications, 2021-2022

Type of cause	Causes	Number of hospitalized cases	Proportiona l morbidity	Number of deaths	Proportional mortality	CFR
Direct causes	Complications of Abortions all	1382	4.1%	23	7.14%	1.7%
	Ectopic pregnancy	1093	3.3%	4	1.24%	0.4%
	Antepartum Haemorrhage	1966	5.9%	4	1.24%	0.2%
	Post-partum hemorrhage	2781	8.3%	77	23.91%	2.8%
	Eclampsia	358	1.1%	15	4.66%	4.2%
	Severe Pre Eclampsia	2153	6.4%	22	6.83%	1.0%
	Post C-Section infection	1780	5.3%	23	7.14%	1.3%
	Other Postpartum infections	588	1.8%	9	2.80%	1.5%
	Prolonged or Obstructed labor	4356	13.0%	0	0.00%	0.0%
	Uterine rupture	427	1.3%	13	4.04%	3.0%
	Amniotic embolism	42	0.1%	5	1.55%	11.9%
	Complications of anesthesia	37	0.1%	2	0.62%	5.4%
	Direct Obstetrical Complications Other	8590	25.6%	18	5.59%	0.2%
	Indirect causes	Anemia Severe <7gm/dl	1875	5.60%	0	0.00%
HIV Opportunistic Infections		273	0.80%	1	0.31%	0.37%
Pulmonary embolism		46	0.10%	8	2.48%	17.39%
Pneumonia on pregnancy		191	0.60%	3	0.93%	1.57%
Malaria in pregnancy		1095	3.30%	2	0.62%	0.18%
Indirect Obstetrical Complications Other		4536	13.50%	93	28.88%	2.05%
Total		33569		322		0.96%

The most common direct and indirect obstetric complications that require hospitalization are presented in Table 2. In total 33,569 cases of obstetrical complications were recorded compared to 34,637 in the previous reporting period. The number of deaths increased to 322 from 261³ in health facilities. There were increases in all direct causes except prolonged labour, Antepartum haemorrhage and problems of anaesthesia compared to 2020-21. The highest increase in number of deaths were abortions (23 this year compared to 14 last year), Post partum haemorrhage (including haemorrhage post C/S) (77 this year compared with 56) and severe eclampsia (22 this year compared with 9). Other indirect causes increased from 60 to 93 while pulmonary embolism decreased from 18 to 8 deaths. Prolonged labour, Postpartum hemorrhage and severe eclampsia are predominant causes of morbidity. While post-partum hemorrhage, severe eclampsia, post- C/S infections are the main causes of death. Case Fertility Rate is 0.96% for all causes.

³ There may have been under-reporting of maternal deaths in 2020-21 in the HMIS

Figure 8: Trend of Caesarean sections as a proportion of all deliveries

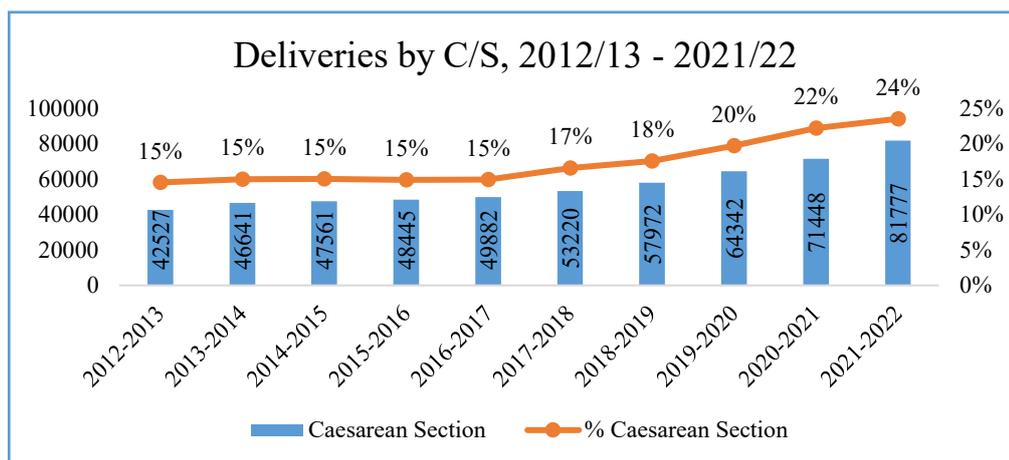


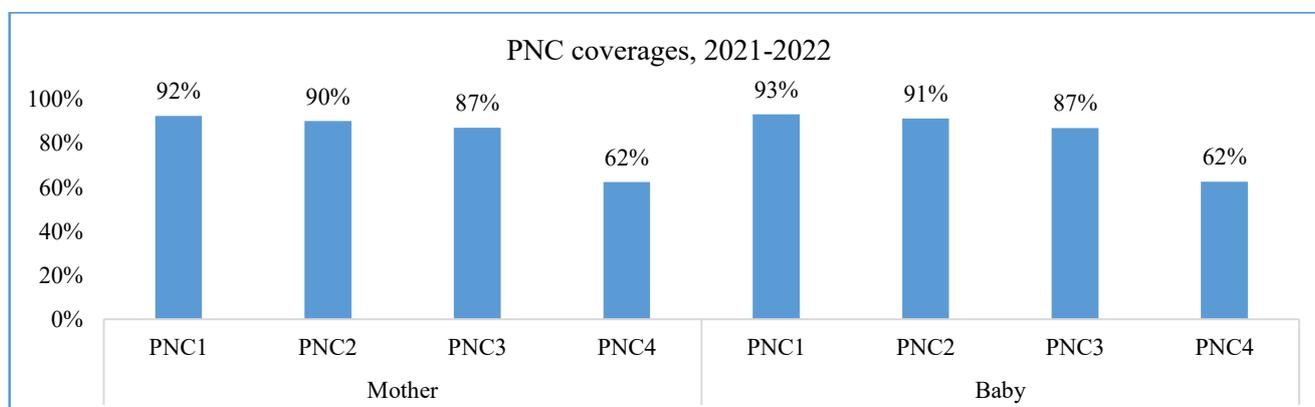
Figure 8 shows that Caesarian Section rates in Rwanda are 24% of all deliveries. There is an upward trend in the proportion of deliveries conducted by C/S

from 15% in 2012-13 to 24% in 2021-22. An increase of C/S beyond 10% does not reflect a decrease in maternal deaths (WHO). The increase in institutional maternal mortality from last reporting period is concurrent with the increase in number and proportion of C/S. The range per District is 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. It should be noted that referral hospitals receive the complicated cases from health centres and hospitals in other Districts.

1.1.1.3 Postnatal care (PNC) for mother and babies, July 2021 – June 2022

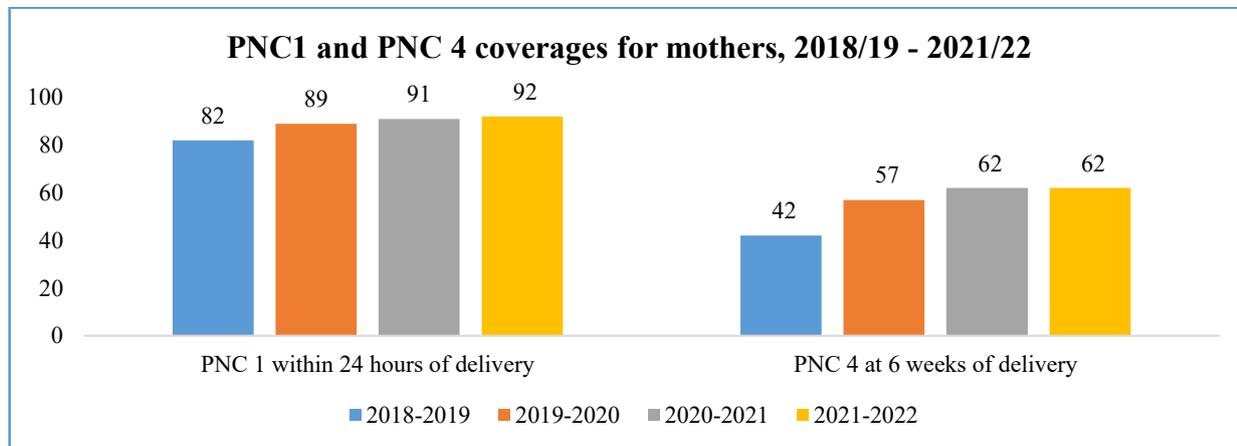
Post-natal care (PNC) is recommended in Rwanda for mother and baby within 24 hours of birth and for three additional visits. The majority of women deliver their babies in a health facility so, as expected, the proportion of mothers and babies who receive the first PNC screening is above 90%. There is drop-out between PNC1 and PNC4. There are 8% mothers and 7% babies who do not receive post natal care before discharge from health facilities. This increased to 38% mothers and babies at six weeks.

Figure 9: PNC_mother & baby coverage, 2021-2022



There is a gap between PNC1 and PNC4. There are 8% of mothers and 7% of babies who are not seen before discharge from health facilities after delivery, also when arrived home around 10% are not seen by CHWs at 3rd day of delivery.

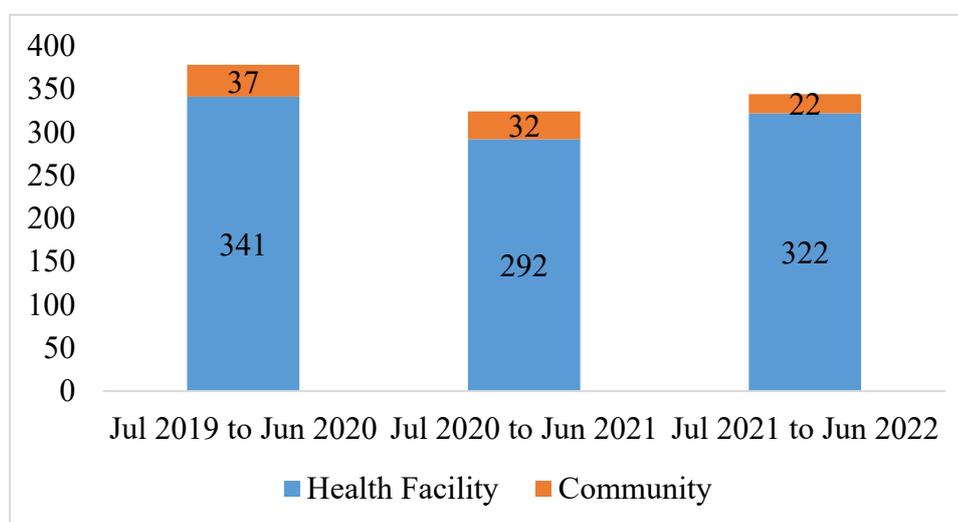
Figure 10: Coverage of PNC1 and PNC 4, 2018/19 – 2021/22



I.1.1.4 Maternal mortality, July 2021 – June 2022

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 11: # Maternal deaths reported at health facility and community) 2019/20- 2021- 2022



The Institutional Maternal Mortality Ratio increased from 81.2 per 100,000 live births (2020-21) to 92.2 per 100,000 live births (2021-22). The proportion of live births of all deliveries remained stable at 98%.

In 2021-2022, 344 maternal were recorded countrywide through HMIS (322 among them occurring in health facilities and 22 in the community). However, a death in the community can result from to early discharge from a health facility delivery and a death in a health facility may have been as a result of a home delivery. Investigatoin is ongoing at MCCH There is a total increase of 20 deaths compared to previous reporting period (2020-21).

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.

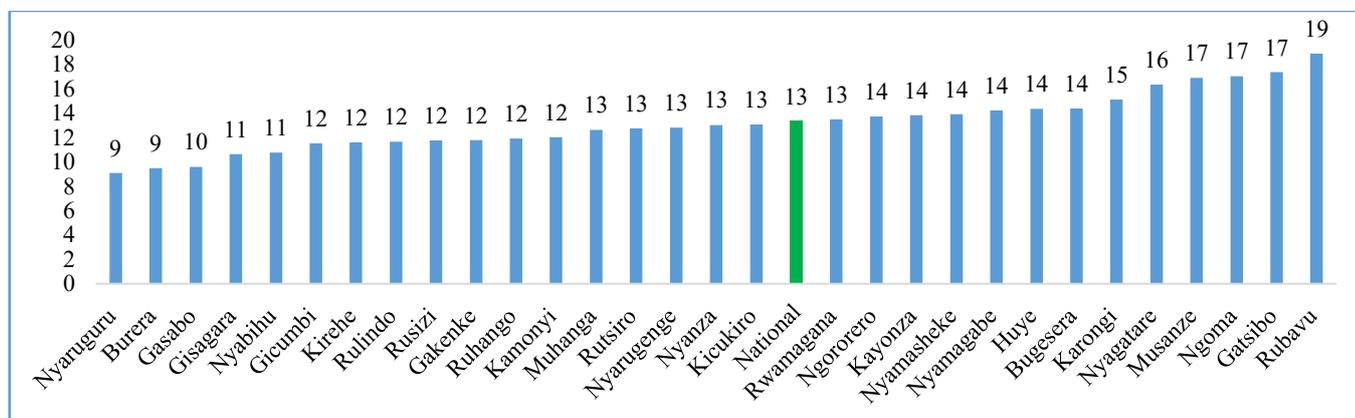
Table 2: Newborn indicators (HMIS), July 2021 – June 2022

	Q1	Q2	Q3	Q4	Total/Average
Total births	87,699	85,286	85,653	93,242	351,880
Live births	86,492	84,189	84,518	91,986	347,185
%Live births	98.6%	98.7%	98.7%	98.7%	98.7%
Still births	1,207	1,097	1,135	1,256	4,695
% Still births fresh (≥ 28 weeks or ≥ 1000 grams)	39%	43%	40%	40%	41%
% Congenital malformations	0.3%	0.3%	0.3%	0.3%	0.3%
% Low Birth Weight	5.8%	6.5%	6.6%	6.5%	6.4%
% Premature newborns (alive, 22-37 weeks)	3.4%	3.8%	3.5%	3.4%	3.5%
Death at birth	197	179	171	180	727
% Newborns breastfed within 1 hour of delivery	95%	96%	95%	96%	95%
Live newborns who didn't cry/breath at birth	3,369	2,917	2,805	2,990	12,081
% Live newborns who didn't cry/breath at birth	3.9%	3.5%	3.3%	3.3%	3.5%
% Live Newborns who didn't cry/breath at birth and were resuscitated successfully (cry/breath within 5 minutes, APGAR score >5 at 5min	73%	74%	76%	76%	75%
% Low birth weight_2000 gr admitted to KMC	74%	70%	69%	75%	72%

Total births registered in 2021-2022 were 351,880 (an increase of 25,754 from last reporting period FY 2020/21). Of these births 99% were live births. In total 4,695 still births (1% all births) were registered (100 more than last reporting period), of these 41% were ‘still birth fresh’. Among all live births, 0.3% were born with congenital malformation and 6.4% were low birth weight (LBW), an

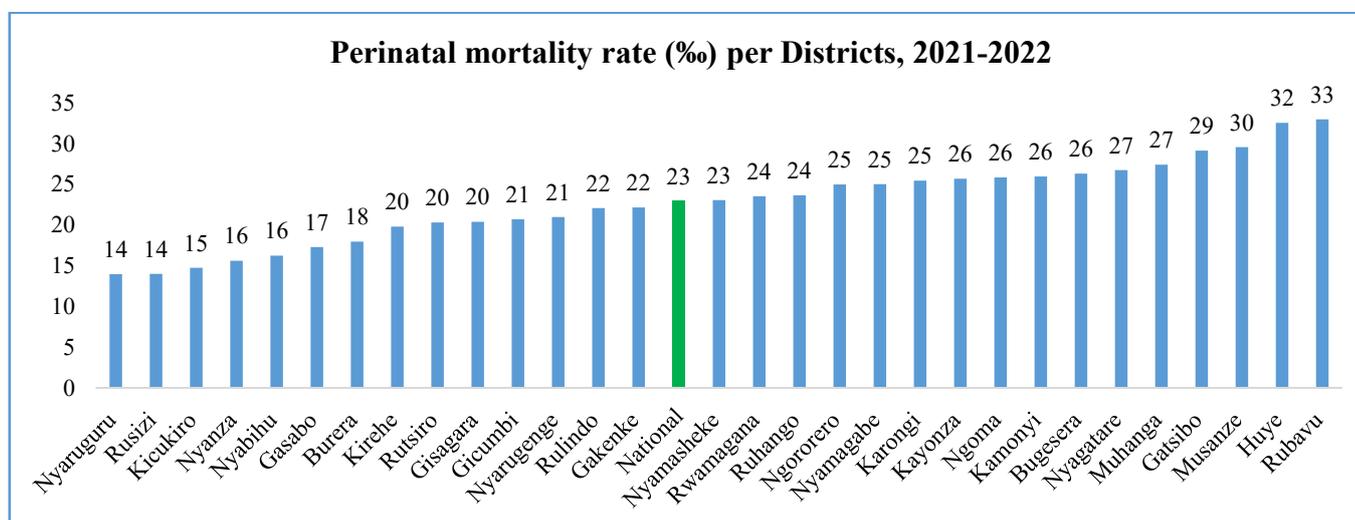
increase of 0.2% from 2020-21, while 3.5% were born prematurely. The proportion of babies who were born alive but did not cry at birth decreased by 0.5% from last year and the resuscitation success rate increased from 71% to 75%. The proportion of neonates registered in KMC fell from 77% to 72% in the last two years.

Figure 12: Proportion of still births per 1000 births by District, 2021-2022



The stillbirth rate (SBR) from July 2021 to June 2022 was 13 per 1000 births at national level. Whereas last year 14 districts reported still birth rate over 15 per 1000 births this reduced to five districts (Rubavu, Gatsibo, Ngoma, Musanze, Nyagatare and Karongi) in this reporting period.

