Rwanda Biomedical Centre

Healthy People, Wealthy Nation

Maternal, Child and Community Health Division | Annual Report 2022-2023

Kigali, August 2023

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Acronyms and abbreviations

AEFI	Adverse Event Following Immunization
ANC	Antenatal Care
ASM	Agent de la Santé 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	Caesarean Section
CBMNH	Community Based Maternal Newborn Health
CBP	Community-Based Provision
CCD	Child Care Development
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 Multiyear 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 Influenza 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 Systems 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
LARCs	Long Acting Reversible Contraceptives
LLINs	Long Lasting Insecticide treated bed nets
M&E	Monitoring and Evaluation
MCCH	Maternal Child and Community Health
MCCOD	Medical Certification of Cause of Death
MCH	Maternal and Child Health
MDSR	Maternal Death Surveillance 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

MVA	Manual Vacuum Aspiration
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 Projects' 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	United States Aids
VCAT	Values Classification and Attitudes Transformation
VLMIS	Vaccines Logistic Management Information System
WHO	World Health Organization

Foreword

It is an honour to avail the Maternal, Chid and Community Health (MCCH) Annual Report for 2022-2023 to our esteemed partners, especially the stakeholders working with RBC/MCCH. The report showcases the accomplishments of the RBC/MCCH division and its partners across its three units: Health Facilities Programs, Community Health Programs, and Vaccine Programs Unit. This reporting period aligns with the concluding year of the Fourth Health Sector Strategic Plan (HSSP IV).

I extend my gratitude to the collaborative efforts of various entities and institutions, ranging from national to decentralized levels. These include local administrative authorities, hospitals, health centers, and Community Health Workers, all of whom played a crucial role in advancing MCCH initiatives throughout the fiscal year 2022/2023. A special acknowledgment also goes to our development and implementation partners, private sector entities, civil society organizations, academic institutions, and all other partners closely engaged with RBC/MCCH. Their invaluable support has significantly contributed to enhancing reproductive, maternal, newborns, child, and adolescent health for Rwandans.

The achievements of FY 2022/23 would not have been possible without the unwavering dedication of health facility staff, MCCH Division personnel, support from development partners' technical experts, and other divisions across Rwanda Biomedical Centre (RBC) and the Ministry of Health (MoH).

The compilation of the MCCH Annual Report 2022-2023 was made possible by the active participation and commitment of staff from MCCH Division, the Single Projects' Implementation Unit (SPIU) and our partners. I wish to extend my heartfelt gratitude to all contributors during the development of this report.

To this end, I would like to call upon all the institutions and organizations involved in MCCH area to heed the recommendations presented in this report and to support implementation of the planned interventions during FY 2023/2024. RBC stands committed to providing support, ensuring the harmonious execution of these planned activities, and realizing the objectives of the MCCH Division and the health sector in general.

Prof. Claude MAMBO MUVUNYI
Director General
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Executive summary

The Government of Rwanda, through the Ministry of Health, its affiliated agencies, including Rwanda Biomedical Centre, and development partners, is committed to achieving the health-related Sustainable Development Goals (SDGs) and the goals of the Global Strategy for Women's Children and Adolescent's Health. This commitment is channelled through 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).

The *"No woman should die giving life"* campaign was launched in the ended Fiscal Year, accompanied by a comprehensive roadmap. This roadmap integrates the Global Initiative for Ending Preventable Maternal Deaths and the *"Every Newborn Action Plan"*, both launched in May 2023. This unified effort builds upon the accomplishments of the past five years and addresses challenges contributing to maternal and child mortality.

This report details the status of critical Maternal, Child, and Community Health (MCCH) indicators for FY 2022/2023, aligned with the roadmap's activities. Key observations include a moderate increase of 648 deliveries compared to the previous year – a significantly smaller increase than the previous increase of 25,754 reported between FY 2020/2021 and FY 2021/2022. The Contraceptive Prevalence Rate (CPR) increased from 1% to 55% among women of reproductive age. The Post-partum family planning (PPFP) acceptance increased from 60% to 67%, primarily involving long-lasting methods. The most preferred methods for family planning are Implanon and Jadelle. Efforts were also directed towards extending family planning services to women delivering in faith-based health facilities.

Rwanda introduced new guidelines for pre-natal clinic (ANC) visits, including a recommendation for eight ANC visits during pregnancy. Despite a rise in the number of women attending at least four visits (49%), this is still below the global Ending Preventable Maternal Mortality (EPMM) initiative's 90% target. Notably, over 94% of deliveries occurred within health facilities, surpassing the EPMM 90% target by 2023. The Maternal Mortality Ratio (MMR) decreased to 89 per 100,000 Livebirths from 119 per 100,000 Livebirths in FY 2019/20. The leading cause of maternal death include post-delivery bleeding (PPH) (34%), complications of eclampsia (5%). Deaths classified in the 'other' categories are 6% direct and 25% indirect. Enhanced data capture aims to better comprehend 'other' causes.

A well-structured Maternal, Perinatal, and Child Death Surveillance and Response (MPCDSR) strategy exists, with ICD-10 training ongoing and conducting near miss and death audits. The excessive bleeding during delivery (PPH) has remained constant over three years at around 8 deaths per 1000 deliveries. The proportion of deliveries that were conducted by caesarean sections (C/S) stabilized at 23.5% following targeted pilot projects. Training and mentorship in the use of ultrasound machines installed for early detection of complications of pregnancy and to health workers in provision of ANC services continued.

Postnatal care visits remained high at over 90% meeting the ENAP/EPMM target. However, a drop-out rate from the first to the fourth visit has remained around 30% since last FY 2021/2022. In addition to a reduction of maternal deaths, the proportion of perinatal deaths (including stillbirths and newborns within 7 days) has decreased from 26 deaths per 1,000 births in FY 2017/18 to 22 deaths per 1,000 births in FY 2022/23. Neonatal death's primary biomedical factor was asphyxia (28%). Procurement of essential equipment and mentoring programs were key activities in the past year to improve perinatal outcomes.

Deaths of children under five years of age decreased from 14% to 13% live births. The majority of children under five years of age are managed within the Integrated Management of Childhood Illnesses (IMCI) services at the health facility. Treatment of the three most common and important diseases is done by Community Health Workers (CHWs) at community level. CHWs managed 68% of malaria, 30% of pneumonia, and 19% of diarrheal cases. The removal of user fees for management diarrhea and pneumonia cases by CHWs, in March 2023, led to improved service utilization at the community level.

Currently, 12 antigens are given to all children below one year. Child immunization rates remain high above 90% for all vaccines, with a 10% drop between first and second measles-rubella vaccines in some districts. The Human Papilloma Virus (HPV) vaccines administered to all girls aged 12 years of age, reached 83% and 79% coverage for two doses respectively, an effective strategy in preventing cervical cancer. Adequate nutrition for children under five years remains a key priority. Nutrition screening improved from 72% to 91% for acute malnutrition (weight for age) in the past ten years. Chronic malnutrition (stunting) remained a concern, affecting 25% of children under two years, based on screenings during the Mother and Child Health (MCH) week campaign.

COVID-19 vaccination continued with the inclusion of children aged 5-12 years, achieving an increase from 70% in FY 2021/22 to 85% for the first dose. The second dose coverage increased from 67% to 80%, while 44% received booster dose (for those 18 years and above).

The Mother and Child Health (MCH) week was conducted in November 2022 and June 2023 with very good results: 95% children were given for vitamin A supplementation and 96% 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 at 94%, 93% and 80%, for children aged 6-59 months respectively. For malnutrition prevalence (among children aged 6-23 months), the rate for stunting is 25%, for underweight is 6.8% and for wasting is 5.8% and 82% children received micronutrient MNP powder (Ongera) products. In the same campaign, 3,626 children who missed their routine vaccinations were traced and vaccinated. A total of 20,342 clients received family planning methods including 2,088 for Jadelle, 6,014 for depo-provera, 1,290 for implanon, 2,454 for microgynon, 122 for IUD and nine for permanent methods.

Efforts were made during the FY 2022-23 to strengthen data quality and use. Trainings, monitoring and ad hoc data quality assessments using the World Health Organisation (WHO) outlier tool were conducted, including to health centre level, in seven districts and nationwide, with particular attention to selected indicators. The 2022 census data was used as denominator for some indicator coverages. Weekly notifications of maternal deaths and HMIS reports were reconciled on a weekly basis.

Coordination and governance mechanisms including Technical Working Groups (TWG), data audits and supportive supervision are part of the work of the RBC/MCCH Division. There is 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 base. This report outlines achievements, challenges, and lessons learned.

In FY 2023/24, building on this year's lessons, RBC/MCCH Division aims to identify high-impact interventions for maternal, neonatal, and child survival, aligned with national and international targets. The RMNCAH Strategic Plan (2024-29) will draw upon this report's insights.

INTRODUCTION

Program overview

The Government of Rwanda (GoR), through the Ministry of Health, and development partners, is committed to attaining health-related Sustainable Development Goals (SDGs), with a significant focus on maternal and child health targets. The Rwandan Mother, Neonatal, Child and Adolescent Health (RMNCAH) policy, along with the Family Planning /Adolescent Sexual and Reproductive Health (FP/ASRH) and Maternal, Newborn and Child Health (MNCH) Strategic Plans (2018-2024), alongside the Roadmap for *'No woman should die giving life*,' collectively direct efforts to meet both SDG and Rwandan health objectives.

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.

Purpose, target audience and methodology

The purpose of this annual report is to improve health outcomes in newborns, children, adolescents, men and women of Rwanda through efficient use of resources by the presentation of the performance of MCCH division for the FY 2022/23.

The primary target audience is key decision-makers, programme managers and other stakeholders involved in planning, funding and implementation. The information contained in this report is also valuable to the Ministry of Health (MoH) and Ministry of Finance and Economic Planning (MINECOFIN) and other policy-makers. The information in this report enables informed decision-making for efficient program implementation and resource allocation. Current and future potential financial development partners, the organisations and communities that support the RBC/MCCH Division in programme implementation will also benefit from the information presented.

The report tracks progress against the roadmap for the *'No woman should die giving life'* initiative, encompassing both data and activities conducted. The data primarily come from health facilities and community reports within the Health Management Information System (HMIS). The denominator used for 'coverage' comes from the 2022 population census projections.

The MCCH Annual Report is structured into six key sections:

1. Introduction comprising purpose, target audience, methodology, programme overview,
2. Status of indicators
3. Implementation of activities
4. Strategic information
5. Financial report
6. Key recommendations and priorities for next year

I.1: MATERNAL, NEWBORN AND CHILD HEALTH

I.1.1 Maternal health indicators

Antenatal care

The objective of antenatal care clinics is to enhance pregnancy outcomes for both mother and child by conducting consistent screenings and providing preventive and curative services.

The Ministry of Health prioritizes timely antenatal care (ANC) attendance, aiming for every pregnant woman to start attending at a nearest health center within the first three months of pregnancy. In FY 2022/2023, new ANC guidelines were launched, outlining procedures and increasing recommended contacts to eight. Timely initial attendance becomes crucial for accomplishing the eight-contact goal during pregnancy.

Figure 1 shows the proportions of *expected* pregnant women visiting ANC clinics at least once during pregnancy (ANC new registrations), with the first visit within the initial 12 weeks of pregnancy (ANC 1st standard visit), and those attending at least four ANC visits (ANC four standard visit).

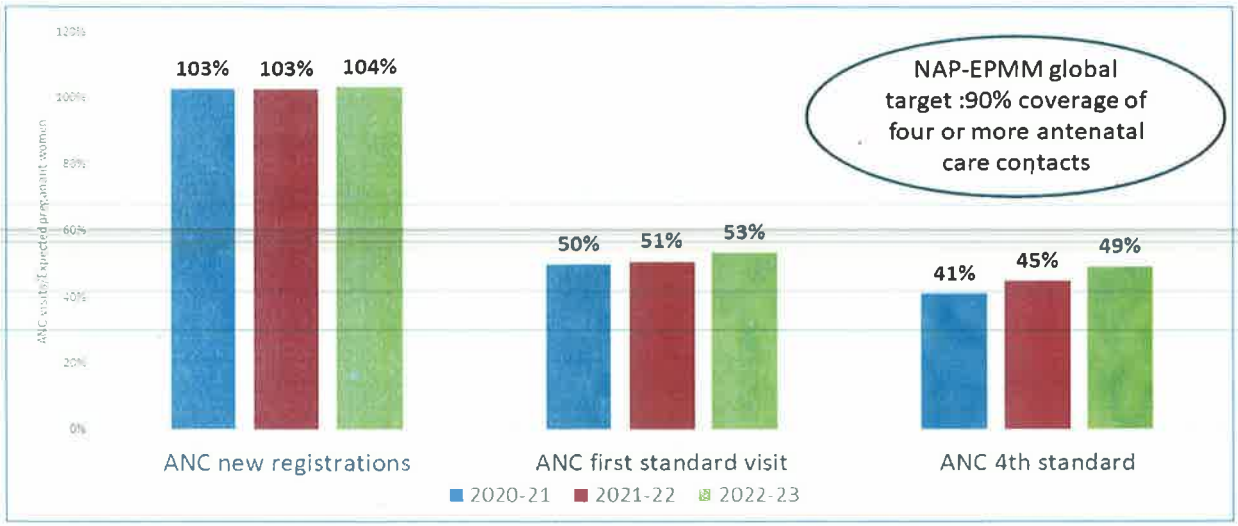


Figure 1: Proportion of all expected pregnant women (census projections) receiving any ANC, ANC during the first trimester and ANC four times during the pregnancy in FY 2022/2023 (Source: HMIS).

The vast majority of pregnant women receive ANC care at least once during their pregnancy,[1] and 53% of them receive ANC within the first three months whereas 49% made at least four standard visits. However, there is an increase in both indicators since the previous year (2% increase for early ANC and 4% increase in four visits).

[1] While it is possible for a woman to have two ANC visits within one year, the new registrations at 104% of all expected pregnant women is likely to be due to double counting of some women who attend in different health facilities. The ANC tracking tool, currently in pilot will improve data quality of this data element.

The pattern over the last ten years also shows a small but steady increase reaching the highest attainment in this reporting period. The ten-year trend for ANC fourth standard visit follows the same pattern with 49% expected pregnant women receiving antenatal care four times during their pregnancies; an increase of 15% over the past ten years (see Figure 2).

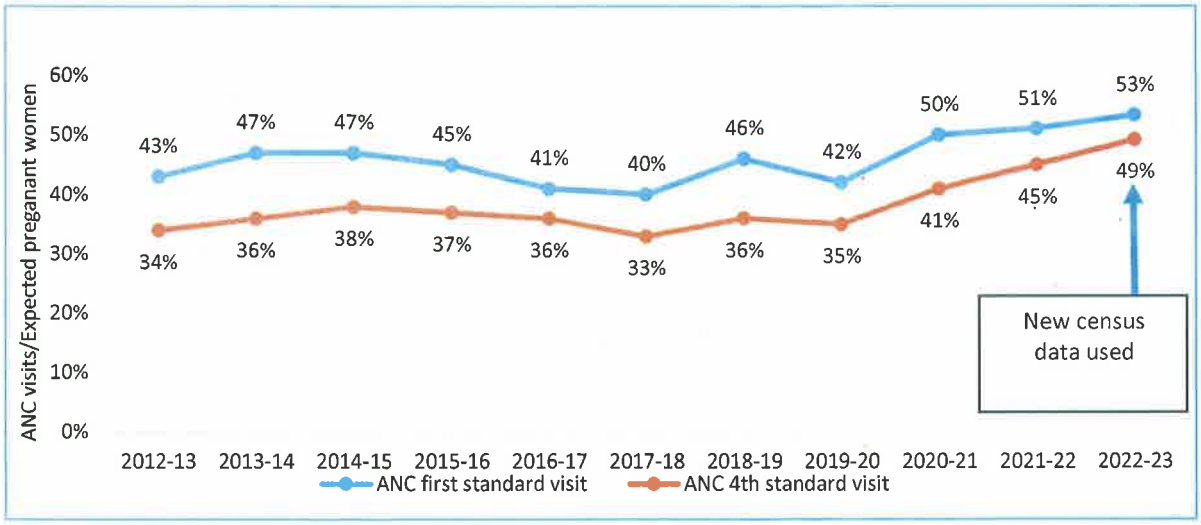


Figure 2: Proportion of all Expected Pregnant Women (census projection) receiving ANC 1st visit within the first trimester and 4 Standard visits in FY 2022/2023 (Source: HMIS).