Figure 13: Perinatal mortality per 1000 births per District, 2021-2022

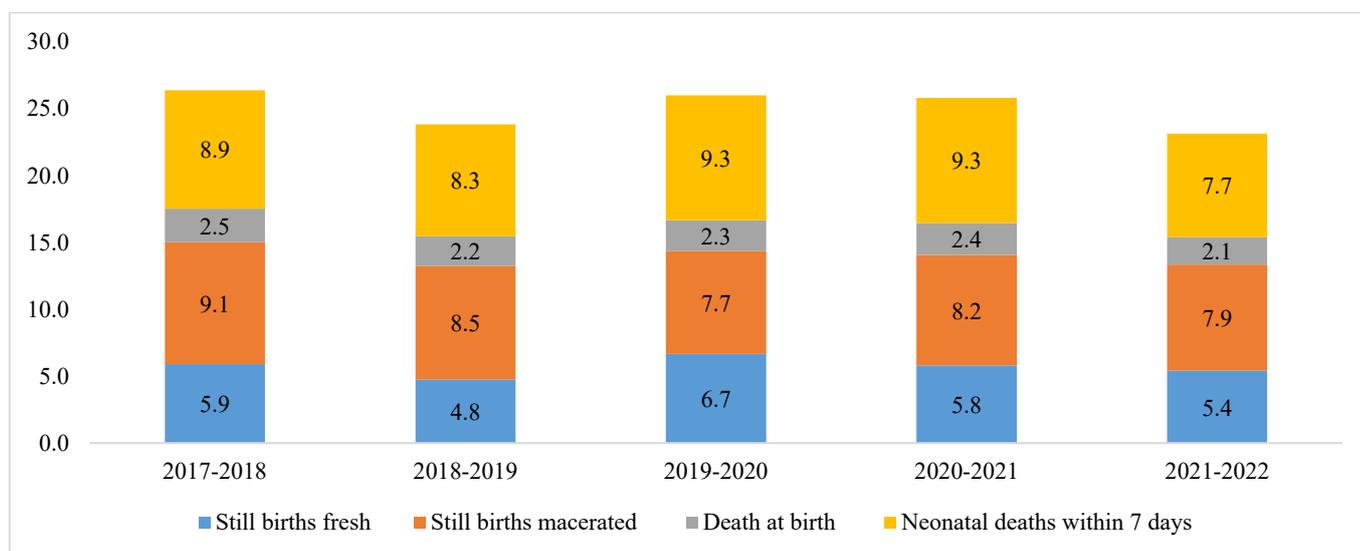


The perinatal mortality rate (PMR) includes still births and neonatal deaths. A reduction from 25 to 23 per 1000 births was noted between the two reporting periods. Furthermore, whereas six Districts had a perinatal mortality rate over 30 per 1000 births in 2020-21 only three Districts showed such rates this year.

There is a downward trend in perinatal mortality in all categories, still birth fresh and macerated, death at birth and death within seven days from 2017-18 to 2021-22 (see figure 14). The biggest and

most consistent decrease is in neonatal deaths (within seven days). There was a corresponding increase in equipment for Neonatal Intensive Care Units during this period (see Part III).

Figure 14: Perinatal mortality per 1000 births by category, 2017/18 – 2021/22



I.1.3.3 Neonatal morbidity and mortality, 2021-2022

Prematurity, neonatal infections and asphyxia are associated with neonatal morbidity and mortality; whereas asphyxia, prematurity and congenital malformations have the highest case fatality rate (CFR) (see table 3).

Table 3: Top causes of neonatal morbidity and mortality (HMIS), July 2021 – June 2022

	Hospitalized cases	Proportional morbidity	Neonatal deaths	Proportional mortality	NCFR
Asphyxia	5,297	11.4%	1,105	31.2%	20.9%
Prematurity_ 22 to 37 weeks	10,252	22.1%	1,623	45.8%	15.8%
Congenital malformation	1,411	3.0%	360	10.2%	25.5%
Neonatal infections	6,470	13.9%	324	9.2%	5.0%
Hypothermia	5,683	12.2%	3	0.1%	0.1%
Other causes of neonatal morbidity	17,348	37.3%	125	3.5%	0.7%
Total cases	46,461		3,540		7.6%

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.

Among all under 5 children received and treated in health facilities (1,873,965), 96% were seen and treated in the Integrated Management of Childhood Illness (IMCI) service facilities across the country. However, in three Districts (Kirehe, Nyamasheke and Kayonza) less than 90% children were treated in these units, the remainder received treatment through the adult health services, i.e. not using the IMCI guidelines 90:.

Figure 15: Proportion of Under 5 children treated in IMCI services of those treated in the health facilities, July 2021 to June 2022

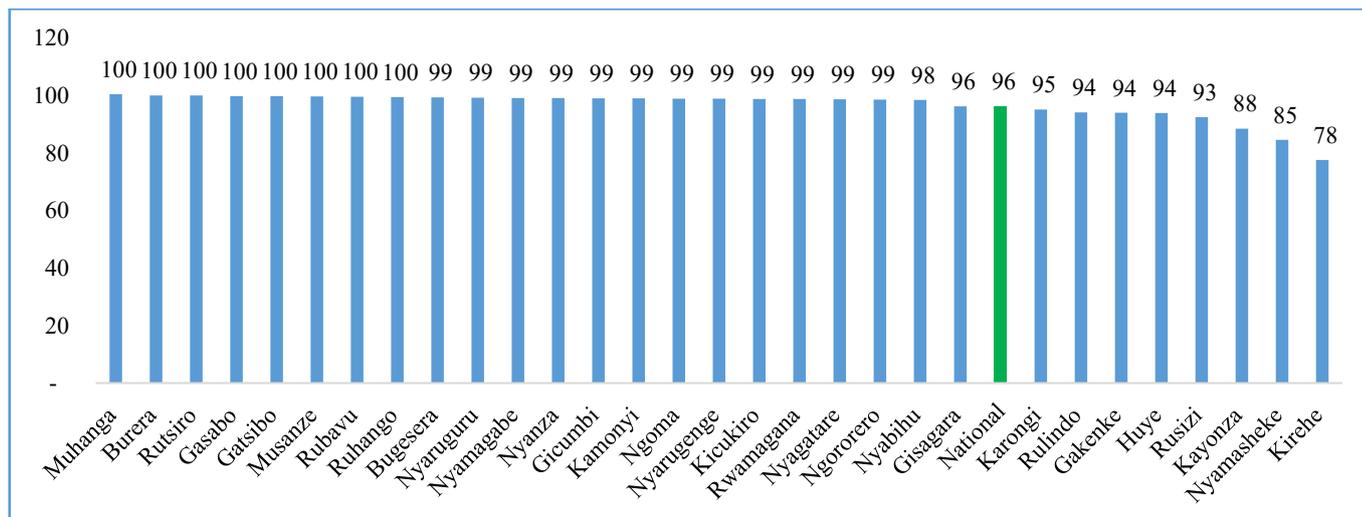


Figure 16: Trend of Under 5 children treated with IMCI services of those treated in a health facility, 2012/13 – 2021/22

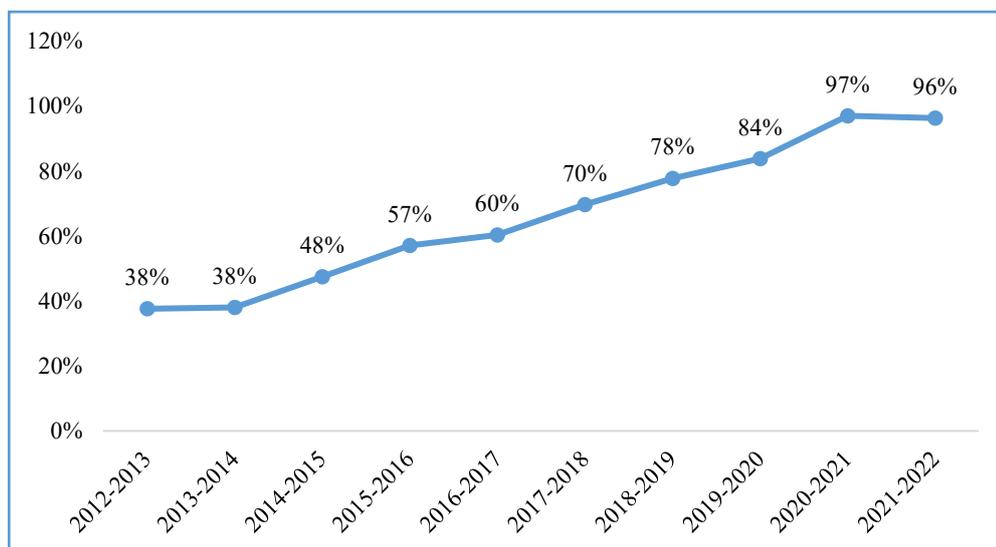


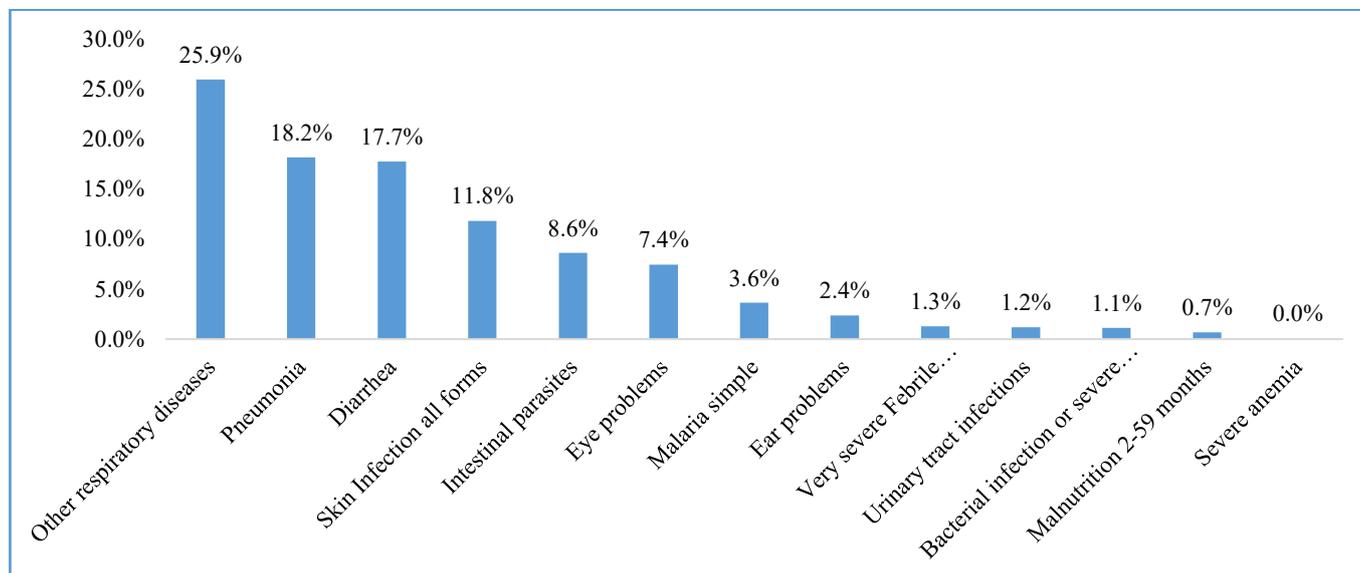
Figure 16 shows that the proportion of under 5 children who attended a health facility and were treated with IMCI services across the country kept on increasing within 10 consecutive years.

There was a 58% increase in the last ten years.

Respiratory diseases including pneumonia, diarrhoea diseases, skin infections, intestinal parasite, eye problems and malaria are the leading causes of morbidity in under five children received at health

facilities. There was an increase in the % cases diagnosed as pneumonia from 17.4% to 18.2% but a reduction in % diarrhoea cases from 18.5% to 17.7%.

Figure 17: Most common causes of attendance at health facility for children under five years of age in the IMCI units July 2021 – June 2022



I.1.4 Status of CBMNH and CCM indicators

CHWs identified 281,077 new pregnant women; 4,390 home deliveries were reported⁴ compared to 5,544 in 2020-21. Among those only 25% received misoprostol within the recommended time period and 66% were accompanied to health facility for PNC. Of the 6,712 women screened 6,069(0.4%) women were identified as malnourished (MUAC < 21 cm). Early pregnancy testing by CHWs was performed on 32,398 women of which 19,973 (62%) tested positive. (see table 4)

Table 4: Community based maternal health indicators, 2021/2022

Indicator	2021-2022
Number of pregnant women newly identified by ASM confirmed pregnant	281,077
Number of women within 3 months of pregnancy referred by ASM to ANC	226,880
Number of women referred to health center for PMTCT	252,018
Home deliveries	4,390
Number of women who delivered at home and received mizoprositol to prevent Post Partum Hemorrhage	1,094
% of women who delivered at home and received mizoprositol to prevent Post Partum Hemorrhage	25%

⁴ The reported home deliveries in 2019/20 reported in the RDHS were 5.6% compared with 3%, 2.7%, 2.6% and 2.1% reported in HMIS in the same corresponding years. Data quality reviews also identified some unreported homebirths by health workers. An assessment is planned for 2022-23 to review home delivery data.

Indicator	2021-2022
Number of women accompanied to postnatal visit within 24 hours of home delivery	2,884
% of women accompanied to postnatal visit within 24 hours of home delivery	66%
Pregnant women accompanied to HC by CHW for deliveries	212,510
Number of mothers identified with danger signs upon the visit by the Community Health Worker	1,244
Number of mothers referred to the health center for danger signs in post partum period after receiving home visits	931
Number of mothers referred to the health center after miscarriage	1,361
Number of pregnant women with MUAC < 21cm	6,712
Number of breastfeeding women with MUAC < 21cm	6,069
% of women (pregnant+ breastfeeding) with MUAC < 21cm	0.3%
Number of women tested for pregnancy by CHWs using urine pregnancy test (UPT)	32,398
Number of women tested positive for pregnancy by CHWs using urine pregnancy test (UPT)	19,973
% women tested positive for pregnancy by CHWs using urine pregnancy test (UPT)	62%

Table 5: Community based newborn health indicators, 2021/2022

Indicator	2021 -2022
All live births (including home and facility based deliveries)	259,768
Number of newborns accompanied at the health center within 24 hours after home delivery	2,911
% of newborns accompanied at the health center within 24 hours after home delivery	66%
Number of newborns who received home visits on the third day after birth	243,391
% of newborns who received home visits on the third day after birth	94%
Number of newborns who received home visits between 7 and 14 days after birth	230,176
% of newborns who received home visits between 7 and 14 days after birth	89%
Number of newborns who received home visits on 28th day after birth	30,960
Number of newborns identified with danger signs upon the visit by the Community Health Worker	2,405
Number of newborns referred to the health facility for danger signs	1,654
% of newborns referred to the health facility for danger signs	69%
Number of children under Kangaroo mother care in the village	1,986
Number of children < 2 months referred to a health facility due to danger signs	2,736

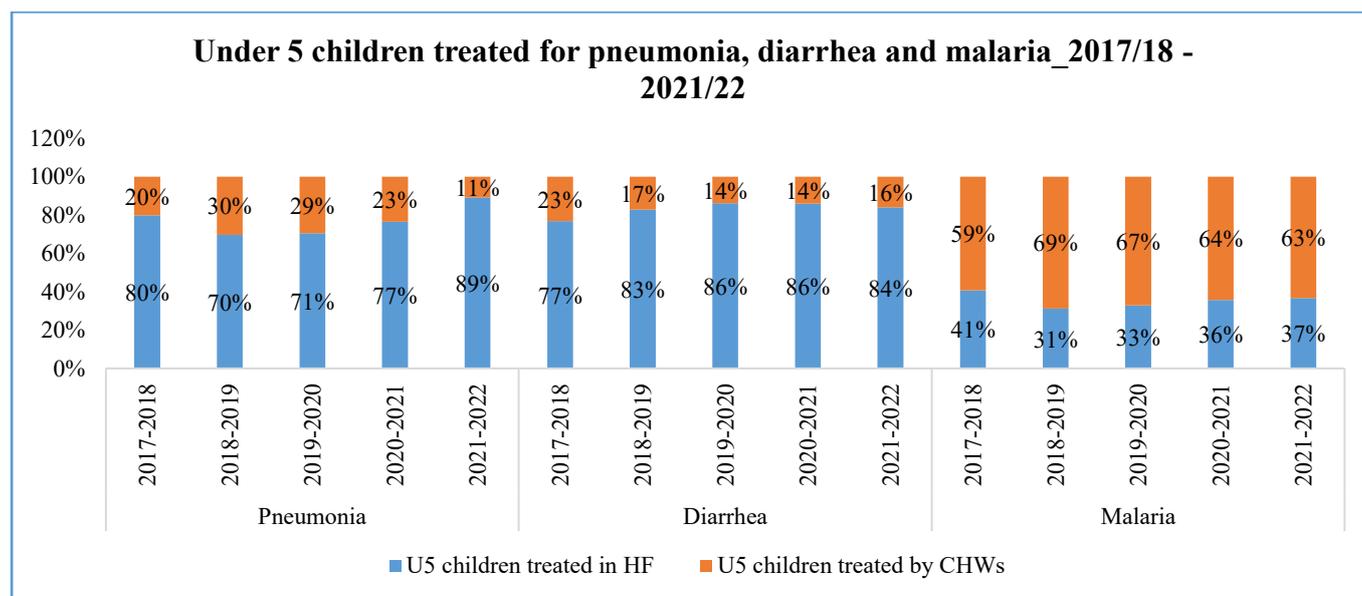
During 2021/22 FY, CHWs received 1,309,148 adults and children (see table 6) Of those presenting to the CHWs 91% had symptoms of malaria (77% were adults and children > 5 years with fever, 24% were children 6-59 months with malaria), 5% with symptoms of pneumonia and 4% with diarrhoea. Among all those cases received, 643,773 (49%) were treated at community level, others were referred to health centres for further investigations. Malaria treatment was given to 46% of children and adults received with fever, 89% were treated for diarrhoea and 69% received pneumonia treatment. Of those presenting with malaria care-seeking 90% was within 24 hours of onset of fever. All malaria cases treated had an RDT positive test.

Table 6: Integrated Community Case Management health indicators, 2021/2022

Indicator	2021-2022
Total cases received: Children and adults	1,309,148
Malaria cases (6-59 months)	312,089
Malaria cases (Adults and children > 5 years)	884,077
Diarrhea cases (2-59 months)	60,858
Pneumonia cases (2-59 months)	52,124
Total cases treated: Children and adults	643,773
Malaria cases (6-59 months)_treated	100,740
Malaria cases (Adults and children > 5 years)_treated	452,921
Malaria cases (6-59 months) presenting within 24 hrs_treated	94,649
Malaria cases (Adults and children > 5 years) presenting within 24 hrs_treated	418,140
Diarrhea cases_treated	54,390
Pneumonia cases_treated	35,722
<i>% cases treated: Children and adults</i>	<i>49%</i>
<i>% Malaria cases (6-59 months)</i>	<i>32%</i>
<i>% Malaria cases (6-59 months) presenting within 24 hrs_treated</i>	<i>94%</i>
<i>% Malaria cases (Adults and children > 5 years)</i>	<i>51%</i>
<i>% Malaria cases (Adults and children > 5 years) presenting within 24 hrs_treated</i>	<i>92%</i>
<i>% Diarrhea cases (2-59 months)</i>	<i>89%</i>
<i>% Pneumonia cases (2-59 months)</i>	<i>69%</i>
Number of RDTs (all) carried out	1,213,754
Number of RDTs (all) carried out_positive	553,350
<i>Proportion of total malaria cases received vs RDTs carried out</i>	<i>99%</i>
<i>Proportion of malaria cases treated vs positive RDTs</i>	<i>100%</i>

All CHWs are trained and equipped to provide screening and treatment for malaria, diarrhoea 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 18) for pneumonia and diarrhoea. This has been consistent for the past five years. For malaria, many children are seen and treated by CHWs though it is still at a lower level than the policy target.

Figure 18: Under 5 children treated for pneumonia, diarrhea and malaria, 2017/18 – 2021/2022



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 7. Vaccination schedule, Rwanda.

Immunization schedule		
Vaccines	Total doses	Age at administration
BCG	1	At birth
OPV	4	At birth, 6, 10, 14 weeks
DTP-HepB-Hib	3	6, 10, 14 weeks
Pneumococcal vaccine (PCV13)	3	6, 10, 14 weeks
Rotavirus (Rotarix)	2	6, 10 weeks
IPV	2	14 Weeks, 9 months
Measles-Rubella (MR)	2	9 and 15 months,

Tetanus toxoid (pregnant women)	2	During pregnancy
HPV	2	12 years old girls

1.2.1 Status of routine vaccination indicators

BCG and Polio 0 immunization coverage is calculated based on census projections for children under the age of one year based on the 2012 census. Coverages for other antigens are calculated based on BCG numbers as a proxy denominator. From July 2021 to June 2022, 93% of expected children received a BCG vaccine, 84% received polio 0, while 97% of children have been vaccinated for penta 1 and other vaccines at the same age, 96% children have been vaccinated for penta 2 and other vaccines at the same age, 95% children have been vaccinated for penta 3 and other vaccines at the same age, 92% were vaccinated for MR1 at 9 months of age and 86% have been received MR2 at 15 months of age. TT coverages stands at 91%.

As a result of the successful vaccination programme there have been no reported cases of polio, rubella or diptheria. There were 33 cases of measles hospitalised and nine deaths and four confirmed cases of neonatal tetanus in 2021-22.

Figure 19: Immunization coverage rate, July 2021 – June 2022 (Proxy denominator is BCG numbers)

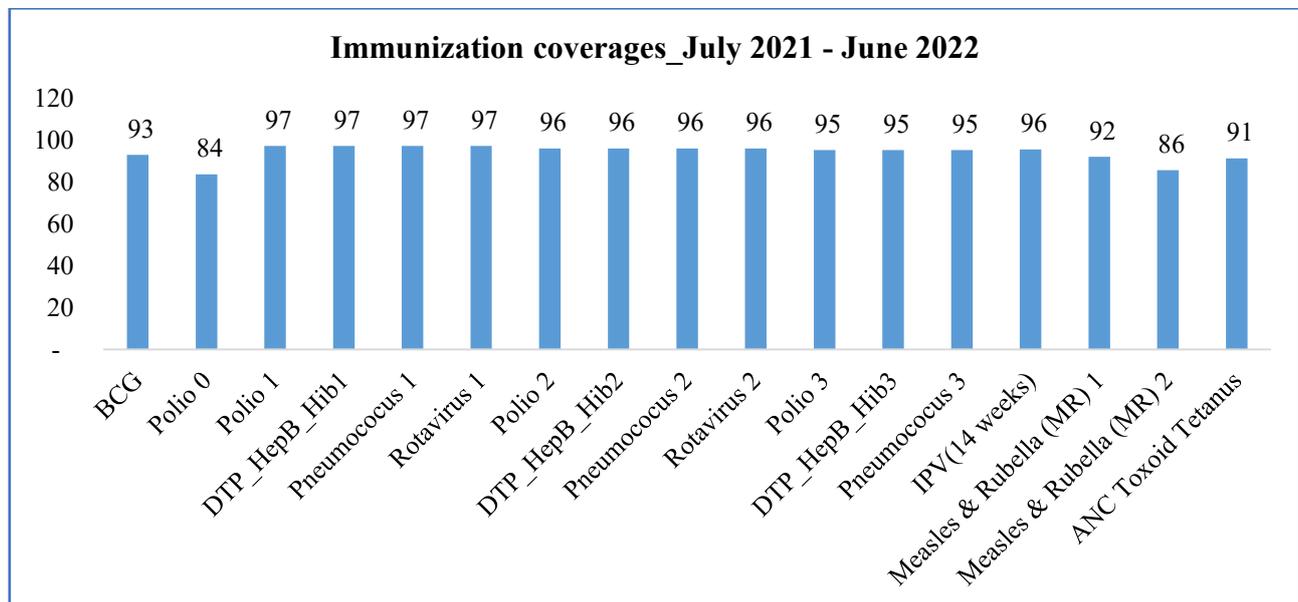


Figure 20: Trend of Immunization coverage rates, 2017/18 – 2021/22

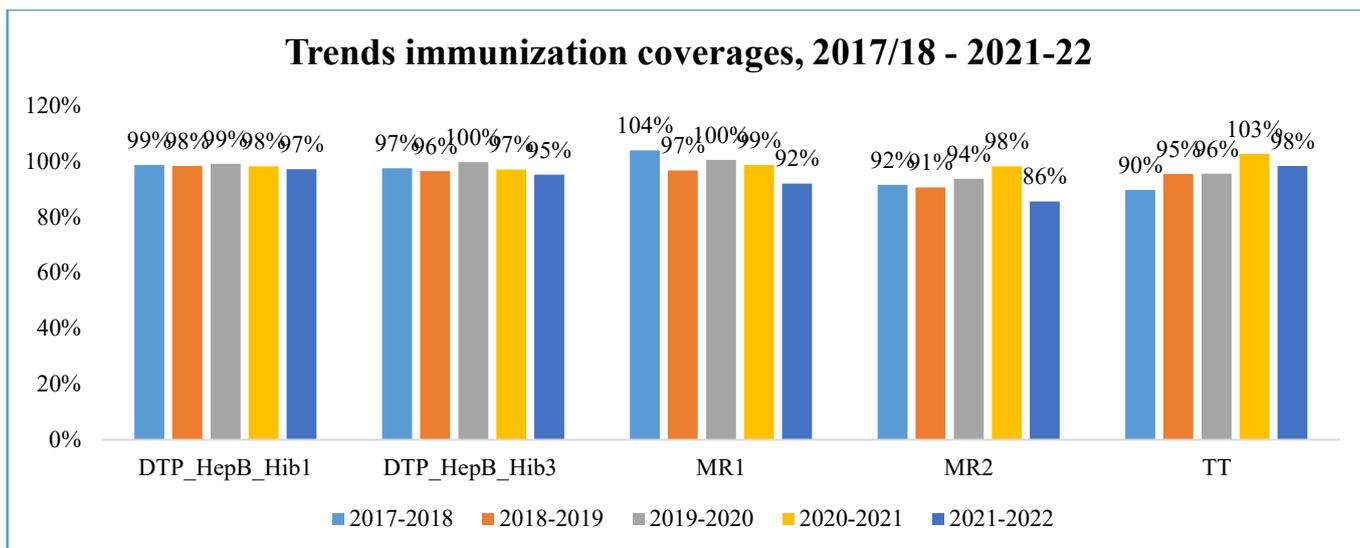
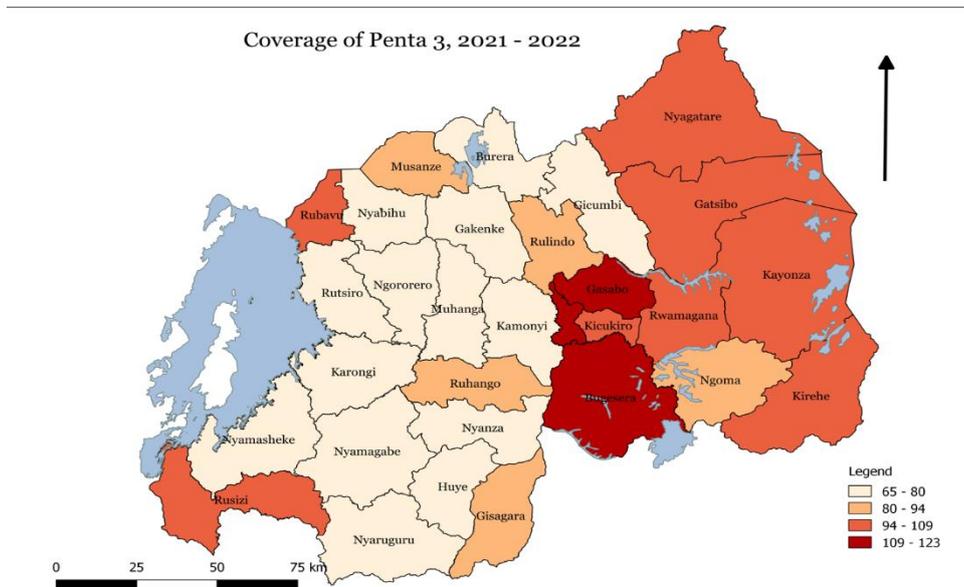


Figure 21: Penta 3 Coverage, 2021- 2022

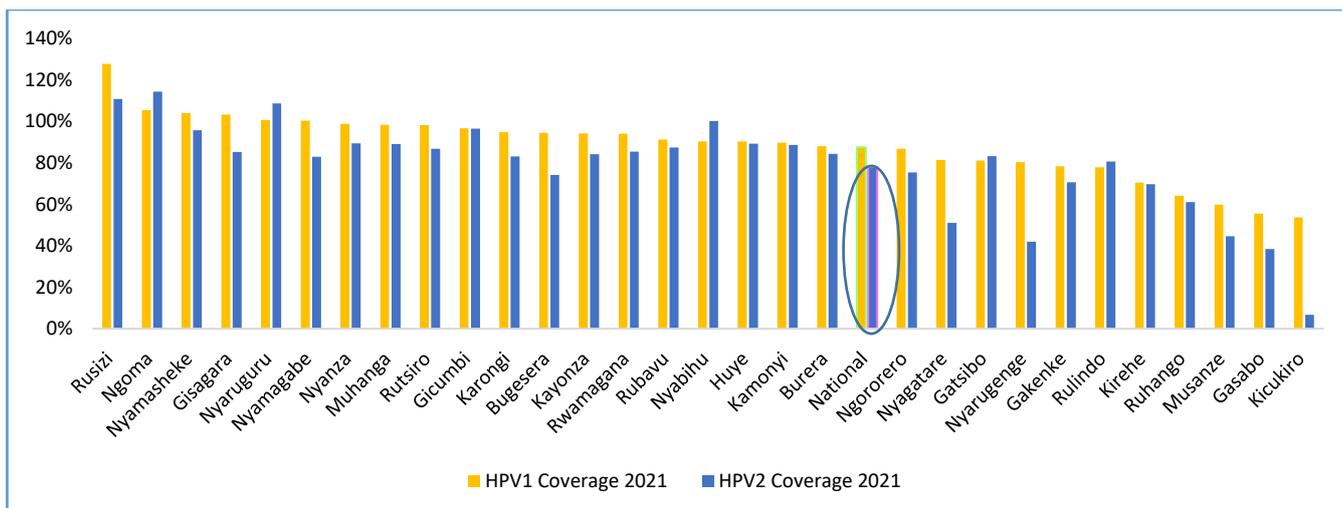


There are 14 Districts with low coverage, the majority are in the Southern and West provinces. The explanation may be linked to an overestimation of the children under one year of age, projected by the census data of 2012.

1.2.2 HPV Coverage 2021

Vaccination against the Human Papilloma Virus (HPV) was introduced in 2021 for girls aged 12 years of age. . The coverage rates are 88% for first dose and 78% for the second dose: a dropout rate of 10% between 1st dose and 2nd dose.

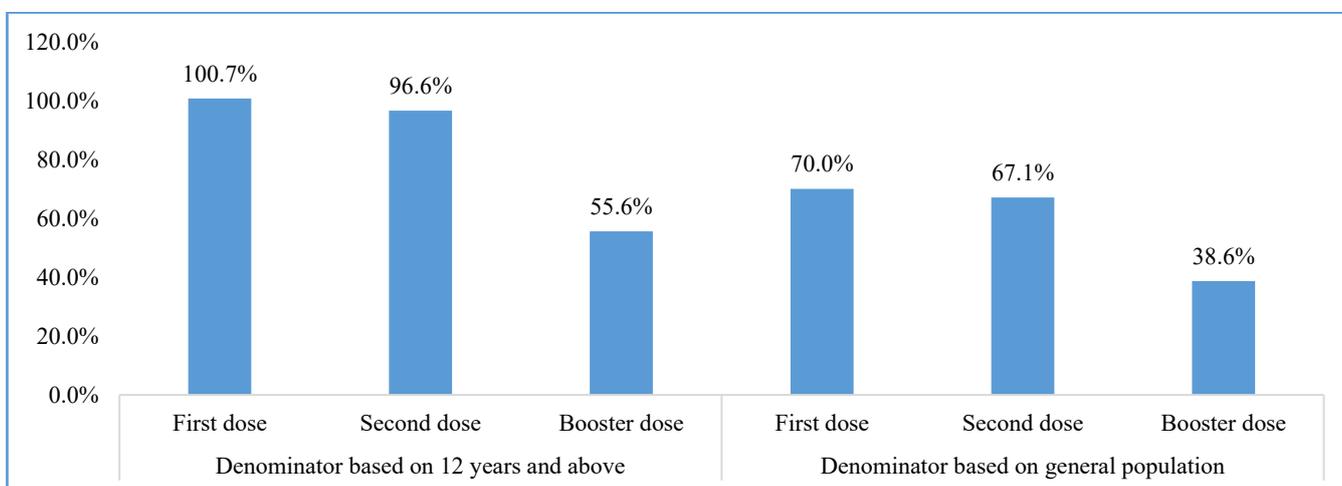
Figure 22: HPV Coverages, in 2021



1.2.3 COVID-19 vaccination Coverage

By the end of June 2022, a total number of 9,130,139 (100.7%) people had received 1st dose of COVID19 vaccine; a total number of 8,755,611 (96.6%) people had received second dose of COVID19 vaccine and 5,042,098 (55.6%) people had received a booster dose. These coverages are calculated using target population of 12 years and above. Coverages by general population are as follows: first dose is 70%, second dose is 67.1% and third dose is 38.6%.