A wide range of coverage of first ANC within first trimester and four standard visits can be seen among districts, from 80% in Burera to 35% in Kamonyi (see figure 3).

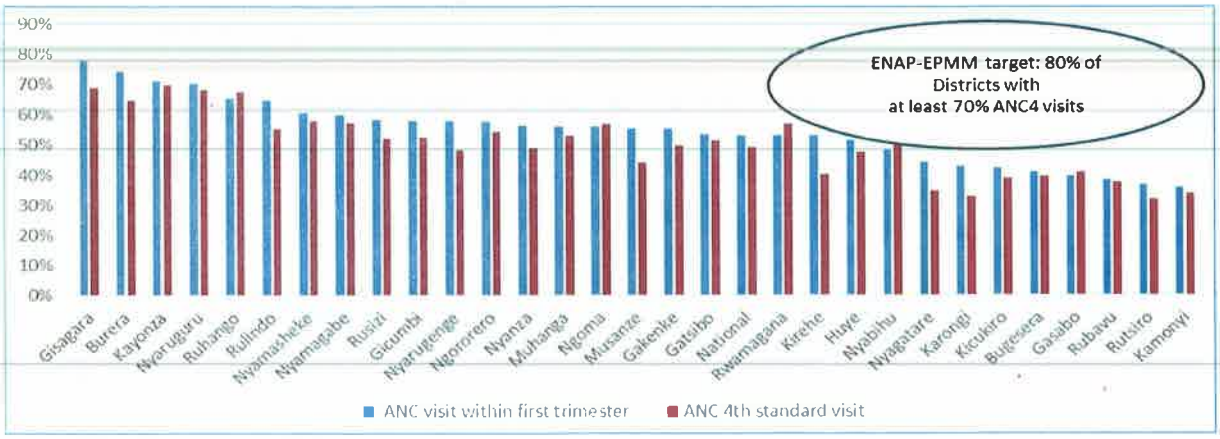


Figure 3: ANC 1st visit within the first trimester and four Standard visits of all Expected Pregnant Women (EPW) by District, in FY 2022/2023 (Source: HMIS).

The services provided at ANC are: testing for HIV, syphilis and anaemia, provision of long lasting insecticide-treated bed nets (LLINs), iron / folic acid tablets and tetanus, diphtheria (TD) vaccination as well as screening for malnutrition.

Figure 4 shows the proportion of women attending ANC for any visit who received these services.

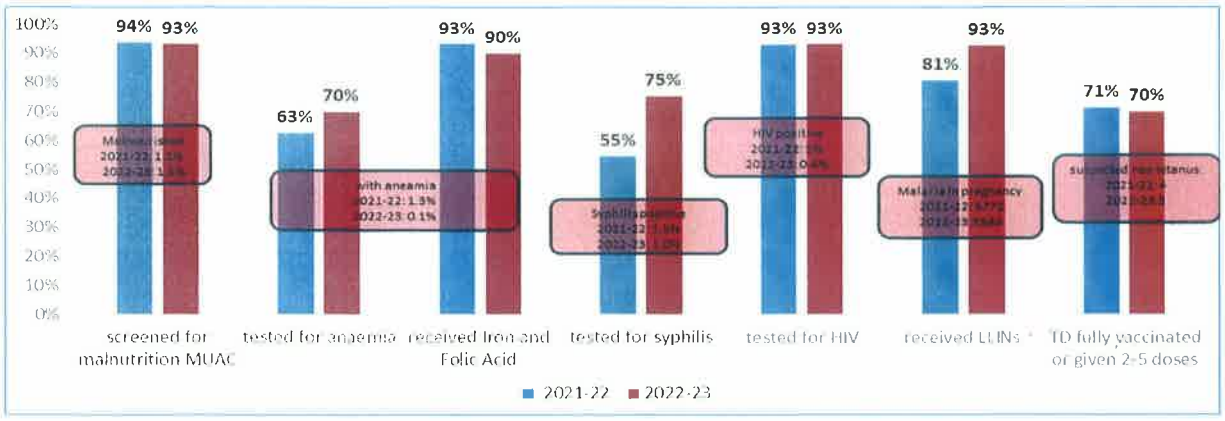


Figure 4: The proportion of women attending at least one ANC visit who received each of the required services in FY 2021/2022 & FY 2022-2023 (Source: HMIS).

In this FY 2022/2023, pregnant women visiting ANC services *at least once* during pregnancy is 104%; 93% were tested for HIV and 0.4% found positive, down from 1% positivity rate last year. Out of all women who attend ANC at least once during the pregnancy, 90% received iron and folic acid supplements compared with 93% last year. Among the 93% of screened women, 1.1% exhibited signs of malnutrition. There was an increase in the proportion of pregnant women receiving Long-lasting insecticide-treated nets (LLINs) from 81% to 93%. While malaria testing is no longer routine during ANC, health facilities confirmed 3,586 cases of malaria during curative consultations among pregnant women, a decrease from 5,772 in the previous fiscal year. There was also a 7% increase in the proportion of women attending ANC tested for anaemia and an increase from 55% to 75% tested for syphilis. The positivity rate also declined from 1.5% to 1% between the two reporting periods. Tetanus vaccine was given to 70% women with only three cases of suspected neonatal tetanus reported.

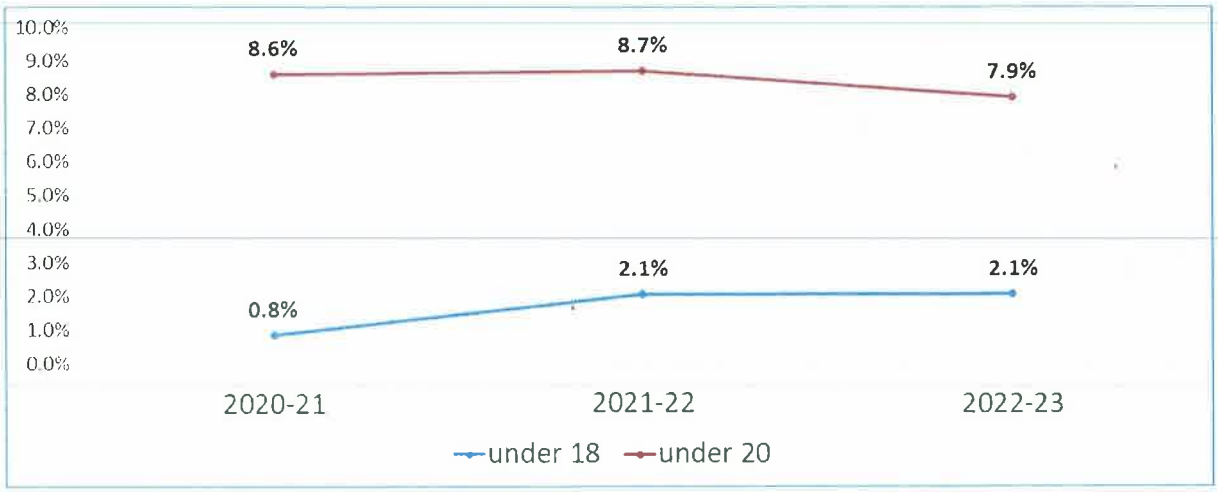


Figure 5: Proportion of women under 18 and 20 years of total pregnant women from FY 2020/2021 – FY 2022/2023 (Source: HMIS).

For FY 2022/2023, the proportion of women under 20-years-old registered in ANC services accounted for 7.9% of all ANC registrations across all age groups in Rwanda. The rate is linked to the number of women aged less than 20 years of those total pregnant women who attend ANC. Seventeen districts

reported higher than national proportion (see figure 6) [2]. These Districts were mostly in the Eastern Province.