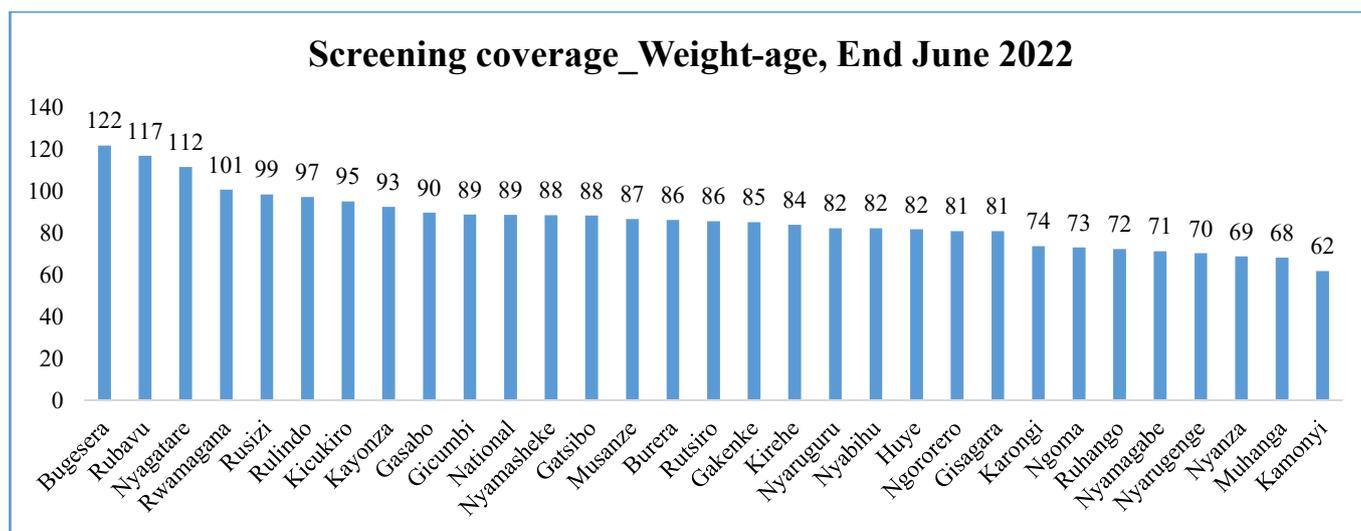
Figure 23: COVID-19 vaccination coverage by 30th June 2022



I.3 NUTRITION

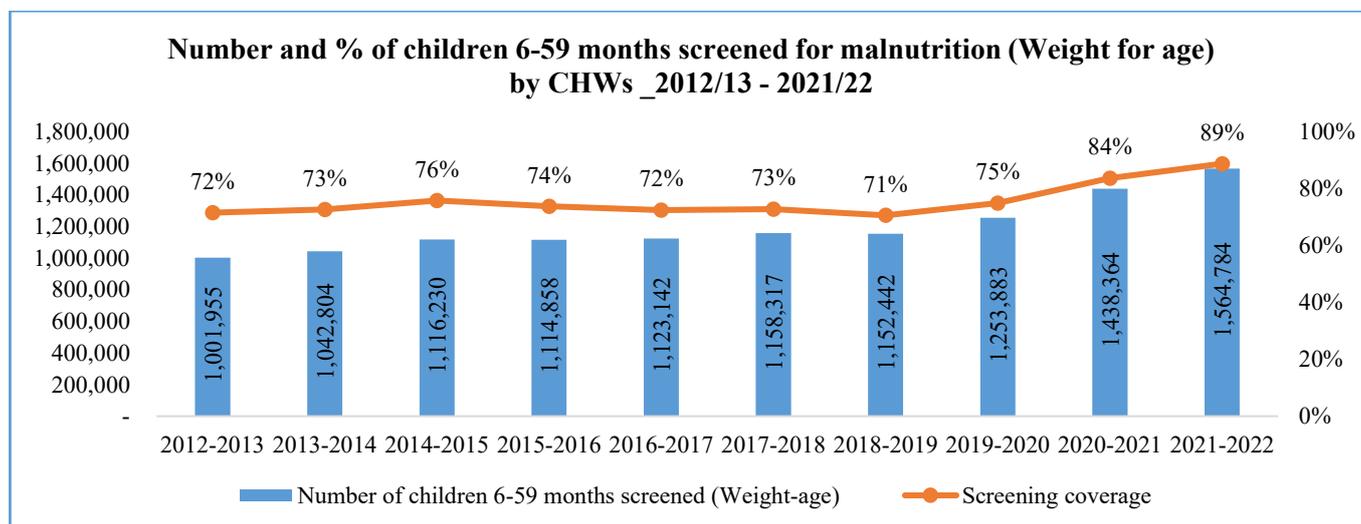
The screening for nutritional status of children under five years or age using weight-for-age measurement increased to 89% by June 2022 compared with 84% in June 2021. Coverage in three Districts was below 70% (Kamonyi: 62%, Muhanga:68% and Nyanza: 69%). Children who are screened and found to have malnutrition should be referred to health centers for nutrition rehabilitation. Coverages are lower in highly urbanized areas compared with rural areas due to the different living situations between these areas (see figure 24).

Figure 24: Proportion of expected children 6-59 months screened for malnutrition (Weight for age) by CHWs per District 2021-2022



Over part 10 years the GoR has put a focus on prevention and reduction of malnutrition across the country in under 5 children. Many interventions were brought in place and were successfully implemented in all districts. CHWs were equipped to enable them to provide good services at village levels. All these interventions resulted in an increase of 17% from 72% to 89% from July 2012 to June 2022 (see figure 25).

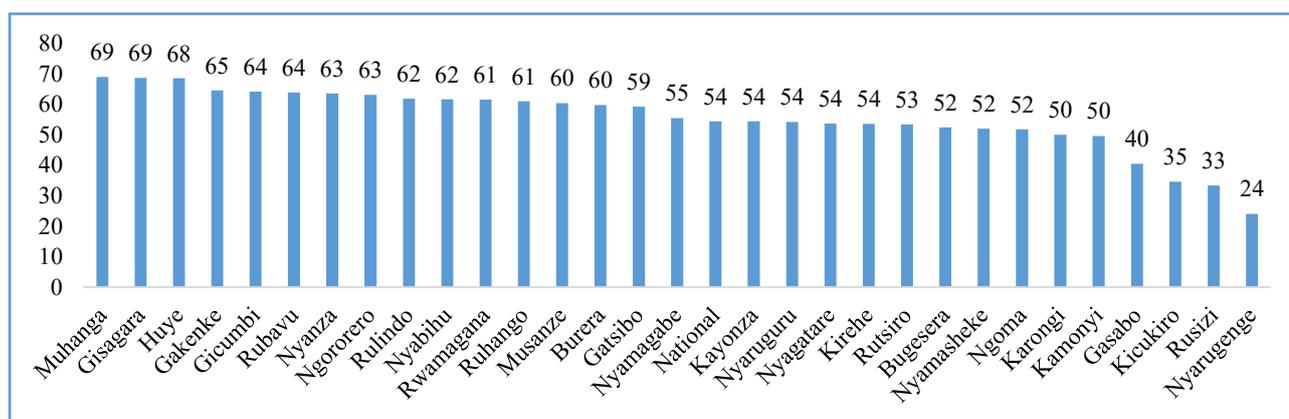
Figure 25: Trend children 6-59 months screened for malnutrition (Weight for age) by CHWs, 2012/13 – 2021/22



I.4 FAMILY PLANNING & REPRODUCTIVE HEALTH

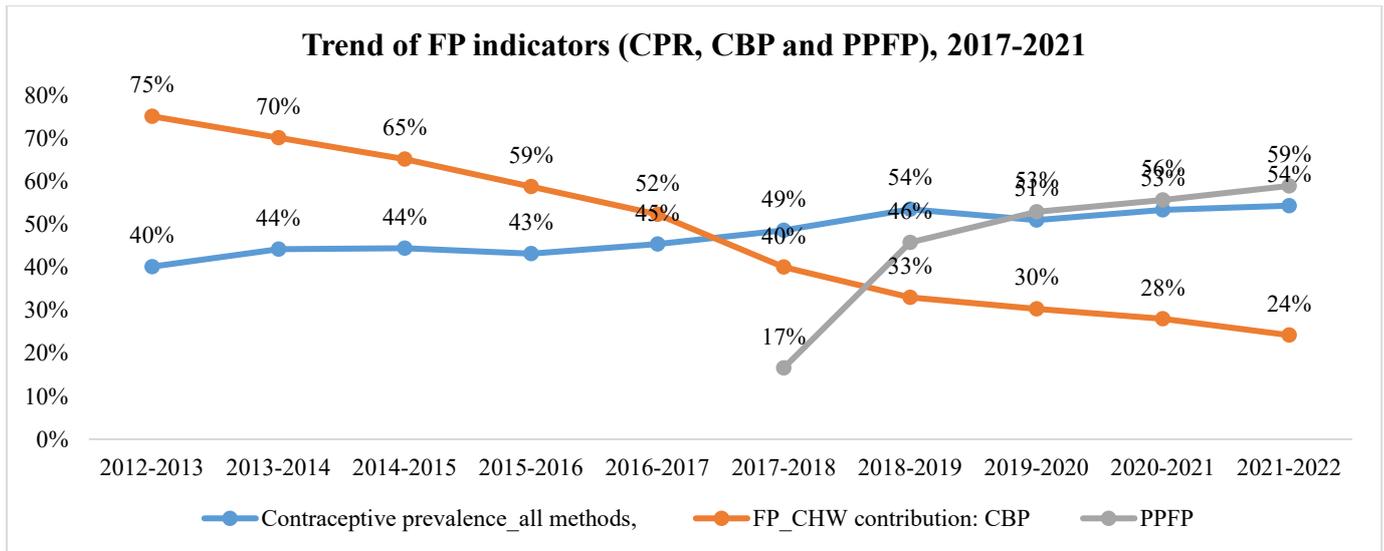
By the end of June 2022, the National average Contraceptive Prevalence Rate was at 54% for all methods combined. Fifteen districts were below the National average, and three districts Nyarugenge (24%), Rusizi (33%) and Kicukiro (35%) have a contraceptive prevalence below 40% with no improvement on the previous reporting period. The low prevalence is affected by low reporting rate of private health facilities in cities and insufficient awareness of population in those Districts. In Rusizi District in particular some faith based health facilities do not provide family planning services (see figure 25)

Figure 26: Contraceptive Prevalence Rate (CPR) (all methods) in health facilities by District/ projected women of reproductive age 30th June 2022.



The CPR, based on expected WRA, increased from 40% in 2012/13 to 54% in 2021/22. However, the contribution of CHWs in follow up of FP users decreased from 75% to 24% in the same period. The introduction of Post Partum Family Planning (PPFP) in January 2018 compensated for the fall in CHW provision of FP methods to women. The increase from 17% in 2017/2018 to 59% in 2021/2022. The result of the increasing PPFP rates and falling CHW contribution was a stagnation in overall CPR in the last two years. This is evident from the increase of 25,754 deliveries from 2020-21 to 2021-22. Further investigations and deep analysis are highly required to understand the decline of CHWs contribution in FP.

Figure 27: FP uptake (all methods) by District_HMIS 2012/13 – 2021/22



Of the women who gave birth in a health facility 59% received a FP method before discharge. PFP is highly impacted by the mobilization performed during ANC visits and in intra and postpartum education of mothers. Possible causes of low performance in PFP for different districts are that faith based health facilities do not provide FP services with modern methods and low reporting rate of private health facilities particularly in Kigali City.

Figure 28: PFP per District, July 2021 - June 2022

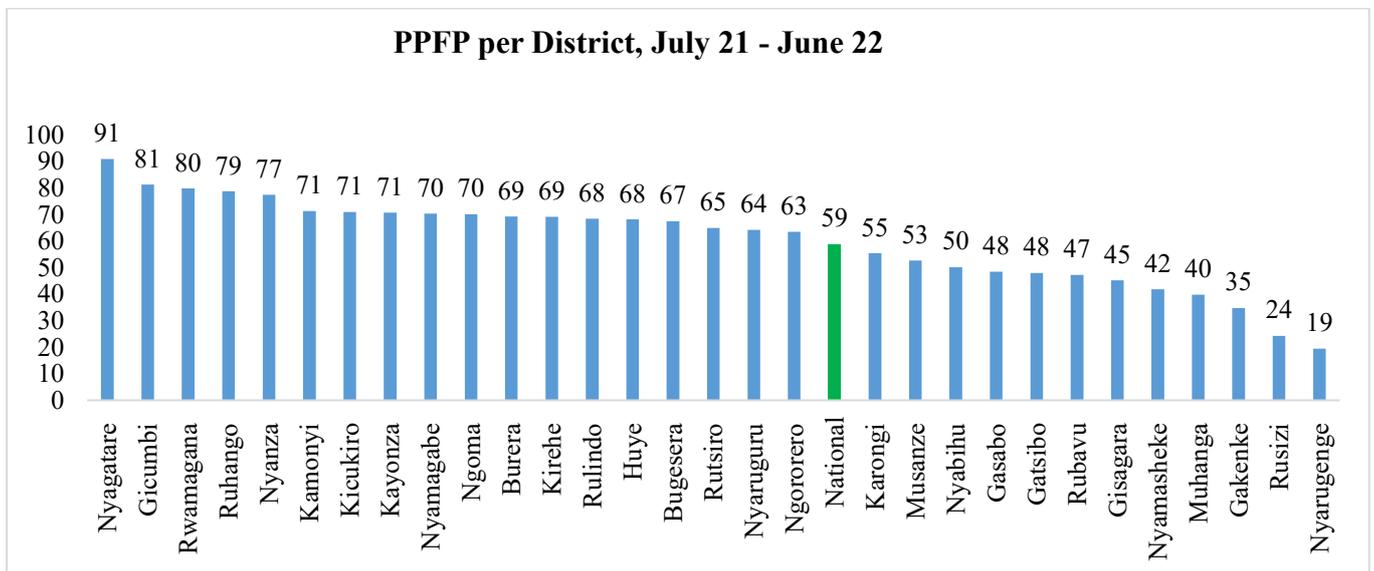
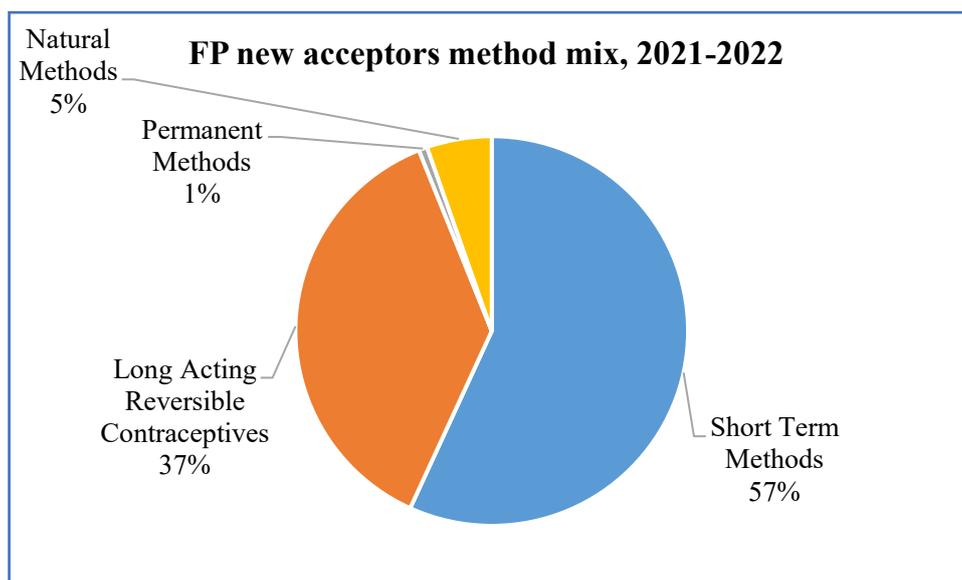


Figure 29: Couples accepting to use family planning method for the first time/ expected women aged 15-49 years 2021-2022



From July 2021 to June 2022, health facilities reported 300,854 new acceptors of family planning methods; 57% chose short term methods, 37% chose Long Acting Reversible Contraceptives (LARC), 1% chose permanent methods and

5% chose natural methods. Many clients accepted the implants (35.5%) followed by pills and injectables.

I.5 GENDER BASED VIOLENCE AND LEGAL ABORTION

In the reporting period 38,066 tl GBV victims reported to the health facilities. Of these 51% were victims of sexual violence, 40% victims of physical violence . Of all victims 44% were under 18 years of age (see figure 29 and table 7).

Figure 30: GBV cases reported by type and age group, 2021/2022

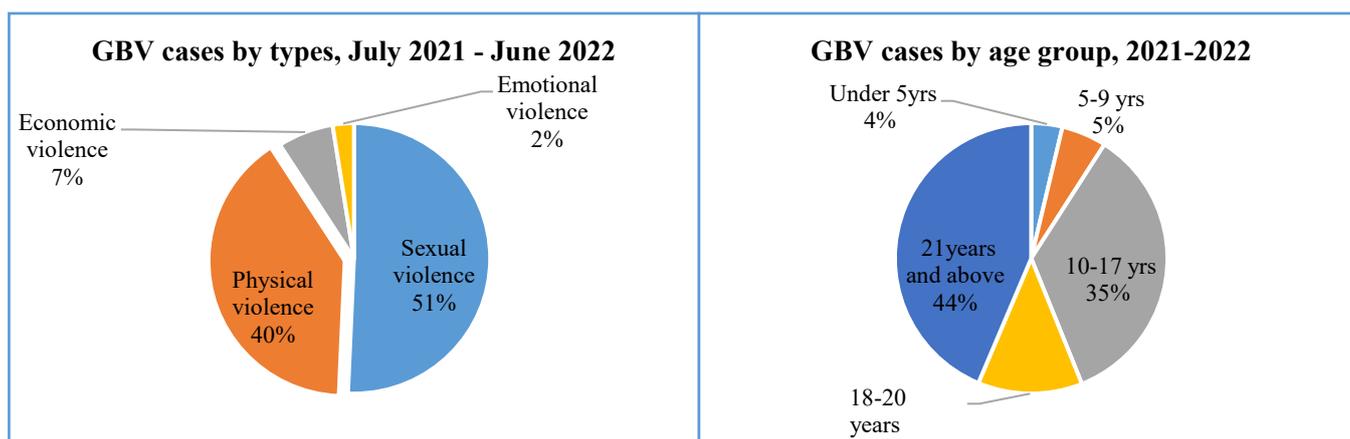


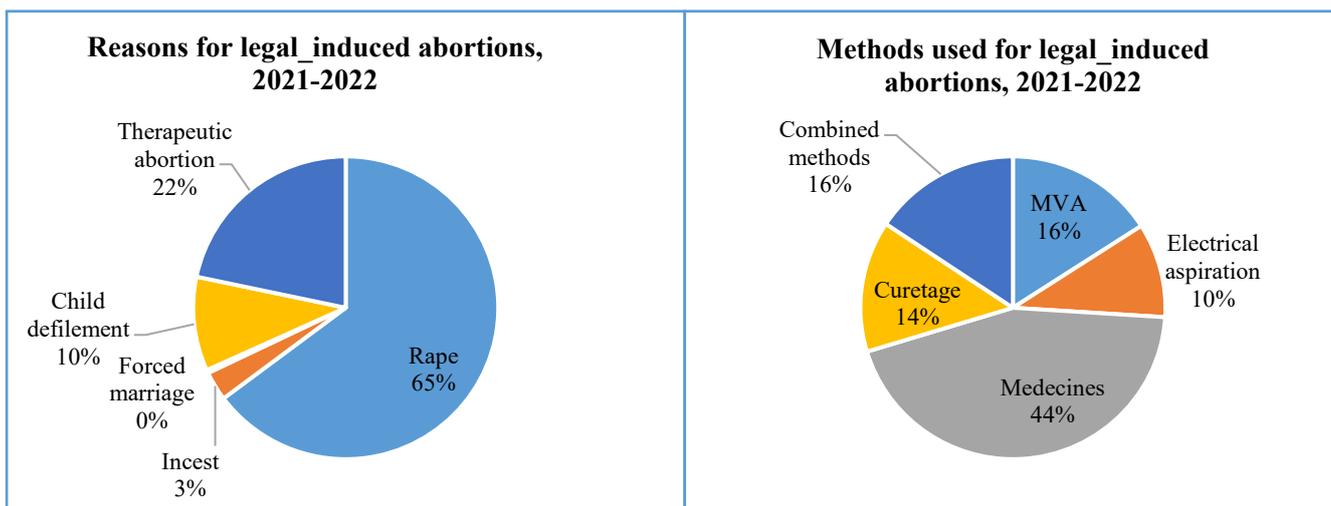
Table 7: Other GBV important informations_ July 2021 to June 2022

	2020-2021	2021-2022
Total GBV victims	33,636	38,059
GBV victims with symptoms of physical violence	40.5%	40.2%

<i>GBV victims with symptoms of sexual violence</i>	52.4%	50.7%
<i>GBV Victims with economic violence</i>	5.5%	2.5%
<i>GBV Victims with emotional violence</i>	1.5%	6.6%
<i>Female GBV victims</i>	88.3%	89.0%
<i>Male GBV victims</i>	11.7%	11%
GBV victims referred to this facility by RIB	55.7%	48.6%
GBV victims referred to this facility by community health workers	7.4%	9.7%
GBV victim Deaths	43	27
GBV victims with irreversible disabilities due to GBV	70	113
GBV victims HIV+ seroconversion 3 months after exposure	72	106
GBV victims received emergency contraception within 72 hours	2,912	2,979
GBV victims received post exposure HIV prophylaxis within 48 hours	3,825	3,798
GBV victims referred for care to higher level health facility	3,395	4,684

A number of 1184 abortions were legally induced. The main reason for seeking safe abortion was rape at 65%, 22% for therapeutic abortion and 10% for child defilement. 44% of safe abortions were performed with medicines, 16% were done by medical and surgical methods (combined).

Figure 31: Legal abortions: Reasons for legal abortions and Methods used, 2021-2022



I.6 STRATEGIC INFORMATION

I.6.1 Routine data systems

All Maternal and Child health programs are reported through DHIS and use standard data collection tools. The completeness and timeliness during the reported period was 97 % and 88% 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 heads of health centres. MCCH conducted regular data quality check using WHO data quality tool to identify outliers and inconsistency and provided feedback to data managers of health facilities. **Weekly data use sessions** with individual programmes allowed data inconsistencies to be easily identified by each programme. The programmes were able to identify actions to improve both data quality and key indicators. The meetings will continue in the coming FY.

Use of the WHO outlier tool was promoted in various sessions both ad hoc and in formal workshops. All district data managers were trained. Training of Health Centre data managers will be the focus for next year. Data managers from 7 districts were trained on the use of WHO data quality tool and M&E officers from all districts were trained on MCCH indicators data collection reporting and analysis using DHIS2.

The **‘other’ direct and indirect obstetric complication** data element contained a high proportion of entries. Efforts were made to better understand these entries and make corrections as appropriate.

MCCH M&E team conducted **data quality review** visits in 59 health facilities including 13 hospitals and 46 health centres Ngororero, Gatsibo, Nyanza, Ruhango, Muhanga, Gicumbi, Huye, Gisagara, Rutongo districts. The objectives were to cross-check the HMIS reported data versus data sources, Conduct a triangulation for some correlative data elements, discuss with health care providers on possible reasons for discrepancies, propose the recommendations to address the gaps identified. The findings showed a low level of data discrepancy for Deliveries at health facilities (0.4%), DTP_HepB_Hib3 data (2%), Sexual GBV indicators (5%). For family planning (FP) indicators, data discrepancies were found in almost all health facilities visited. Reasons for data discrepancy identified include: 1. FP client files are not updated regularly, clients do not have files, 2. FP clients who have stopped using a method are not recorded in the FP register: Some clients are not removed on report while recorded as ‘stopped’ in register and files 3. Follow up visits are not recorded in FP registers, 4. Nurses in charge of FP service are not given enough time to work in FP service, 5. Poor archiving 6. incompleteness of register, 7. some women received methods without elaboration of FP File, 8.

health facilities do not use echeanciers. It is recommended to speed up the digitization of FP reporting system.

1.6.2 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. 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 analyzed 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.

An assessment by the **Auditor General** requested for a plan of action against its key findings. This included an increase in vacuum assisted delivery through capacity building, mentorship and procurement of supplies and equipment.

Researches conducted

1. Rapid Emergency Obstetric and Newborn Care (EmONC) Assessment 2021

Rwanda conducted a rapid, but comprehensive, Emergency Obstetric and Newborn Care (EmONC) assessment in 2021; while the first was conducted in 2004 in few districts. The primary aim of the 2021 EmONC assessment was to generate evidence on the current availability, utilization, and quality of EmONC services in the country.

The assessment provides insightful information on the availability of infrastructure, equipment, essential drugs, and supplies; the range of practices related to user fees; availability and current EmONC practices of human resources; insight into quality of clinical monitoring and management of caesarean deliveries, Comprehensive Abortion Care (CAC), and newborns with complications; geographic availability of critical services; status of routine and emergency obstetric and newborn services; availability and use of records for MNH services; and the referral system

The assessment was a national cross-sectional census of public and private hospitals, health centers, Poly clinic centers, and clinics that had a minimum of 20 deliveries per month in the 2020 and 2019 HMIS data. Health posts that had a minimum of 15 deliveries per month were also included in the assessment. The assessment used abridged versions of Averting Maternal Death and Disabilities (AMDD's) recent EmONC assessment tools (Modules 1 to 5) plus case review modules of cesarean delivery, CAC, and newborn morbidities (newborns with breathing difficulties, low-birth weight babies – less than 2000 grams, and young infants with infections < 60 days).

A total of 444 hospitals, health centers, Poly clinic centers, clinics, and health posts with the above-mentioned criteria of minimum births per month were visited and included in the analysis. A team of 15 with two data collectors per team (total 30) with a minimum qualification of health background at Diploma (with 2 years of college education) level served as data collectors and supervisors. The data collectors and supervisors received a five-days training and they worked in teams of two with one of them serving as a team leader. Data collection had begun in mid-April and ended in mid-June 2021.

Objectives of the assessment: The overall objective of this EmONC assessment is to generate evidence on availability, utilization, and quality of EmONC and routine delivery services and to provide benchmarks to monitor EmONC services for improving quality of care in Rwanda

The results of this study will be published in the next FY.

2. A qualitative study exploring women's, men's and providers' perceptions and motivators for intention to use, recommend or provide intrauterine contraception including Hormonal-IUD

This research aimed to respond to following questions:

- What are the key barriers and motivators that influence the uptake of contraception based on the perspectives of women, men, and providers in Rwanda?
- What are the key product attributes of the hormonal IUD that are most appealing or unappealing to women (and male partners) at different stages in their reproductive lives?
- What are the potential enablers and barriers to integrating hormonal IUD into contraceptive provision based on the perspectives of family planning providers in Rwanda?

Key Findings:

The study established several demand (client) and supply (provider and health system) related enablers/facilitators and barriers to the uptake of family planning in Rwanda.

- The main supply-related facilitators of family planning use in Rwanda included: The availability of family planning commodities, supplies, teaching aids and reporting tools; The various modes of accessing family planning services
- The key client-related barriers included: Lack of support for use of family planning by men, Lack of autonomy in decision making on family planning use among women, Side effects and misconceptions about family planning
- The main supply-related barriers included: Low motivation among the CHWs to family, Poor quality of counselling and limited counselling time by health providers, Providers bias towards their preferred methods, Inadequate staffing and high workload, Inadequate appropriate sterile environment and equipment for IUD insertion and removal, Stock out of commodities

These facilitators and barriers were found to also affect the uptake of H-IUD in Rwanda possibly. However, there was an overall acceptability of the H-IUD due to its attractive profile including safety profile and quick return to fertility on removal. Clients rated H-IUD favourably and expressed desire to know more about the method and possibly choose it as a preferred method of family planning. There was varied opinion on who the potential clients for H-IUD would be; with health providers and clients agreeing that women of high socioeconomic status and those living in urban areas are likely to use it due to ease of access, affordability, and their levels of education. Poor women, especially those with many children and those who have experienced failure while using another method were also noted as potential users of H-IUD. The key questions raised by clients included the side effects, comparison with copper IUD and were satisfactorily answered. Health providers emphasized on the importance of training on H-IUD for better understanding and allow them to improve counselling on the method.

Based on the findings of the study, recommendations are the following: restore at health facilities an environment that is client friendly by availing at least 2 staff fully dedicated to solely provide family planning services; the program should ensure that the staff at family planning service is well trained, and their knowhow is constantly updated, regarding the tools and equipment to use as well as the biology of those whose bodies they touch; the FP program in collaboration with partners should design radio and TV program spots that target various layers of adults in reproductive age, explaining and discussing various methods and enlightening people's next choices; Institute a forum whereby various family planning program stakeholders biannually meet to evaluate and plan the next steps towards « Good Health and Well-being goal »; Involve men in family planning.

3. Family Planning Spending Assessment (FPSA)

FPSA is a new methodology designed to track FP expenditures to allow global comparisons, it uses standardized methods to reconstruct all the financial transactions related to the FP program. FPSA undertakes a comprehensive inventory of all resources (financial and non-financial) addressed to FP and trace the expenditure flow of FP related services at national and sub-national level. This is the second study applying FPSA methodology in Rwanda. The main objective of FPSA in Rwanda is to determine what is disbursed or spent in a country for FP in Rwanda during the FY 2018/2019, to evaluate expenditures and track financing flows from its sources to the providers.

The finding from this FPSA show that the total family planning expenditures in Rwanda amounted to RWF 15,267,052,885 (US\$ 17,315,473) in the fiscal year 2018-2019, the government FP expenditures was estimated at RWF 3,218,886,894 (US\$ 3,650,773) and accounted for 21.1% of the total FP spending. More than half (63%) of GoR spending in FP went to public outpatient care centers (health centers and posts), followed by departments inside the MOH & RBC (29%). The level of Government expenditures on contraceptive commodities remains very low. No transaction on contraceptives was made in the FY 2018/19. There was a remarkable overall increase in FP spending in Rwanda in FY 2018-19 compared to the fiscal year 2006-2017. However, the FP program is heavily funded by external resources.

Recommendations

MCCH Division/ RBC and its stakeholders should continue to play a critical role in advocating for increasing domestic resources for FP program and for contraceptive commodities & supplies, ensure that FP program has its own budget line and mobilize additional resources to support research and advocacy activities due to significant funding gaps. Produce FPSA evidence regularly in order to track improvements and gaps in FP funding and inform progress and future alignment as well as resource mobilization efforts.

4. Improvement of neonatal and maternal outcomes at CHUB using a multi-method approach

An evidence-based, hospital-wide project to improve maternal and neonatal outcomes was designed at CHUB Teaching Hospital. The research protocol, consisting of 25 sub studies, received ethical approval. The findings of the observational sub study indicated that staff time was used for paperwork (22%), indirect care (22%) direct patient care (39%) and time between activities (17%).

Recommendations: Short term

Within resources	<ul style="list-style-type: none"> • Temperature control by monitoring the thermometers, keeping doors and windows closed. • Review and, if necessary, revise the practice of immersion bathing for sick and very premature babies. Taking axillary temperature of babies before and after bathing. • Blood cultures of all admissions to control for sepsis. • Allocate one of the CPAP machines to the operating room, train nurses or allocate a nurse from NICU to be present at birth of premature baby. This also applies to the delivery room. • Use of mentorship programme to improve the care, preparation and transfer of sick neonates from District Hospitals. • Temperatures of neonates taken on admission to monitor the care of neonates after birth to admission to NICU. Continue discussions with maternity unit and follow up on recommendations of briefing session including using KMC for transfers. • Encourage contact with parents including fathers even with sick neonates. • Closer, systematic communication system with District hospitals for appropriate transfer of neonates.
Needs resources	<ul style="list-style-type: none"> • Install room thermometers that send alarm if the temperature drops below 22 degrees. Add hinges that allow doors to swing shut. • Provide food (or vouchers for canteen) and clean water to all mothers at KMC. • Install a TV in NICU and source education materials from Partners in Health. • Consider conducting post-mortems for babies when cause of death remains undetermined in a teaching hospital. • Replace temperature probes or radiant warmers that are not working.
Long term	<ul style="list-style-type: none"> • A new fully equipped NICU unit that includes living quarters for mothers, isolation unit, and KMC with dining and sanitation and show facilities.

PART II: IMPLEMENTED ACTIVITIES UNDER MCCH DIVISION 2021-2022

2.1. Maternal, Newborn and Child Health

- ✓ ***Capacity building of healthcare providers on maternal and newborn health, related interventions:*** 10 health care providers (nurses and midwives) from 3 Health Posts (Mishungero, Cyanyirankora and Ruhinga) were trained on Emergency obstetrics and neonatal care (EmONC); 18 health care providers (5 medical doctors and 13 nurses) from 3 Districts (Rusizi, Nyamasheke and Karongi) were trained on obstetric fistula prevention and screening for providers; 48 matrons of maternity in all public hospitals across the 30 Districts were trained on on safe abortion and post abortion care with integrated family planning; 102 health care providers from Musanze, Nyabihu, Rusizi and Nyamasheke Districts were trained on basic obstetric ultrasound; 32 health care providers from Gahini District hospital were trained on IMCI/ICATT; 64 health care providers (medical doctors and nurses) from 7

Districts (Nyarugenge, Rulindo, Gakenke, Gisagara, Karongi, Nyamasheke and Rusizi) were trained on Emergency, Triage, Assessment, treatment Plus Admission ETAT+

- ✓ ***Distribution of medical equipment and other tools:*** 10 incubators, 35 anesthesia machines, 23 basic obstetric ultrasound machines were distributed to hospitals. However, 50 more ultrasound were purchased for Rusizi and Nyamasheke but still in pipeline, not yet received.

2.2 Vaccine preventable diseases program

During the reporting period, much effort was focussed on COVID-19 vaccine deployment activities, routine vaccination, catch up for Inactivated Polio Vaccine (IPV) and Maternal Child Health (MCH week).

1. COVID-19 vaccination activities and evaluations

COVID-19 Vaccination: COVID-19 vaccination is ongoing. Vaccination sites were set up in all health facilities/ sites countrywide. The WHO target of 40% population fully vaccinated was achieved by December 2021 and reached 67% by June 30th 2022 using projections from the census 2012 as a denominator. Booster doses were given to 38.% population. Coverage rates for people over 12 years were higher at 96.6% fully vaccinated and 55.6% having received a booster dose. While Rwanda experienced two additional ‘waves’ of high incidence during the reporting period, from 11th March to 30th June 2022 no deaths from Covid19 were reported.

NDVP and Intra Action Review (IAR): The revision of the National Deployment Vaccine Plan and the Intra Action Review allowed for adaptation of the vaccine strategy to increase vaccine coverage. The document was elaborated on during a workshop to identify best practices, challenges and adapt the NDVP accordingly.

Covid-19 delivery support (CDS) application: The CDS Needs-Based Funding application was applied and used to develop funding requests, planning, vaccine delivery, rollout, and monitoring activities of COVID-19 vaccination. Sufficient supplies of vaccines, vaccine devices and were

Vaccine safety monitoring and management of AEFI and injection safety: A surveillance system was set up within the existing AEFI surveillance for Covid 19 vaccinations. All adverse events were investigated.

2. Routine immunization activities

Routine vaccinations for children under five years of age were provided as per programme (see table 10).

Catch up IPV Campaign

Rwanda introduced Inactivated Polio Vaccine (IPV) first dose in March 2018 to reduce the number of polio cases transmitted through the live polio vaccine. Campaigns were conducted in September 2021, March and April 2022 in 30 Districts, and during Mother and Child Health (MCH) week, for children who did not receive this vaccine with a coverage rate of 78.69% (using census projections as denominator). An evaluation was conducted in June 2022. No cases of polio were reported in 2021-22. Eradication status was granted and Rwanda continues Acute Flaccid Paralysis surveillance (1 case of AFP in 100,000 children under 15 years) to maintain this status.

Supervision was conducted on use of immunization e-tracker, COVID-19 vaccines cold chain assessment, planning and conducting vaccination sessions, vaccine stock management and quality of vaccination data. Key challenges were identified and recommendations made. COVID-19 activities disrupted the supervision activities in some Districts.