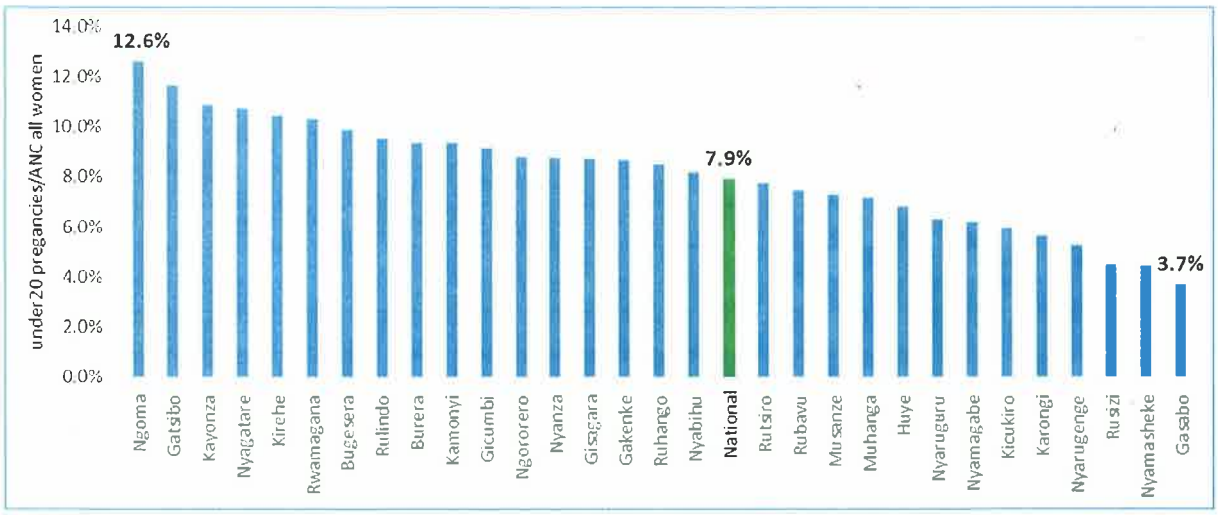


Figure 6: Proportion of under 20 year old pregnant women of ANC registrations (all ages) by District in FY 2022/2023 (Source: HMIS).

Delivery & Obstetric complications

As per the national policy, all women are encouraged to give birth at a health center, while those deemed at risk for complications are advised to go for a hospital delivery. The number of deliveries remained almost constant with an increase of 648 compared with the much larger increase of 25,754 between FY 2020/2021 and 2021/2022. In this reporting period, the 2022 census data is used as a denominator. This factor potentially contributed to the rise in the calculation of the proportion of expected pregnant women delivering in a health facility (see figure 7).

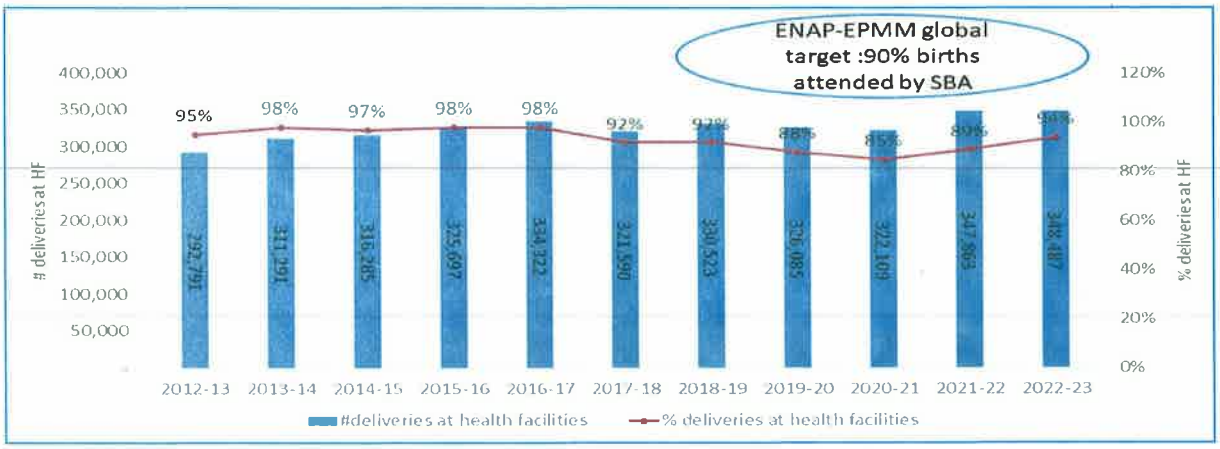


Figure 7: # deliveries and % deliveries of expected pregnant women at a health facility from FY 2012/2013 – FY 2022/2023 (census projections) (Source: HMIS).

[2] The proportion of women under 20 within the population who became pregnant in the previous year was not calculated. The calculation also excludes women under 20 years' old who do not attend ANC/continue the pregnancy.

In contrast, using the reported number of home deliveries out of the health facility deliveries in HMIS, the proportion of home deliveries is only 1.2% (see figure 8). This difference from the projected 6% of deliveries outside health facilities, based on population census estimates, suggest a potential underreporting of home deliveries. This difference is currently under investigation.

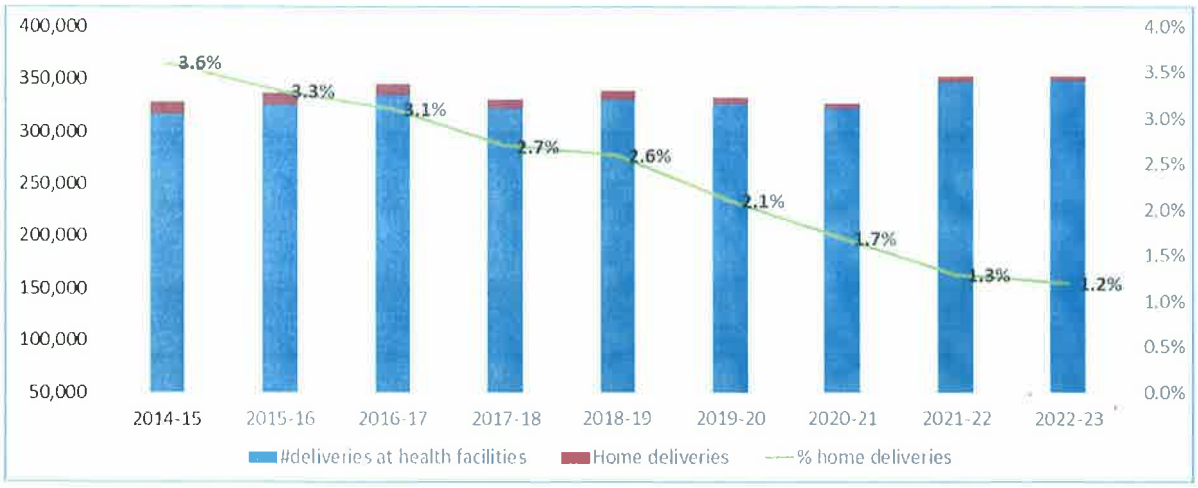


Figure 8: Total deliveries at health facility deliveries & home deliveries from FY 2014/2015 – FY 2022/2023 (Source: HMIS/ SISCOM).

Over the past ten years, maternal death audit data indicated an increase maternal deaths in relation to an increased proportion of deliveries conducted by caesarian section (C/S). Enhanced mentorship program focusing on both the indications of C/S in District Hospitals and the quality of care was conducted and consequently, the rate of C/S as a proportion of all deliveries has plateaued at 23.5% (see figure 9).

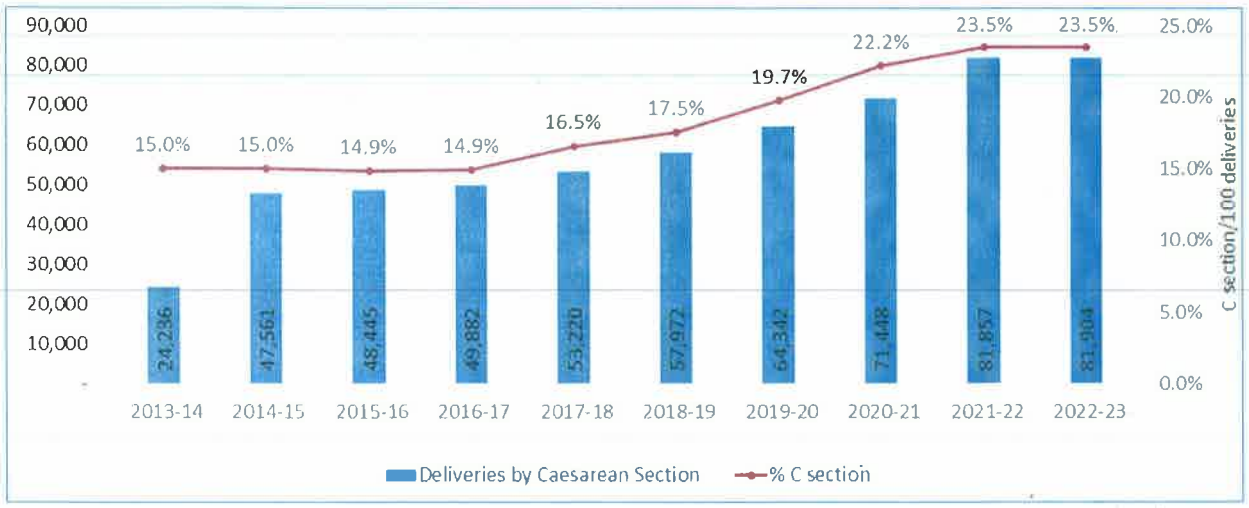


Figure 9: Caesarean sections as a proportion of all deliveries from FY 2013/2014 – FY 2022/2023 (Source: HMIS).

One of the recommendations of the Emergency Obstetric Care (EmoC) Assessment and the MCCH performance audit report from the Office of Auditor General in FY 2021/2022, was to increase the proportion of Vacuum Extraction as a means of assisted delivery in specific circumstances. This procedure can reduce the need for C/S and reduce newborn asphyxia in certain situations, such as

prolonged labor. Figure 10 shows % deliveries conducted using vacuum extraction of all health facility deliveries, over the past ten years.

Figure 10: % Deliveries conducted using Vacuum Extraction of all Health Facility Deliveries from FY 2014/2015 - FY 2022/2023 (Source: HMIS).

Most common direct and indirect obstetric complications

Table 1 shows the most common direct and indirect obstetric complications that require hospitalization. A cumulative 34,651 cases of obstetrical complications were recorded, marking an increase from 33,569 in the previous reporting period. The number of deaths *decreased* to 290 from 322[3] in health facilities. There were decreases in direct causes in particular those due to abortion (decrease from 7.14% to 5.9%), severe eclampsia from 6.83% to 3.1%, post-caesarian section (C/S) infections from 7.14% to 4.1% and ruptured uterus from 4% to 3.1%). However, the corresponding increases were due to post-partum haemorrhage (including haemorrhage post-C/S) from 23.9% to 33.4%: an overall increase of 198 cases compared with the previous reporting period. The complications registered under the 'other' data element remain considerable for both direct and indirect obstetric complications.[4]

Table 1: Obstetric complications in FY 2022/2023 (Source: HMIS)

Types causes	Causes	# of hospitalised cases	Proportional morbidity	Number of deaths	Proportional mortality	CFR
Direct Causes	Post-partum haemorrhage	2979	8.6%	97	33.4%	3.3%
	Complications of Abortions	1443	4.2%	17	5.9%	1.2%
	Complications Other	9956	28.7%	17	5.9%	0.2%
	Eclampsia	275	0.8%	15	5.2%	5.5%
	Post Caesarean Section infection	1662	4.8%	12	4.1%	0.7%
	Severe Pre-Eclampsia	2308	6.7%	9	3.1%	0.4%
	Uterine rupture	462	1.3%	9	3.1%	1.9%

[3] Room for improvement in reporting of maternal deaths in 2022-23 in the HMIS
[4] Ongoing advocacy to include more data elements in the HMIS to reduce the proportion of cases in 'other' categories.

Types causes	Causes	# of hospitalised cases	Proportional morbidity	Number of deaths	Proportional mortality	CFR
	Other Postpartum infections	555	1.6%	7	2.4%	1.3%
	Amniotic embolism	14	0.0%	5	1.7%	35.7%
	Antepartum Haemorrhage	1738	5.0%	4	1.4%	0.2%
	Prolonged or Obstructed labour	4232	12.2%	4	1.4%	0.1%
	Complications of anaesthesia	27	0.1%	4	1.4%	14.8%
	Ectopic pregnancy	1394	4.0%	3	1.0%	0.2%
Indirect Causes	Pulmonary embolism	73	0.2%	15	5.2%	20.5%
	Anaemia Severe <7gm/dl	1831	5.3%	1	0.3%	0.1%
	HIV Opportunistic Infections	164	0.5%	0	0.0%	0.0%
	Pneumonia on pregnancy	157	0.5%	0	0.0%	0.0%
	Malaria in pregnancy	387	1.1%	0	0.0%	0.0%
	Malaria in postpartum	39	0.1%	0	0.0%	0.0%
	Complications Other	4955	14.3%	71	24.5%	1.4%
Total		**34651**		**290**		**0.8%**

The proportion of reported post-partum haemorrhage of all deliveries has been stable at around 8% (see figure 11). Trainings and mentorship on management and reporting of PPH at health facilities will be intensified to enhance reporting accuracy.

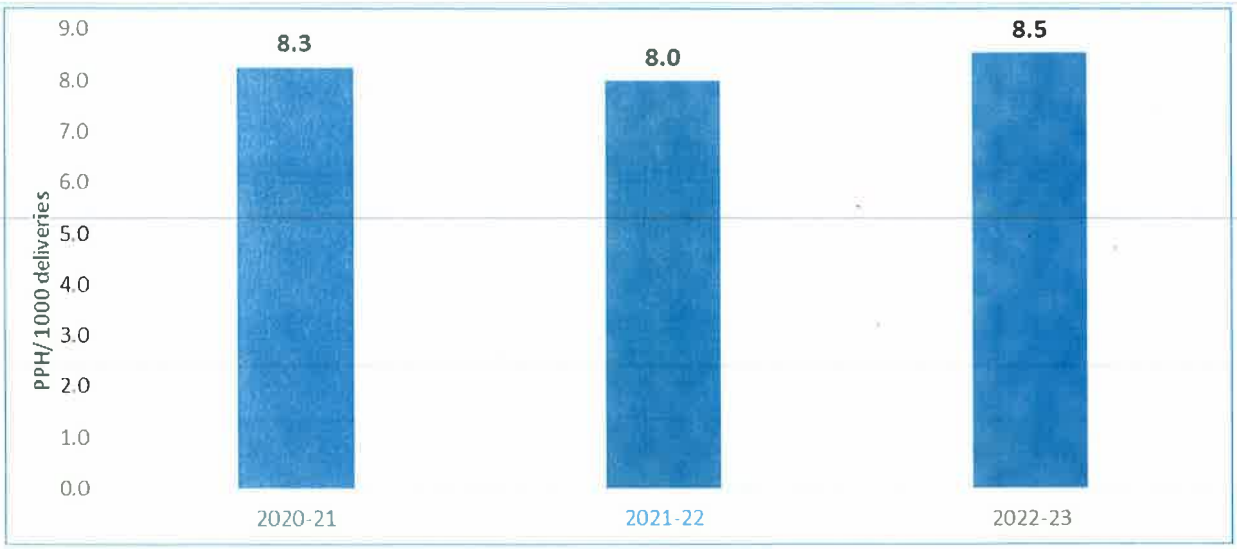


Figure 11: Proportion of postpartum hemorrhage of total health facility deliveries from FY 2020/2021 – FY 2022/2023 (Source: HMIS)

The reported range of post-partum hemorrhage cases in relation to total health facility deliveries varies significantly across districts, ranging from 2.5% to 18%. Districts housing teaching hospitals, where complex cases are often referred, tend to report higher proportions.