National Immunization Strategy: A new vaccination strategy was developed and finalised in December 2021. Costing of the report will be conducted in 2022-23.

E-tracker system introduced: E-register (e-tracker) was introduced to record all vaccinated children and their demographic information with the objective of reducing dropout, for ease of follow-up of defaulters and data analysis, to reduce printing costs, and to strengthen other related programmes, such as growth monitoring.

Score cards: Scorecards were introduced to strengthen data use and evidence-based decisions across all levels of the health sector including visualization, data analysis, and monitoring. Hospital EPI supervisors were trained on the Scorecard and equipped with the required skills to use Bottleneck analysis and Action tracker.

Reaching Every Child (REC) micro planning: Training in REC Micro plan was organized in 23 District (260 health centers 435 health providers).

Joint appraisal: A joint review was held to discuss the vaccine implementation progress and performance. Key priorities and activities for the coming year were determined.

Performance-based Financing (PBF) indicators were revised to include Community Health Worker indicators.

Meetings: The following meetings were held during the year: Interagency Coordinating Committee (ICC), National Immunization Technical Advisory Group (NITAG), Adverse Effects Following

Immunization (AEFI), EPI data review. The VPU was represented on the RBC Scientific Advisory Group and presented vaccine strategy data during the meetings.

3. Supply chain for vaccines cold chain management

Covid related: Monitoring the installation and preventative maintenance of cold storage equipment. Continuous monitoring of temperatures of cold chain equipment were possible through wireless. During 2021- 2022 routine immunisation costs were USD 1,371,648 (57% Government/ 43% co-funding). The stock levels are presented in tables xx for routine vaccines and xx for non-routine vaccines.

Table 9: Status of routine vaccines stock management

	BCG	bOPV	IPV	Pent.	Pcv13	Rota	MR	TT	HPV
B/F	580400	100528 0	423600	943260	520600	57420 0	52560 0	60320 0	24272 0
Vacc. received	500000	900000	183640 0	111950 0	145540 0	35550 0	50000 0	60000 0	18730 0
Distributed	583800	153090 0	165410 0	104900 0	106360 0	77810 0	75464 0	54882 5	26446 0
Balance June 2022	496600	144380	605900	101376 0	912400	15160 0	27096 0	65437 5	16556 0
Qty Period in/M	10.2	1.0	4.4	11.6	10.3	2.3	4.3	14.3	N/A

Table 10: Status of non-routine vaccines stock management

	HepB1 0	HepB 1	Yellow F	Antirabies	MMR
B/F	155450	0	12000	1000	50000
Vaccine received	0	10000	20000	0	0
Distributed	134130	0	9000	1000	50
Balance June 2022	21320	10000	23000	0	49950

Vaccine forecasting, procurement and distribution: Vaccines and vaccine materials forecasting is annually basis with shipments twice per year. UNICEF initiates procurement activities in accordance

with the valid memorandum of understanding between Ministry of Health and UNICEF. Currently, the EPI purchases 12 antigens in routine immunization including: BCG; DTP-HpB-Hib, bOPV, Rotavirus vaccine, MR, TT vaccine, PCV-13, HPV, IPV (see table x) and non-routine vaccines include Rabies vaccine, Yellow Fever vaccine, HepB vaccines (see table x).

Impact of routine vaccination

The impact of the vaccination campaign can be monitored by the number of reported cases and deaths of the targeted diseases.

Polio: No cases of polio were reported in 2021-22.

Neonatal tetanus: There were five *unconfirmed* cases of neonatal tetanus reported in 2021-22 in Kayanza, Kicukiro, Nyagatare (2 cases) and Rusizi Districts

Non-bloody diarrhoea deaths (including Rotavirus):

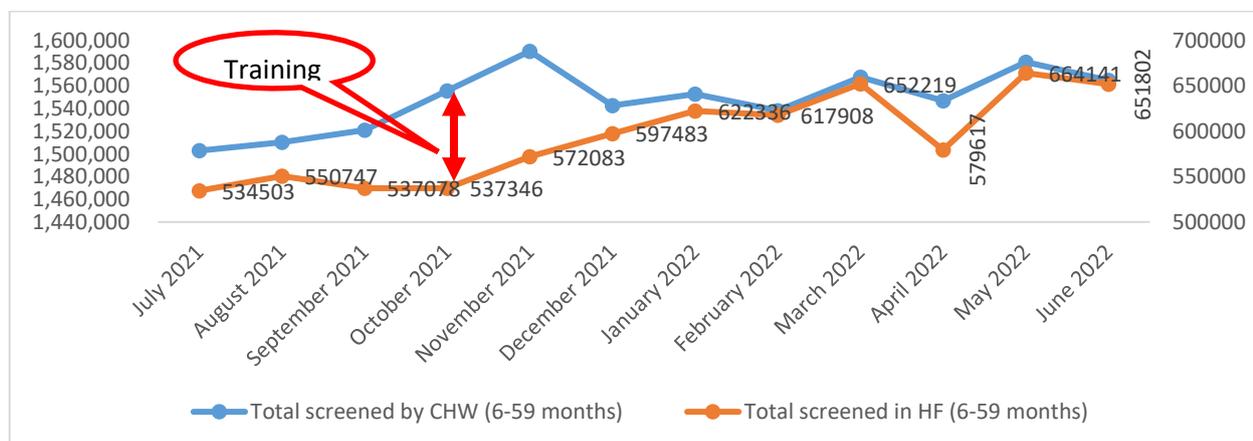
2.3 Community health

The Community Health Programme conducted activities in the areas of nutrition, adolescent and sexual reproductive health, community based provision including introduction of the new polyvalent model and supply chain.

Nutrition activities included: A. Trainings on Nutrition measurement (1,064 health providers) and nutrition package (123 health centre in charge); B. Workshops conducted 1. to disseminate the additional guidelines for prevention and management of moderate acute malnutrition and 2. to review the performance of nutrition indicators; C. Supervision of SAM management and nutrition interventions conducted in health facilities and Communities nationwide.

The training on nutrition measurement resulted in an immediate increase in growth monitoring in the communities across Rwanda (see figure 31 below).

Figure 31. # children ages 6-59 months screened for malnutrition (weight for age) by CHWs and in Health Centres (July 2021- June 2022).



Adolescent and sexual reproductive health activities included A. Conducting ASRH supervision in Rulindo and Gakenke Districts B. Conducting ASRH mentorship in 62 Barambe supported Health Centres in September 2021, 50 PIH supported Health Centres in September and December 2021 and 20 Ingobyi supported Health Centres on a continuous basis. C. Training of 678 healthcare providers on the integrated adolescent health training manual between January and May 2022 D. Masters training of 28 health providers in March 2022 and 270 trainer of trainers (TOT) in April-May 2022 on peer education program on ASRH friendly services from Nyagatare, Gatsibo, Kayonza, Ngoma, Kirehe and Rwamagana Districts, E. Conducting ASRH awareness activities

Community based provision including introduction of the new polyvalent model activities included: A. Training of Trainers (CHWs and key support staff) in Nyamasheke (300 in October/November 2021), 1110 participants from Nyabihu, Gakenke (December to February) and Nyaruguru, Nyamasheke, Nyanza (March to April). B. Training of CHWs in the selected districts (Nyamasheke District: 2631, Nyabihu District: 1876, Gakenke District: 2468, Nyamagabe District: 2144, Nyaruguru District : 1325, Nyanza District: 1639)

Supply Chain activities included A. Quarterly supply review plan B. Implementation of procurement and supply plan C Monthly stock analysis of three essential commodities. Results showed that Amoxicillin 125 was out of stock for some months. 2.34 million doses received in April , Zinc supplies were sufficient and Misoprostal was out of stock but shipment is imminent.

Co-ordination and ongoing support activities included A coordination meetings and supervision of 14,391 CHWs in 14 districts (Gicumbi, Kamonyi, Muhanga, Ngororero, Musanze Gasabo, Kicukiro, Nyagatare, Ngoma, Gatsibo, Rwamagana, Bugesera, Huye and Rubavu). B. ongoing support, mentorship and supervision for CBP-FP implementation by strengthening the capacity of CHWs to provide quality FP services in the same 14 districts. C.

Other Community Health Program activities included A. Preparation of Rwanda Policy Dialogue for CHWs. B. Procurement of registers and reporting forms.C. Community Health Unit Budget execution D.

Integrated Maternal and Child Health week is conducted twice a year, and was successfully implemented in all the 30 districts of the country in November 2021 and May 2022. The key interventions during the campaign were Vitamin-A supplementation among the children aged 6-59 months, de-worming for the children aged 12 to 59 months, malnutrition status screening for the children aged 6 to 59 months, provision of family planning methods, provision of micronutrient powder/ONGERA for children aged 6-23 months and IPV vaccinations for children aged 5-6 years.

Besides those interventions, some other opportunities were also taken such sensitization on malaria prevention, family planning, and hygiene and sanitation promotion. Each population target was calculated based on the fourth Rwanda Population and Housing Census 2012, with consideration of each district population profile. Thus children aged 6-23 months , 6-59 months and 12-59 months were estimated at 583,814, 1,756,810 and 1,563,093 respectively. Data from Districts showed the coverages as follows: 93% (1,633,441/1,756,810) for vitamin A, 97% (1,460,132/1,563,093) for deworming, while nutritional screening for the 3 anthropometric measurements (MUAC, Weight for age and Height for age) were 92% (1,583,933/1,756,810), 91% (1,570,864/1,756,810) and 69% (401,512/583,814) respectively. Malnutrition screening included all the three anthropometric measurements (Height for age to detect stunting, Weight for height to detect wasting, and Weight for age to detect underweight, and Mid-Upper Arm Circumference (MUAC)) to detect acute malnutrition.

For malnutrition prevalence, the same report showed the following results: in children aged 6-23 months, stunting is 32%%, under weight is 7.1% and wasting is 6.6%, acute malnutrition by MUAC is 3.4%, 1,801 (0.3%) were found with oedema. 3,718 children aged 5-6 years were vaccinated for IPV. A total of 11,062 clients received family planning methods including 6,183 for condoms, 4,360 for depo-provera, 2,174 for implanon, 1,695 for microgynon, 71 for IUD and 16 for permanent methods. 2,782 adolescents girls were screened/tested for anemia in Bugesera, Rusizi and Nyamagabe Districts.

2.4 Family Planning and ASRH

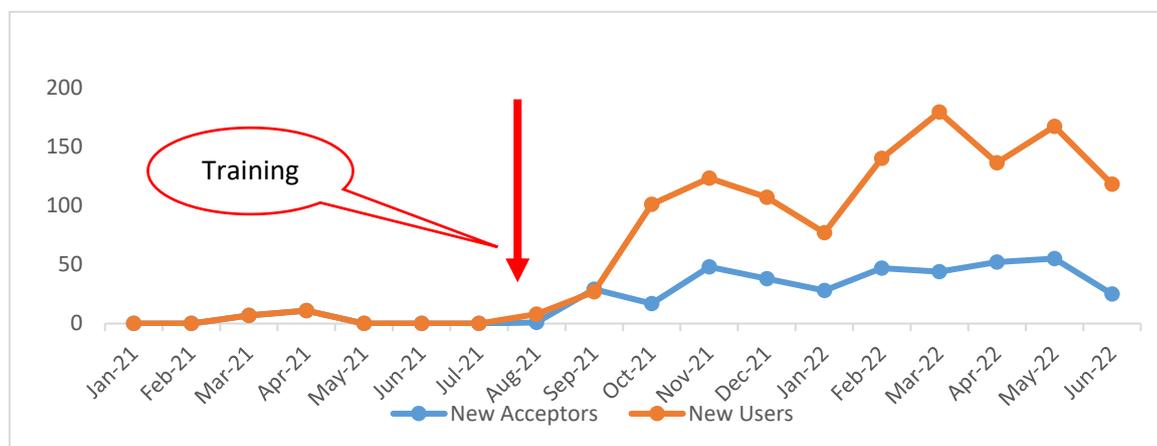
2.4.1 Family planning

During the FY 2021/22, FP/PPFP clinical mentorship visits were conducted. Before embarking with mentorship, an orientation workshop was organised and attended by 22 participants who in tern conducted the mentorship visits. The FP/PPFP clinical mentorships were conducted by national mentors in collaboration with FP team and 65 district-based mentors in 189 health facilities. In total 285 mentees were reached during this period including nurses, midwives, and data managers. in 14 FP technical competencies.

FP Supportive Supervision conducted in 27 private health facilities located in Gasabo, Kicukiro, Nyarugenge, Kamonyi, Muhanga, Nyanza, Huye, Rulindo, Musanza, Bugesera and Rwamagana Districts. The main focus of the supportive supervision was the working environment for FP services (space, materials ...), the FP data reporting in HMIS on monthly basis and identification of other gaps and proposition of solutions to be taken.

Training of health care providers: 77 health care providers from Nyanza, Nyaruguru, Ruhango and Nyarugenge were trained on DMPA sub-cutaneous (Sayana Press). 311 participants attended the training on hormonal IUD; during the practical session of the training 243 clients were reached and used IUD after voluntary informed choice. 18 health providers (17 medical doctors and 1 midwife) were trained on FP permanent methods; during the practical sessions, 61 tubal ligations and 26 no-scalpel vasectomies were performed by trainees under close supervision of trainers. The Onsite training on Quality Family Planning services delivery benefited 196 healthcare providers from Health Facilities(HFs) including Health Center and Health Posts(HP) from 7 districts (Kirehe, Kayonza, Gakenke, Rulindo, Rusizi, Nyamasheke, Karongi).

Figure 32: #women newly accepting FP and those re-using FP with Sayana press after training in selected districts (Nyanza, Nyaruguru, Ruhango, Nyarugenge)



Technical workshops and meetings were organized as follows: A. workshop with Clinical directors and FP focal points from all hospitals on the progress of FP new methods introduction and peer to peer learning. B. A meeting to review and update of FP training manual and FP brochure. C. FP technical working groups were organized each quarter throughout the year: discussions of FP TWG focused mainly on updates on the new FP commodity supply plan, commitments & gaps and updates on ongoing commodity shipments, national FP 2030 commitment and its implementation, Pre-service HIUD introduction project presentation.

FP Outreach services to in hard-to-reach health facilities were conducted: 179 clients were reached and adopted a FP permanent method (139 adopted tubal ligations and 28 used no scalpel vasectomy, 14 used IUD and 6 adopted implants). Integrated Maternal and Child Health Week was successfully implemented in all the 30 districts of the country in November 2021 and May 2022. The key interventions during the campaign were Vitamin A supplementation among the children aged 6-59 months, de-worming for the children aged 12 to 59 months, malnutrition status screening for the

children aged 6 to 59 months, provision of family planning methods, provision of micronutrient powder/ONGERA for children aged 6-23 months and IPV vaccinations for children aged 5-6 years.

The community sensitization was done by participating in radio talks on FP methods including new methods DMPA S/C (Sayana Press) and HIUD as new methods and airing Radio spots for a period of 4 months from March to June 2022. Those radio talks were organized on Radio Rwanda which is listened by many people and private radios (like Royal FM and Flash Radio, ect..). From those radio talks information on the methods mix used in Rwanda as well the new methods introduced (Sayana Press and hormonal IUD) were explained, response to audience's questions were responded.

2.4.2 Adolescent health

ASRH activities were centred around supervision, mentoship, training and awareness-raising.

- ✓ **Supervision** of the implementation of ASRH activities was conducted in September in eight health centres in Rulindo and Gakenke respectively.
- ✓ **Mentorship** was conducted in Karongi, Nyamasheke and Rusizi in September 2021 and in Burera, Kayonza and Kirehe in February 2022. The remaining 20 districts were provided mentorship on an ongoing basis. The total number of mentees is 925.
- ✓ **Training** sessions included A. Training of Trainers for Adolescent Health training manual in December 2021 and B. Training of 28 master trainers (March 2022) and 270 nurses from Nyagatare, Gatsibo, Kayonza, Ngoma, Kirehe and Rwamagana Districts (Feb to May 2022) on the peer education on ASRH friendly services.
- ✓ **Awareness raising** activities included:
 - Distribution of 100 TVs for health centres in Rwamagana, Ngoma, Nyanza, Nyamagabe, Musanze, Ngororero, Rubavu, Rutsiro, Gicumbi , Kamonyi, Gasabo districts for awareness raising.
 - Distribution of 1494 ASRH awareness raising magazines in four schools in Kamonyi and Gasabo respectively.
 - Parent/ adolescent communication sessions reaching 490 adolescents and 505 parents.
 - Mass media campaign through urunana soap opera, umuhoza magazine and radio talks.
 - Development of YAhealth digital tool to provide ASRH information
 - Conducting ASRH awareness raising at HCs and outreach strategy including at weekends.

2.5 Gender Based Violence

The GBV programme activities included provision of technical assistance, mentorship, Trainings and workshops.

- ✓ **Technical Assistance** was provided:
 - To MINEPROF for the development of digital technologies for GBV
 - To RIB on revision of the SoPs for Integrated One-stop Centres (IOSC)
 - In the review of the training module for GBV victims and protocol for case management including ToT in the revised training module.
 - Review and printing of the GBV register.
- ✓ **Mentorship** was conducted on the IOSCs in Kabaya, Rulindo, Rwamagana, Bugasera Districts. In particular on safe abortion and harmonizing reporting tools in November 2021 and April 2022.
- ✓ **Training** was provided for 34 mentors in 16 District hospitals in Rusizi, Rulindo, Nyarugenge, Karongi, Nyamasheke and Gakenke on IOSC and case management.
- ✓ **Other GBV activities** included a workshop that encouraged GBV victims to share their stories and National multisectoral co-ordination meeting in September during which the importance of IOSCs was emphasized.