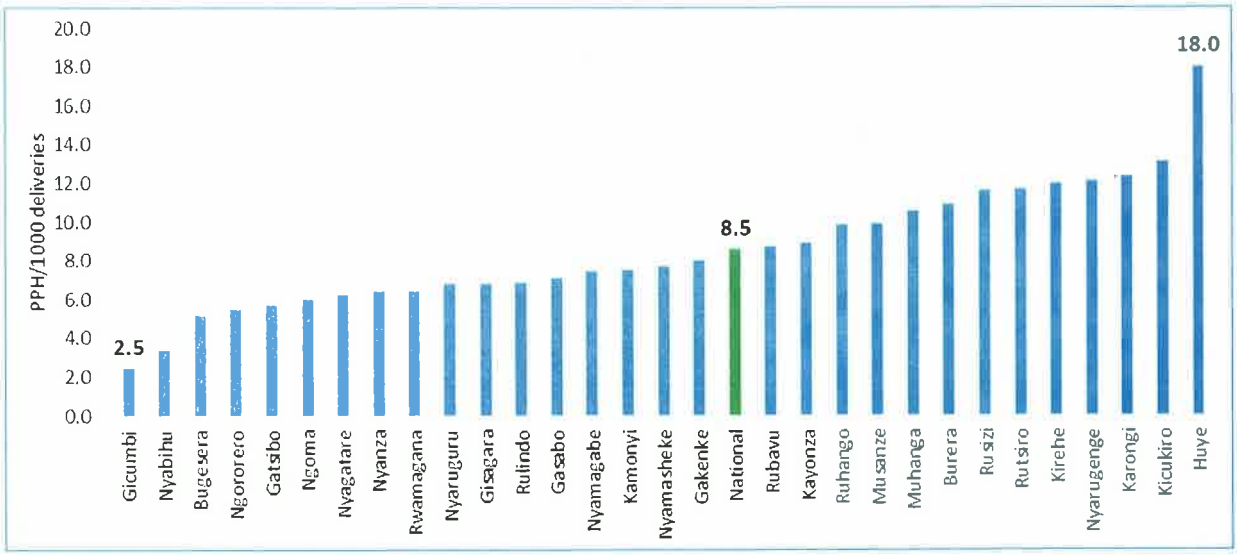


Figure 12: Proportion of postpartum hemorrhage of total health facility deliveries per district in FY 2022/2023 (Source: HMIS)

Postnatal care (PNC) for mothers and babies

In Rwanda, post-natal care (PNC) is advocated for both mother and babies within 24 hours of birth, including three subsequent visits to the nearest health facility. The majority of women deliver their babies in a health facility, giving a proportion of mothers and babies who receive the first PNC screening above 90%. Nevertheless, a gap exists between the first visit (PNC 1) within 24 hours and the recommended fourth visit (PNC 4) at six weeks after delivery. Given the similar proportions of mothers and babies receiving postnatal care, the figures primarily focus on PNC for babies.

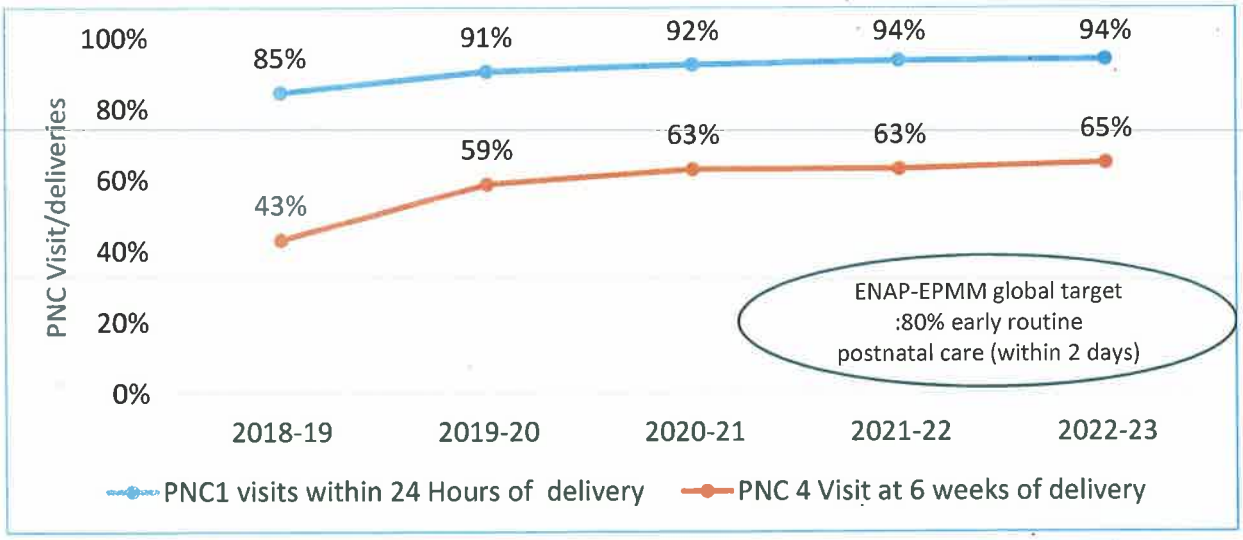


Figure 13: % PNC 1 and PNC 4 to babies of all health facility deliveries from FY 2018/2019 – FY 2022/2023 (Source: HMIS.

Maternal mortality

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*".

In FY 2022/2023, a total of 313 maternal deaths were recorded countrywide through HMIS (290 among them occurring in health facilities and 23 in the community). This marked a reduction of 42 from the previous year. The Maternal Mortality Ratio decreased from 119 in FY 2019/2020 to 88.9 per 100,000 live births in FY 2022/2023 (see figure 13). A substantial proportion of community deaths involve women who delivered in health facilities and were subsequently discharged, as revealed by verbal autopsy data.

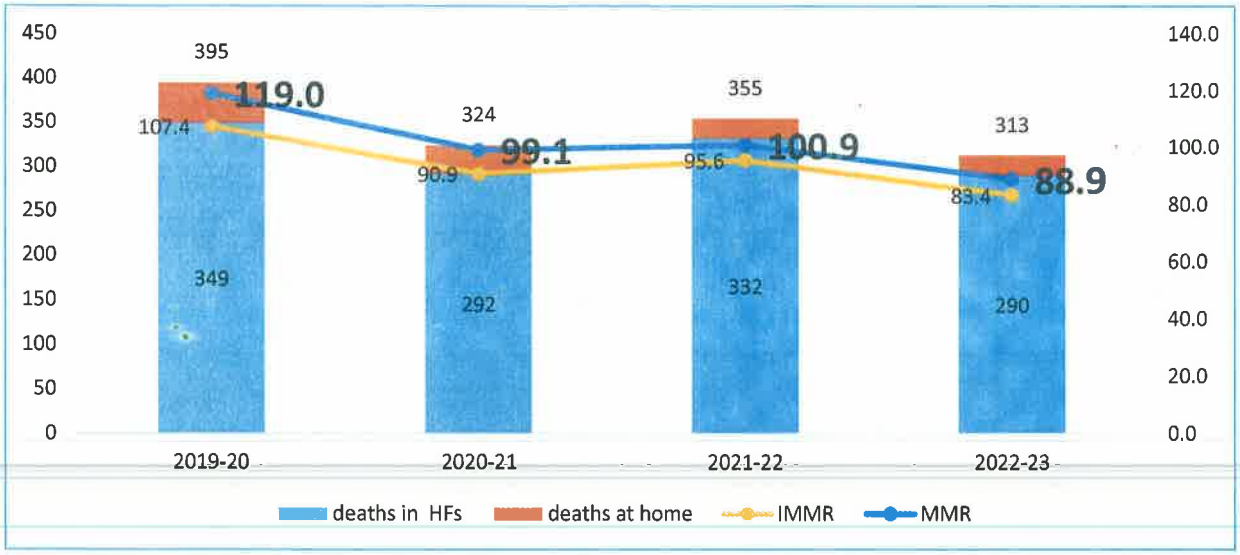


Figure 14: Maternal deaths per 100,000 live births and number of maternal deaths reported at health facility and community from FY 2019/2020 - FY 2022/2023 (Source: HMIS/SISCOM).

The most important intervention to reduce postpartum haemorrhage is the immediate postpartum administration of a uterotonic, within one minute of birth. Oxytocin is the currently recommended uterotonic of choice. Table 2 shows that the reported number of mothers who receive oxytocin for active management of third stage of labour increased from 83% in FY 2018/2019 to 97% in FY 2022/2023.