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

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

During 2021-2022, the total budget allocated to activities under MCCH Division was 104,017,547,307Fr, 51.2% of this budget is from domestic funds which includes 51% of ordinary budget and 0.2% of own revenues. DP contribution is estimated at 48.8%.

Table 11: 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	902,239,188	0.9%	892,311,479	99%
Bloomberg	28,351,200	0.0%	11,252,700	40%
GAVI	418,496,069	0.4%	331,546,724	79%
GAVI - VIG	422,161,656	0.4%	352,441,391	83%
Ordinary budget	53,031,971,932	51.0%	48,853,591,204	92%
Own revenues	203,495,514	0.2%	202,433,264	99%
RBF HIV	24,711,280	0.0%	23,797,126	96%
RBF-Enabel MCCH	1,692,897,065	1.6%	1,624,313,363	96%
UNFPA	291,147,993	0.3%	159,807,583	55%
UNICEF	670,232,845	0.6%	568,196,118	85%
WB-COVID-19	44,193,933,407	42.5%	29,282,354,283	66%
WHO	109,932,408	0.1%	72,414,972	66%
World Bank - SPRP	2,027,976,750	1.9%	2,014,959,162	99%
Total	104,017,547,307		84,389,419,369	81%

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 12: Disbursements made to RBF Enabel Account during FY 2021_2022

	Disbursed amount in Euros	Period
Instalment 5	3,366,852	29 November 2021
Instalment 4	2,076,097	29 November 2021
Total	5,442,949	

Table 13: RBF ENABEL budget and expenditure per MTEF chapter for the year ended 30 June 2022

MTEF Chapter	Budget in EUR	Expenditures in EUR	Variance in EUR	Performance in %
22 Use of goods and services	1,570,459	1,413,602.81	156,856	90%
34 Acquisition of fixed assets	1,687,076	1,616,319.36	70,756.64	95.81%
26 Grants	791,549	791,548.53	0.47	100%
28 Other expenditures	1,493,418	1,479,411.74	14,006.26	99%
Total	5,542,502	5,300,882	241,620	95.64%

As per the table above for FY 2021-2022, Enabel is contributing to RBF Enabel expenditures the total budget of EUR 5,542,502 with Expenditures by budget activities of EUR 5,300,882 representing 95.64 % of total budget planned for Fiscal year 2021-2022.

Table 14: Reproductive, Maternal, Neonatal, Child and Adolescent Health –RBF Enabel Annual Budget Execution rate FY 2020/2021

RBF- Enabel Annual budget Execution rate FY 2021/2022						
BNR Exchange rate, annual average 2021/2022 =1136,355798						
Planned activities	Approved budget in EUR	Commitment in EUR	Budget Balance in EUR	Budget execution rate	Comments on budget execution rate	
RBF-Enabel MCCH	5,542,502.369	5,300,882.445	241,620	95.64%		
Administrative And Support Services	4,052,742.675	3,871,476.826	181,265.8494	95.53%		
Procure office supplies	1,694	1,694	0	100%	This activity was successfully implemented	
Provide Communication airtimes	2,408	2,408	0	100%	This activity was successfully implemented	
Pay salaries to SPIU project staff	81,502	81,348	154	99.81%	This activity was successfully implemented	
Surveillance of Rehabilitate of old maternities, 2 maternity per year	144,491	0	144,491	0%	The activity was not implemented due to delayed sites assessment	
Supervision of project activities	2,319	2,319	0	100%	This activity was successfully implemented	

RBF- Enabel Annual budget Execution rate FY 2021/2022

BNR Exchange rate, annual average 2021/2022 =1136,355798

Planned activities	Approved budget in EUR	Commitment in EUR	Budget Balance in EUR	Budget execution rate	Comments on budget execution rate
Transfer to Rusizi District for completion of Construction works of Shagasha Health Center	49,280	49,280	0	100%	This activity was successfully implemented
Support to C-PBF focusing on indicators not financed in current model	668,187	668,187	0	100%	This activity was successfully implemented
Support to HF PBF focusing on indicators not financed in current model	74,082	74,082	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	368,732	368,732	0	100%	This activity was successfully implemented
Conduct monthly coordination meeting	434,449	434,449	0	100%	This activity was successfully implemented
Increase FP uptake in catholic church affiliated HF	538,523	538,523	0	100%	This activity was successfully implemented
Rehabilitate of old maternities, 2 maternity per year	11,440	11,440	0	100%	This activity was successfully implemented

RBF- Enabel Annual budget Execution rate FY 2021/2022						
BNR Exchange rate, annual average 2021/2022 =1136,355798						
Planned activities	Approved budget in EUR	Commitment in EUR	Budget Balance in EUR	Budget execution rate	Comments on budget execution rate	
Youth corners and youth centers equipment (including university dispensaries)	0	0	0	0%		
Procure equipment's for maternity and neonatology units in health facilities	1,675,636	1,650,456	25,180	98.50%	This activity was successfully implemented	
COMMUNITY HEALTH	919,884	918,507	1,377	99.85%		
Procure of ICCM commodities.(Misoprostal,UPT,Zn and ORS)	919,884	918,507	1,377	99.85%	This activity was successfully implemented	
FAMILY PLANNING	569,876	510,898	58,977	89.65%		
Mentorship of Health providers/Health professionals including (teachers and youth clubs) at all levels to offer youth friendly services in and out of schools	70,532	69,244	1,289	98.17%	This activity was successfully implemented	
Procure FP Drugs and Consumables	499,343	441,655	57,689	88.45%	This activity was successfully implemented	

Key achievement registered during FY 21/22 under RBF Enabel Project

1. Detailed study of Kibagabaga Maternity construction works:

Rwanda Housing Authority on behalf of public Institutions through consultancy services is carrying out detailed design for the construction of maternity ward at Kibagabaga Hospital till September 2022, Thereafter, RBC and RHA will proceed with the launch of the tender after development of terms of reference and elaboration of Bills of Quantities. ,

2. Increased Family Planning uptake in catholic church affiliated Health facilities

RBC has supported CARITAS Rwanda for the implementation of planned activities aimed at increasing family planning utilization services and awareness raising related activities including the following:

- Development and production of drama video clips with messages on family planning.
- Provision of Mobile Sound System in low performing districts with low rate of Family Planning, this activity was conducted in 52 Sectors of the Districts of Rusizi, Ngoma and Nyamasheke.
- Conducted Quarterly field visits to decentralized structures including health centers and community to ensure the effectiveness of community-based provision.
- KAP study for the uptake of family planning in catholic church-affiliated health facilities

3. Procurement of Integrated Community Case Management (ICCM) commodities. (Misoprostal)

RBC through Rwanda Medical Supply Ltd has procured ICCM commodities for the hospitals and Health Centers amounting to 285 million and delivered in May 2022.

4. Procurement of Family Planning Drugs and Consumables

RBC through Rwanda Medical Supply Ltd has procured family planning commodities for the hospitals and Health Centers amounting to 285 million, and delivered in May 2022

5. Conduction of community (including Schools and Universities) outreach theatres and Production & broadcast of Family Planning /Adolsecnt Sexual and Reproductive Health and Maternal Newborn Health information to address faced barriers

Faith based Association continued to carry out community mobilization, awareness raising, sensitization, outreach and other related Behavior change communication interventions in all 30 Rwandan Districts to ensure that the overall objective of the project is attained. Specific key messages that were communicated in the community intended to make sure that; Women access anti- natal care services, Women are able access post-natal services, Newborns access the integrated services including exclusive breast feeding, under five products and vaccinations, Women/couples access modern contraceptives and thus increased utilization of modern contraceptives, Youth access ASRH information and services at the Youth corners and among other related services that are offered at the health facilities.

Much as the project is implemented in all 30 Rwandan Districts, FVA was required to put more focus on the following districts with low prevalence rate of facility deliveries and utilization of modern contraceptives; Kamonyi, Ngororero, Nyamagabe, Gakenke, Nyanza, Nyaruguru, Rusizi, Rubavu, Burera, Nyabihu, Ruhango and Rutsiro and others that are still lagging in some other indicators. For proper coordination and effective project implementation, FVA worked closely with key relevant stakeholders to achieve the intended objectives. These stakeholders were Ministry of Health through RBC, ENABEL, Districts (Local Authorities), hospitals, health centers and Health post staff, religious leaders, Youth, Community Health Workers, and the media. Implementation of Q4 activities, FVA engaged in monitoring and evaluation activities and was able to attain a considerable number of achievements under the following expected outputs.

6. Ensured the conduction of Quarterly coordination meetings of Community Health Workers

Access to Health, with the support from RBC, RBF Enabel Project, has coordinated Quarterly Coordination meetings of community health workers held at all health centers, to ensure that meetings discussed key community health reporting issues, data quality and incompleteness of registers, In addition to this, It has provided in kind incentives to community Health Workers (CHWs) such as T-Shirts, It has also availed transport fees to CHWs through their cooperatives.

7. Procure equipment for maternity and neonatology units in health facilities

RBC has procured the following medical equipment's for health facilities during the reporting quarter, these include 26 Incubators, 27 CPAP Machines and 35 Anesthesia Machines; The procured equipment were delivered now under reception process.

8. Support the Health Facilities and Community health cooperatives through incentivization of projects indicators not financed in current model using RBF Enabel project funds

RBC incentives the agreed program indicators reported by community health workers and Health Facilities scattered in 17 districts.

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 Division 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 STWG (FP, Safe motherhood, child health, ASRH and neonatal) prior to the approval by RMNCAH TWG.

The community health STWG 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 Forward Looking Joint Sector Review: MoH, Rwanda Biomedical Centre and Development Partners (DP), Civil Society Organisations (CSOs), Academia and the private sector 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 2022; 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

Challenges	Contributing factors/root causes	Recommendations
At least 4,390 deliveries at home	Possible Covid19 factors related to transport Preference to deliver at home	Investigate Follow pregnant women
Maternal deaths in the community	Weaknesses in follow up of delivered mothers in village (PNC)	Investigate PNC for danger signs and referral
Severe anaemia in pregnant women even though 98% are provided with iron and folic acid at ANC	Possible not taking the tablets.	Investigate
Few LBW babies are in KMC in the community	Poor follow up by CHW	Continue training in polyvalent model Investigate districts reporting less than 80% screening
Delay to receive quality care within the health facilities is more contributive to maternal and perinatal deaths (79%):	<ul style="list-style-type: none"> - Delay to take decision - Non-adherence to protocols - Delay to transfer Not calling for assistance	One of the innovative approaches is to create at least two specialized maternity and pediatric hospitals in each province and gather more gynecologists and pediatricians for better management of complicated cases.
Inadequate skills for new graduate especially to conduct caesarian section	GP not experienced in conducting c/section	Validate GPs before they can start to manage obstetrical complications (C/S specifically) to be able to get enough skills for C/S Reinforce induction period under supervision of an expert before engagement
Most maternal deaths are still remediable (87%), and third delay (within health facility) is more contributing factor (79%) ,mismanagement and inadequate follow up and poor inter-professional collaboration after admission are leading avoidable factors associated with the 3 rd delay	Mismanagement Inadequate follow up	Improve communication between specialist (Ob/Gn) and other clinical staff and Conduct regular meeting of doctors, midwives, nurses on post-operative monitoring and hand over in management of complicated cases.

		All Hospital shall improve monitoring of labor and refer on time all cases that are not in the scope of practice or cases with unclear diagnosis
ANC service not well organised and not done daily like other services.	staff shortage poor institutional organisation	ANC services to be done daily 5/5 days a week
Staff rotation (periodic rotation of staff in services)	Poor management/Leadership	Reinforce the retention of General practitioners and experienced staff in Maternity and Neonatology and make sure the new staff (GPs, nurses and Midwives) allocated in those services have acquired enough skills before being given responsibilities of managing night or weekend duties alone in services
Contraceptive prevalence rate stagnant and 40,000 increase in deliveries	CHWs who are training in provision of FP	Continue training in polyvalent model
Misdiagnosis of children with severe illness	Unavailability of culture/sensitivity lab tests in district hospitals	Avail reagents and supplies for culture and sensitivity testing
Low coverage of IPV catch up campaign	Low dissemination of information about the campaigns	Strengthen the social mobilization of targeted population
Decrease in use of CHW services (diarrhea and pneumonia treatment, FP-CBP and GBV referrals are <10%)	User fees for community treatment of diarrhoea and ARI Poor management of CBP/FP program and many CHWs are no longer providing CBP/FP	Implement removal of user fees for diarrhoea and ARI at community level Continue training in polyvalent model including FP and GBV modules
Stock outs of commodities (Amoxicillin 125mg, Misoprostol, Implanon, Micryogynon, Microlute, Depo-Provera) and equipment at community level (weighing scales, height boards	Delay in Procurement processes at RMS Ltd. HQ Delay in recording the consumptions in eLMIS by health facilities leading to underestimation of needs	Speed up procurement process Stock status to be analyzed and alert leadership level for advocacy/or support
Incompleteness of nutrition information in registers and files	Nutritionist in health facilities especially in health center and they are at 46% intake information, No form for history taking	to recruit the qualified Nutritionists in the health facilities enhancing the quality of service delivery to the Rwandan population

Insufficient home visits by nutritionists	Nutritionists have other priorities Funding for home visits not available	To recruit the medical personels as allowed by the labor structure and this will allow the in charge of Nutrition to fullfill his duties and responsilities because he/she is tasked by his/her supervisor other duties that are not in ligne in his/her duties and rensponsabilities
Insufficient of Nutrition commodities and Weighing scales for CHWs to track the malnutrition in community for under five year old	Insufficient funds allocated in Nutrition program	Advocate to raise budgets for Nuttition
Challenges in the continuity and quality of mentorship	Mentees are not permanent in the same services. Some health providers are still considering mentorship as supervision. Lack of ownership of mentorship by health facility managers	Strengthen the awareness of health facility managers to avail permanent healthcare providers in services for a considerable time period.
Children are not screened for underlying causes of malnutrition	High workload/low priority	Improve staffing levels
Absence of some FP equipment including gynaecological table, BP machine, implant removal kits	<i>prioritization</i>	Continuous advocacy for availability of all necessary materials and equipment in FP services
High discrepancies in FP data and challenge to track movements of FP clients	FP cleints seeking care from a facility to another at each appointment and the follow-up become difficult	Advocate to design an electronic system for FP (eFP) service with <i>unique identifier system</i> to solve the persistent issues/high discrepancies in FP data.
Health Posts not providing FP services everyday	workload	Advocate to the permanent staffs at secondary HP to give this FP
Patients not well informed on FP methods at the health center level during ANC visits	Awareness strategies not reachinh all wiomen..or understanding	Improvement of counselling on FP during ANC Increase mentorship in health care providers and CHWs
Low uptake of permanent and LARC methods	Few trained staff (Untrained health personnel (MD) on permanent methods) Personal and religious beliefs	Train the new and reinforce outreach on FP permanent methods Reduce geographical barriers by availing LARCs at SHP/staff and reinforce

		and follow up of secondary health posts Pre and in service training of newly deployed doctors and other healthcare providers
Insufficient equipped health posts providing FP services	Insufficient funds	Advocate to build and equip new health posts
Acceptability and access to FP services	FP services provided on 1 or 2 days per week	To Organize a specific Family planning campaign especially on FP Permanent methods and other methods to serve all clients in need. Plan FP special sites ahead of time in religious health facilities as some sites do not offer family planning methods to the population in need during campaign or during routine service delivery.
Insufficient domestic resources allocated to FP activities	Priority	Advocate for increasing domestic resources for FP program and for contraceptive commodities & supplies
ASRH is not mainstreamed into the health centre services	No integration of ASRH with other services Tools not used People not trained Underfunded	Include in HC plans
High numbers of physical & sexual violence, pregnancies under 20 years and those resulting in irreversible disabilities and HIV	Low awareness and cultural norms are barriers to full and timely treatment. Poor re-integration of victims results in re-exposure to violence/pregnancy Some hospital does not consider that GBV are emergency whereby in their duty roster they do not highlight service providers who must work at IOSC	Awareness raising of community and CHWs towards timely reporting Local leaders to be informed and address issues in the short and long term
Under-reporting of emotional and economic violence	HCPs are not identifying these types of violence in victims	Train HCP to recognise economic and emotional violence
Proportion of eligible victims receiving preventative care for HIV and pregnancy is not available	Registers do not collect information on eligible victims	Revise registers

Medical Doctors for some Hospitals still have negative attitude to Safe Abortion and bias on screening of Gender Based Violence cases and responding to them accordingly;	Cultural and religious beliefs	Continuous awareness raising regarding safe abortion and to increase the ownership of the service
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V.2 KEY PRIORITIES FOR 2022-2023

For the year 2022-2023, MCCH Divsion priorities are summarized as follows:

- ✓ Continue the training of CHWs on new competence polyvalent model and procure CHWs kit for polyvalent model
- ✓ Contributing to training, M&E and supervision on the new competency-based curriculum for CHWs including MIYCN.ToT & Cascade training in one districts
- ✓ Conduct mentorship and supportive supervisions in health facilities on family planning, performance of basic obstetrics ultrasound, child health, GBV,
- ✓ Procure FP Drugs and Consumables; nutrition commodities and drugs
- ✓ Efforts will be put to increase FP Uptake in Catholic church affiliated HF
- ✓ Community (Including Schools and Universities) outreach theatres and production broadcast of FP/ASRH and MNH information to adress barriers to FP/ASRH
- ✓ Conduct quarterly Monthly coordination meeting of CHWs at HCs level (NGO)
- ✓ Procure equipment for maternity and neonatology units in health facilities
- ✓ Provide Medical equipment in selected Health facilities (ultrasound)
- ✓ Support to C-PBF Focusing on indicators not financed in the current model
- ✓ Conduct MR campaign and catchup vaccination of identified missed and dropout children.
- ✓ Procure vaccines, vaccine devices and cold chain equipment
- ✓ Procurement of solar panel system for the mobile isolation and treatment hospital
- ✓ Provide preventive and curative maintenance for medical equipment
- ✓ Cascade training of Peer eductors on ASRH and out of school CSE
- ✓ Support deworming of children including vitamin A(twice ayear)
- ✓ Phase out of paper based immunization data collection tool and switch to digital data collection tool (immunization e-tracker).
- ✓ Monitor the implementation of key recommendations from the policy dialogue related to new competence polyvalent model

In addition to key priorities listed here, MCCH has an entire action plan to be implemented in 2022-2023 which will be revised and add other activities from stated recommendations.

CONCLUSION

In the year 2021-22 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. 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 2021-22 the 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. The victims of GBV were cared as required by guidelines and protocols, ANC new guidelines for 8 contacts was developed and validated and ready to be used. 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: RBF-ENABEL Result Framework, FY 2021-2022

Program area	Indicator	Baseline_2017-18	Target_2021-22	Results achieved_2021-2022	Data source
Maternal and newborn health	•OCI 1: Facility deliveries – percentage of births attended by skilled health professionals – facility based information °HMIS	92%	≥ 90%	89%	HMIS_Routine data
Reproductive Health	•OCI 2: mCPR : utilization rate of modern Contraceptives – facility based ° HMIS	47%	50%	53%	HMIS_Routine data
Reproductive Health	•OPI 1: PPFPP uptake : Post-Partum Family Planning within the first 6 weeks after delivery : °HMIS : baseline and target to be agreed on	32%	≥ 45%	59%	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	300,854	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%	93%	HMIS_Routine data

Program area	Indicator	Baseline_2017-18	Target_2021-22	Results achieved_2021-2022	Data source
Maternal and newborn health	<ul style="list-style-type: none"> •OPI 4: First routine ANC within 1st trimester: °HMIS: baseline and target to be agreed on 	40%	45.1%	51%	HMIS_Routine data
Maternal and newborn health	<ul style="list-style-type: none"> •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%	75%	HMIS_Routine data

Annex 2: 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	Target FY 2021/22	Results_ FY 2021/22	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%	41%	45%	HMIS
Indicator 4a: Number of children under 5 were beneficiaries of project interventions	-	508,826	515,573	510,326	581,142	511,836	657,784	560,000	686,792	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	1,100,000	403,508	HMIS
IRI 2: Percentage of CHWs who received a quarterly supportive supervision visit from HC	40%	48%	59%	56%	86%	64%	91%	80%	101%	Supervision reports

IRI 3: Percentage of pregnant women who attended the first ANC visit during the first trimester	42%	44%	46%	46%	44%	48%	44%	48%	48%	51%	HMIS
IRI 4: Percentage of pregnant women with anemia	1.6%	1.5%	2%	1.40%	1%	1.3%	0.7%	1%	1%	1%	HMIS
IRI 6: Percentage of children 6-23 months old receiving micronutrient powders	18%	46%	59%	36%	34%	54%	40%	90%	107%	HMIS	
IRI 7: Percentage of children under five with diarrhea treated with ORS and zinc.	0%	95%	93%	95%	85%	95%	82%	95%	85%	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%	85%	96%	HMIS	
IRI 11: Percentage of CHWs with no stock out of Zinc for diarrhea treatment	95%	95%	95%	95%	93%	95%	94%	95%	95%	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	125,000	115,296	HMIS	

Annex 3: Maternal and Child Health week results for November 2021

District	Target population				Vitamin A	Deworming (albendazole)			Screening		6-23 Months with Oedema	Total FP clients
	6-11 months	12-59 months	5-15 years	16+years		12-59 months	5-15 years	16+years	MUAC	Weight		
Bugesera	10,279	65,883	134,412	249,271	70%	64%	90%	62%	51%	50%	801	439
Burera	4,766	44,847	98,715	213,038	80%	87%	98%	57%	71%	71%	46	310
Gakenke	4,721	38,726	86,557	226,790	104%	105%	100%	97%	101%	103%	1,072	263
Gasabo	11,558	69,462	145,221	385,225	105%	112%	134%	18%	83%	80%	-	613
Gatsibo	7,256	63,664	146,289	289,484	86%	86%	105%	79%	81%	87%	1,014	203
Gicumbi	5,969	54,176	108,102	264,565	73%	75%	84%	75%	72%	71%	581	231
Gisagara	5,897	45,512	102,470	223,971	90%	102%	77%	64%	83%	75%	-	116
Huye	5,413	42,470	101,422	203,864	96%	96%	91%	95%	57%	56%	-	328
Kamonyi	5,845	50,923	105,872	495,042	71%	72%	104%	28%	67%	67%	34	252
Karongi	5,036	47,255	98,945	229,357	86%	90%	91%	74%	96%	96%	6	153
Kayanza	6,205	49,444	117,844	244,958	81%	84%	85%	54%	76%	81%	-	191
Kicukiro	5,120	38,790	93,776	192,170	97%	100%	112%	0%	99%	100%	175	441
Kirehe	6,609	51,958	118,267	261,075	85%	89%	93%	65%	81%	81%	647	358
Muhanga	4,812	37,168	95,135	249,297	83%	82%	90%	50%	65%	68%	29	140
Musanze	5,331	37,279	97,548	239,135	96%	104%	107%	59%	82%	78%	371	249
Ngoma	5,509	41,981	105,214	218,891	95%	98%	85%	95%	67%	67%	-	559
Ngororero	5,194	46,892	108,488	233,403	91%	98%	88%	73%	77%	76%	63	88
Nyabihu	4,536	37,378	81,738	179,944	87%	91%	123%	67%	78%	78%	9	17
Nyagatare	9,842	81,396	172,796	400,358	65%	68%	77%	30%	84%	78%	317	572
Nyamagabe	5,147	45,924	100,214	244,732	83%	84%	97%	84%	79%	76%	735	338
Nyamasheke	7,328	57,525	118,989	262,385	64%	79%	75%	43%	70%	71%	225	383
Nyanza	4,147	35,073	86,781	188,140	91%	91%	102%	88%	90%	90%	-	223
Nyarugenge	4,369	43,696	80,158	180,809	89%	91%	118%	57%	87%	87%	-	666
Nyaruguru	5,124	41,169	109,355	198,471	102%	100%	102%	93%	98%	99%	128	192
Rubavu	7,601	70,442	138,356	275,269	85%	89%	98%	53%	63%	59%	301	907
Ruhango	4,628	39,833	87,366	202,991	95%	96%	103%	88%	86%	85%	16	209
Rulindo	4,668	41,290	87,564	222,680	100%	103%	102%	74%	75%	83%	1	235
Rusizi	8,300	58,991	146,766	249,885	73%	101%	53%	64%	72%	73%	1,199	118
Rutsiro	5,330	44,946	105,237	212,181	74%	72%	99%	73%	74%	74%	-	22
Rwamagana	5,658	47,058	116,546	209,590	101%	101%	101%	81%	97%	95%	-	197
National	182,198	1,471,151	3,296,143	7,446,971	85%	89%	95%	61%	78%	77%	7,770	9,013

Annex 4: Maternal and Child Health week results for May 2022

District	Target population						Specific target for Praziquantel		Vitamin A*	Deworming (albendazole)			Praziquantel		Screening			Oedema	Total FP
	Total pop_2022	6-11 months	12-23 Months	24-59 months	5-15 years*	16+years*	5-15 years	16+years		12-59 months*	5-15 years*	16+years*	5-15 years	16+years	MUAC	Weight	Height		
Bugesera	476,358	6,669	16,941	48,942	134,412	249,271	70,926	111,182	88%	81%	108%	95%	78%	96%	74%	75%	71%	1,247	662
Burera	352,035	4,928	11,826	34,164	97,766	215,119	76,665	164,975	86%	95%	110%	81%	95%	81%	91%	90%	80%	20	361
Gakenke	353,763	4,953	10,491	30,306	94,075	242,712	44,430	111,731	101%	101%	104%	101%	95%	75%	99%	98%	82%	272	378
Gasabo	835,714	11,700	22,564	65,186	218,121	385,225			89%	92%	91%	20%	#DIV/0!	#DIV/0!	72%	69%	68%	-	632
Gatsibo	637,988	8,932	17,226	49,763	166,515	290,941	64,781	123,567	86%	89%	97%	83%	33%	28%	81%	86%	41%	1,029	223
Gicumbi	432,668	6,057	14,045	40,576	112,926	261,622	16,361	31,331	90%	91%	95%	100%	130%	141%	93%	92%	74%	195	328
Gisagara	388,839	5,897	11,703	33,809	102,470	223,922	66,569	137,739	107%	123%	101%	98%	118%	99%	110%	112%	76%	-	137
Huye	399,446	5,592	10,785	31,157	104,256	218,814			100%	101%	93%	98%	#DIV/0!	#DIV/0!	70%	69%	51%	12	369
Kamonyi	436,573	6,112	11,787	34,053	113,945	264,563	37,951	73,403	88%	88%	100%	78%	108%	92%	84%	85%	63%	34	379

District	Target population						Specific target for Praziquantel		Vitami n A*	Deworming (albendazole)			Praziquantel		Screening			Oedema	Total FP
	Total pop_2022	6-11 months	12-23 Months	24-59 months	5-15 years*	16+years*	5-15 years	16+years		12-59 months*	5-15 years*	16+years*	5-15 years	16+years	MUAC	Weight	Height		
Karongi	386,167	5,406	12,199	35,240	100,790	231,126	19,571	54,977	92%	96%	93%	83%	114%	79%	104%	105%	71%	6	193
Kayanza	433,594	6,070	12,777	36,913	118,397	241,195	48,416	103,357	92%	94%	99%	76%	96%	64%	98%	103%	84%	984	300
Kieukiro	469,355	6,571	12,673	36,610	122,502	197,447			85%	88%	89%	0%	#DIV/0!	#DIV/0!	87%	87%	53%	183	500
Kirehe	484,450	6,782	13,361	38,597	126,441	261,075			96%	100%	98%	73%	#DIV/0!	#DIV/0!	90%	90%	113%	1,368	2,077
Muhanga	352,162	4,930	9,508	27,469	95,135	213,410	17,684	45,809	94%	92%	102%	85%	92%	57%	84%	87%	60%	29	190
Musanze	432,407	6,054	11,675	33,728	112,858	242,266	13,339	40,344	100%	105%	100%	99%	25%	65%	96%	96%	70%	-	402
Ngoma	467,246	6,541	12,616	36,445	105,077	218,891	45,376	86,804	84%	87%	91%	103%	83%	143%	73%	74%	46%	36	635
Ngororero	388,384	5,437	12,058	34,834	108,488	233,403	6,257	10,916	93%	100%	97%	86%	124%	321%	83%	82%	73%	242	134
Nyabihu	322,353	4,513	8,704	25,144	84,134	141,262			101%	110%	123%	100%	#DIV/0!	#DIV/0!	102%	102%	75%	-	21
Nyagatare	586,917	8,217	20,548	59,360	169,845	355,672	172,796	400,358	89%	95%	99%	61%	94%	65%	120%	115%	117%	173	1,095
Nyamagabe	408,113	5,714	11,809	34,115	106,518	244,732			89%	91%	94%	91%	#DIV/0!	#DIV/0!	83%	83%	63%	735	353
Nyamasheke	444,354	6,221	14,668	42,373	123,582	262,514	66,085	155,519	93%	107%	99%	78%	118%	106%	90%	92%	64%	36	457
Nyanza	407,844	5,710	11,012	31,812	106,447	191,075	41,370	70,144	85%	84%	93%	97%	102%	101%	81%	82%	61%	-	242
Nyarugenge	358,510	5,019	11,236	32,460	93,571	180,809	8,805	19,861	96%	99%	110%	85%	145%	74%	97%	97%	57%	45	827
Nyaruguru	364,368	5,124	10,586	30,583	109,355	198,471			101%	100%	102%	96%	#DIV/0!	#DIV/0!	98%	99%	84%	5	196
Rubavu	540,656	7,569	19,601	56,625	141,111	271,290	51,873	95,208	93%	97%	107%	82%	134%	117%	57%	53%	47%	301	1,004
Ruhango	406,563	5,692	10,977	31,712	106,113	203,481	9,448	25,825	93%	95%	97%	101%	174%	94%	86%	86%	69%	16	228

District	Target population							Specific target for Praziquantel		Vitami n A *	Deworming (albendazole)			Praziquantel			Screening			Oedema	Total FP
	Total pop_2022	6-11 months	12-23 Months	24-59 months	5-15 years*	16+years*	5-15 years	16+years	12-59 months*		5-15 years*	16+years*	5-15 years	16+years	MUAC	Weight	Height	6-23 Months			
Rulindo	360,049	5,041	10,784	31,152	93,973	218,190	8,307	19,705	108%	112%	103%	96%	61%	91%	87%	94%	62%	1	307		
Rusizi	479,062	6,707	16,042	46,345	125,035	266,931	127,929	245,526	88%	110%	81%	77%	92%	101%	86%	88%	83%	1,201	118		
Rutsiro	387,992	5,432	10,476	30,263	102,600	210,016	51,728	105,229	98%	98%	114%	92%	71%	68%	95%	95%	61%	-	34		
Rwamagana	427,215	5,981	12,624	36,469	118,433	213,561	63,455	101,484	98%	100%	101%	95%	103%	87%	104%	102%	111%	-	292		
National	13,221,145	185,572	393,301	1,136,203	3,514,892	7,149,006	1,130,122	2,334,994	93%	97%	99%	82%	95%	86%	88%	89%	71%	8,170	13,074		

Annex 5: MCCH Staff FY 2021-2022

#	Names	Position
1	SIBOMANA Hassan	Current Ag. Division Manager & Director of Vaccine Programs Unit
2	Dr SAYINZOGA Felix	Former Division Manager
3	MUKAMANA Beatrice	Ag Director Community Programs Unit
4	Dr CYIZA Francois Regis	Director of Health Facilities Programs Unit
5	Dr BIKORIMANA Ferdinand	Child Health Senior Officer
6	HAKIZIMANA Jean de Dieu	AEFI Surveillance and Monitoring Officer
7	IRAGUHA Gisele	Vaccine Stock Management Officer
8	MINGA NSENGIYUMVA Fabien	International Vaccination Officer
9	MUHOZA Jered	Cold Chain Senior Officer
10	MUKANYANDWI Irene	SIAs and New Vaccine Officer
11	NGILIMANA Gad	Cold Chain and Maintenance Engineer
12	NSHIMIYIMANA Laurence	International Vaccination Officer
13	RWAGITARE Eraste	Vaccine Program Officer
14	KABANYANA Grace	Immunization epidemiology Senior Officer
15	MUREKATETE Odette	Cashier
16	HABARUREMA Nicodeme	Nutrition M&E Officer
17	KARAMAGE Eliphaz	Adolescent Health Officer
18	KAYITARE Evariste	Community Health Program M&E Officer
19	NGENZI WANE Olivier	In Charge of Commodities Senior Officer
20	NKURUNZIZA Appolinaire	Nutrition Officer
21	SERUCACA Joel	Community Family Planning Officer
22	KARANGWA Eugene	Reproductive Health Officer
23	MUTONI Merab	SGBV Officer
24	NYAMWASA Augustin	MCH Mentorship Officer
25	RUBAYITA Jean Claude	SGBV M&E Officer
26	UMUTESI Sharon	Maternal and Newborn Health Senior Officer
27	BURANGA UMULISA Assumpta	CHWs Training Officer
RBC-MCCH Technical Assistants Staff from Partners		
1	UMUTONI GAGA Alice	Program Liaison/ Intrahealth International
2	MUKASHYAKA Clarisse	Avenir Health M&E Officer/ Avenir Health

#	Names	Position
3	MUKAKABANDA Suzanne	FP Quality of Care Specialist/ Intrahealth International
4	KANYAMANZA Eugene	Focal Point PAC and Safe Abortion
5	NTAGANDA Justin	Nutrition Technical Assistant/
6	NZARAMBA Emmanuel	Routine Immunization Officer/UNICEF
7	TUYISHIME Yvette	Immunization Field Staff / WHO
8	MUDAHERANWA Evodie	Vaccine Supply Chain Officer/WHO
9	NDARUHUTSE Victor	Senior Data Demand and Learning Advisor/Intrahealth International
10	KAYITARE Evariste	Community Health Program M&E Officer
11	RUDASINGWA Silas	Monitoring and Evaluation Officer/ ENABEL
12	KARRKEZI Ray Azades	Senior Associate/CHAI
13	Dr NDUWIMANA Colyse	Associate/CHAI
14	Dr KAGABO Leonard	Analyst/CHAI
15	UMUBYEYI Monia	SRH project M&E officer/Imbuto Foundation
16	GAKOZA Golbert	Senior SRH project Manager/Imbuto Foundation
17	ISHIMWE Jules Christian	Data scientist
18	HEZAGIRA Emery	Community Health Advisor

Annex 6: MCCCH Partners _ FY 2021-2022

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_Barambe 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, Bureta 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	Mentorship	Bugesera, Bureta, Gasabo, Karongi, Kayonza, Kicukiro, Kirehe, Ngororero, HBD
ADRA Rwanda	Child health, Nutrition and mentorship	Nyabihu
CARITAS	Nutrition	Ruhango
Garden for health	Nutrition	Musanze
CRS_Gikururo 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 & Bureta
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