Table 2: Other delivery-related indicators in FY 2018/2019 - FY 2022/2023 (Source: HMIS)

Indicator	2018-19	2019-20	2020-21	2021-22	2022-23
% of women who received oxytocin for active management of third stage of labour	83%	94%	96%	96%	97%
% pregnant women who consulted for risk of premature delivery	4.2%	4.3%	4.4%	3.3%	3.1%
% of women who consulted for risk of premature delivery who received Corticosteroids	44%	50%	57%	79%	85%
% of women who consulted for preterm Premature Ruptured Membranes	1.7%	1.7%	1.7%	1.6%	1.6%
% of women who consulted for preterm Premature Ruptured Membranes that received prophylactic antibiotics	93%	96%	102%	105%	101%

Neonatal health indicators (including perinatal)

The *neonatal* period is from birth to 28 days of life. This section provides updated results against indicators in the neonatal period as well as the *perinatal* period that includes neonatal deaths that occur within *seven* days of birth and stillbirths. Stillbirths categorised as 'fresh' stillbirths are intrauterine deaths that occurs during labour or delivery. 'Macerated' stillbirths are intrauterine deaths that occur before the onset of labour. Interventions to prevent 'fresh' stillbirths are linked to monitoring and responding to signs of foetal distress during labour, while prevention of 'macerated' stillbirths is linked to providing quality pre-conception and antenatal care.

Total births registered in FY 2022/2023 were 352,167 (an increase of 648 from last reporting period). The proportion of live births of all births at the health facility has remained unchanged for the past five years. In total 7,219 stillbirths (2% all births) were reported. Reported 'macerated' stillbirths are around two thirds of all reported stillbirths. This has also remained constant over the past five years.

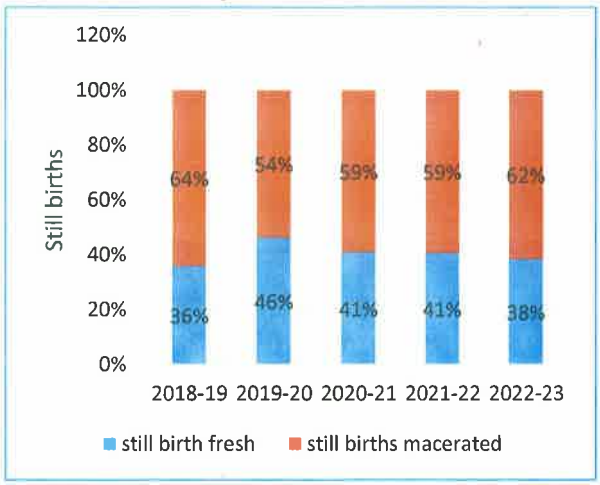


Figure 15a and 15b:

15a. Proportion of still births of all live births in health facilities from FY 2018/2019-FY 2022/2023 (Source: HMIS)

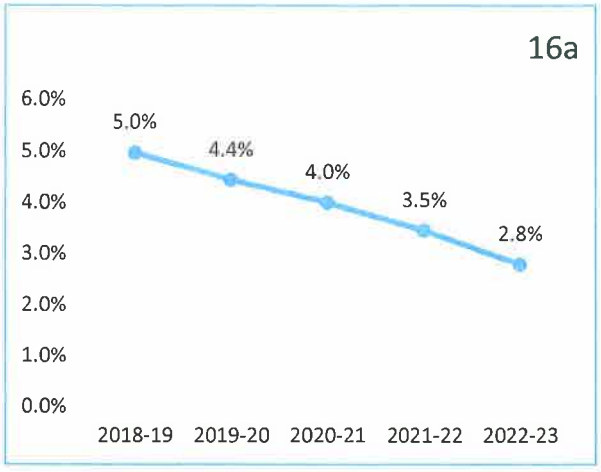
15b. Proportion of reported 'fresh' stillbirths and 'macerated' stillbirths of all reported stillbirths from FY 2018/2019-FY 2022/2023 (Source: HMIS)

Among all live births, 2.4% were low birth weight (LBW), while 3.4% were born prematurely, compared to 3.5% in the previous year. Of the 2.8% newborns that did not cry at birth, 76% were successfully resuscitated, as increase of over 20% in the last five years. Around three quarters of babies with low birth weight were admitted to Kangaroo Mother Care (KMC) units.

Table 3: Newborn indicators from FY 2018/2019-FY 2022/2023 (Source: HMIS)

Indicator	2018-19	2019-20	2020-21	2021-22	2022-23
Total births	332,812	329,742	325,917	352,067	352,167
% live birth of all births	98.7%	98.6%	98.6%	98.7%	98.7%
% stillbirths of all births	1.3%	1.4%	1.4%	1.3%	1.3%
'fresh' stillbirths of all stillbirths	36%	46%	41%	41%	38%
'macerated' stillbirths all stillbirths	64%	54%	59%	59%	62%
% premature newborns of all liveborns	2.9%	3.1%	3.3%	3.5%	3.4%
% Birth Weight under 2000 gr of all live borns	2.2%	2.3%	2.3%	2.4%	2.4%
% newborns breastfed within 1 hour of delivery	93%	95%	94%	95%	96%
% low birth weight < 2000 grams babies admitted in KMC	81%	71%	77%	73%	75%

The proportion of babies who were born alive but did not cry at birth decreased by 0.7% from last year while the resuscitation success rate increased from 75% to 76% (see figures 16a and 16b).



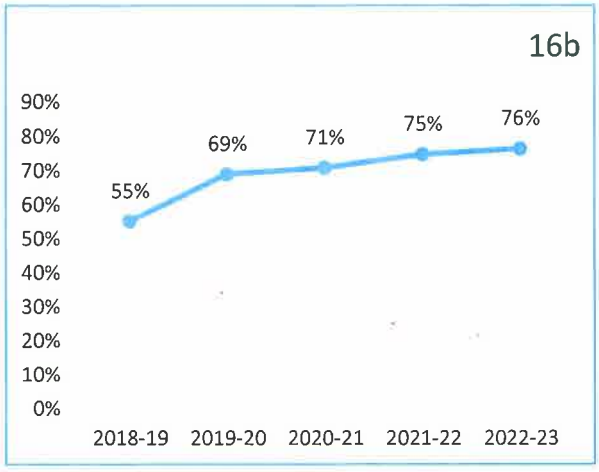


Figure 16a and 16b :

16a: Proportion of babies who were born alive but did not cry at birth from FY 2018/2019-FY 2022/2023 (Source: HMIS)

16b: Proportion of babies who were born alive but did not cry at birth and were successfully resuscitated from FY 2018/2019-FY 2022/2023 (Source: HMIS)

The stillbirth rate (SBR) from July 2022 to June 2023 was 13 per 1000 births at national level. Figure 16 shows the stillbirth rate (fresh and macerated combined) per District for FY 2022/2023. A reduced level of reporting (>2% difference) was found in Ngoma, Nyanza, Nyamagabe, Karongi, Nyagatare, Musanze and Rubavu. An *increase* of >2% was reported in Bugesera, Nyarugenge, Nyaruguru, Gakenke and Rutsiro. The number of districts reporting over 15% still births per 1000 births was 15 in FY 2020/2021, five in FY 2021/2022 and seven in this reporting period (see figure 17).

Figure 17: Proportion of still births per 1000 births by District in FY 2022/2023 (Source: HMIS)

The perinatal mortality rate includes neonatal deaths that occur within *seven* days of birth and stillbirths. There is a downward trend in perinatal mortality in *all* categories, fresh and macerated

stillbirths, deaths at birth and deaths within seven days from FY 2017/2018 to FY 2022/2023 (see figure 18[5]). 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, in particular CPAP machines, during this period (see Part II).

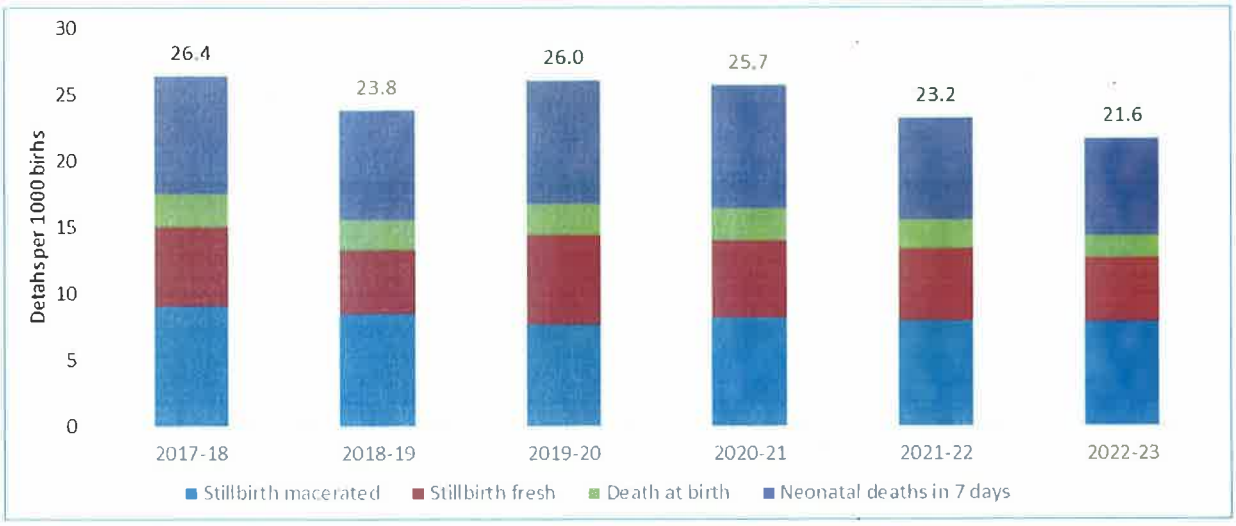


Figure 18: Perinatal mortality per 1000 births by category from FY 2017/2018-FY 2022/2023 (Source: HMIS)

There is a wide range of reported perinatal mortality rates in the district from 14 to 33 per 1000 live births. Nyarugenge, Huye and Kicukiro Districts host the key teaching/ referral hospitals serving as focal points for managing complex and high-risk pregnancies.

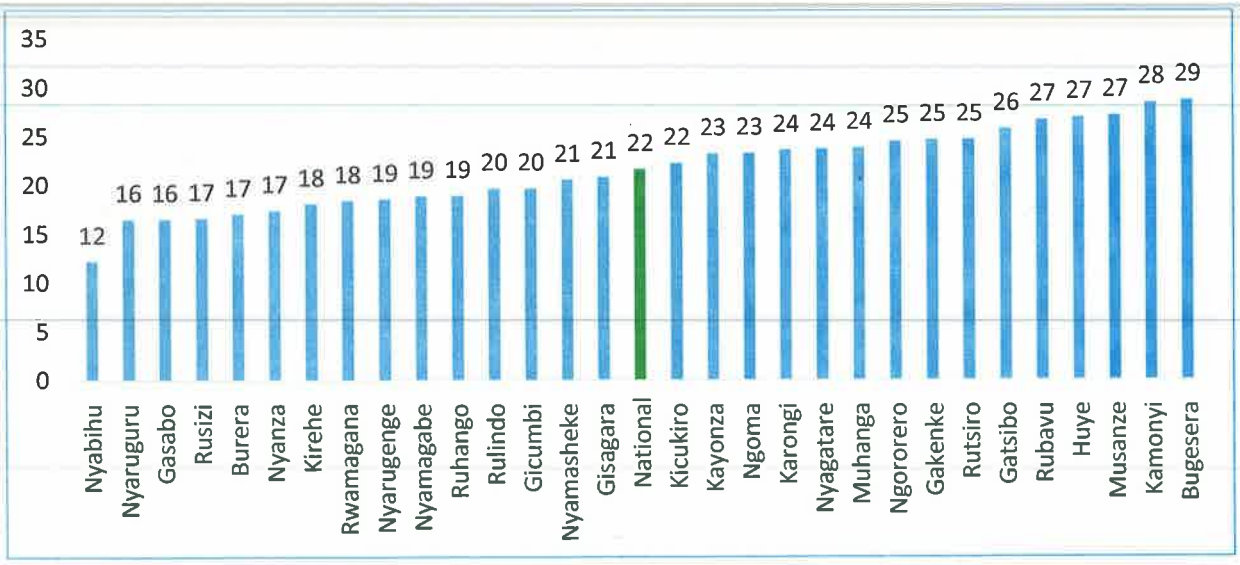


Figure 19. Perinatal mortality per 1000 births per District in FY 2022/2023 (Source: HMIS)

[5] The reason for preventing the different categories in a stacked bar chart is to reduce the influence of reporting biases within the different categories.

Neonatal morbidity and mortality

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). Neonatal sepsis is clinically diagnosed due to insufficient access to blood culture testing in most hospitals. There were 5,226 suspected sepsis cases with a proportional mortality rate of 8.5%. Congenital malformation covers a wide range of conditions, many very severe. This reflects in the high proportional mortality rate. Additional data elements have been recommended to be introduced into HMIS to better reflect the interventions needed to reduce the high mortality in congenital malformation when possible.

Table 4: Top causes of neonatal morbidity and mortality of Neonates in FY 2022/2023 (Source: HMIS)

Condition	Hospitalised cases	Proportional morbidity	Neonatal deaths	Proportional mortality	CFR
Prematurity 22 to 27 weeks	938	1.9%	582	**19.0%**	**62.0%**
Congenital malformation	1,398	2.9%	415	**13.5%**	**29.7%**
Asphyxia	4,803	**9.9%**	854	**27.8%**	**17.8%**
Prematurity 28 to 37 weeks	10,135	**20.8%**	776	**25.3%**	7.7%
Sepsis suspected	5,226	**10.7%**	261	**8.5%**	5.0%
Pneumonia	734	1.5%	30	1.0%	4.1%
Skin infections	299	0.6%	1	0.0%	0.3%
Tetanus neonatal suspected	3	0.0%	3	0.1%	**100.0%**
Hypothermia	6,343	**13.0%**	8	0.3%	0.1%
All other causes of neonatal morbidity	18,785	**38.6%**	141	4.6%	0.8%
Total cases	**48,666**		**3,071**		**6.3%**

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 children under five years of age received and treated in health facilities, 98% were seen and treated in the Integrated Management of Childhood Illness (IMCI) service facilities across the country. This is an increase from 96% in the previous reporting period. District level data is shown in Figure 20.

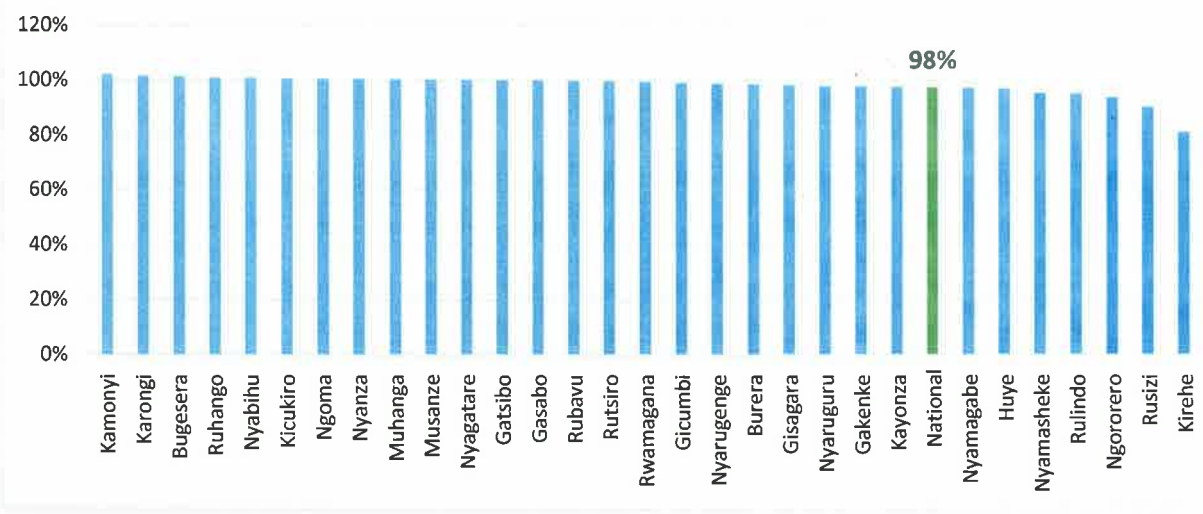


Figure 20: Proportion of children < 5 years treated in IMCI services of those treated in all health facilities by District in FY 2022/2023 (Source: HMIS)

Figure 21 shows that the proportion of children under 5 years of age who attended a health facility and were treated within IMCI services across the country increased on an annual basis for the past ten years. There was a 58% increase in the last ten years.

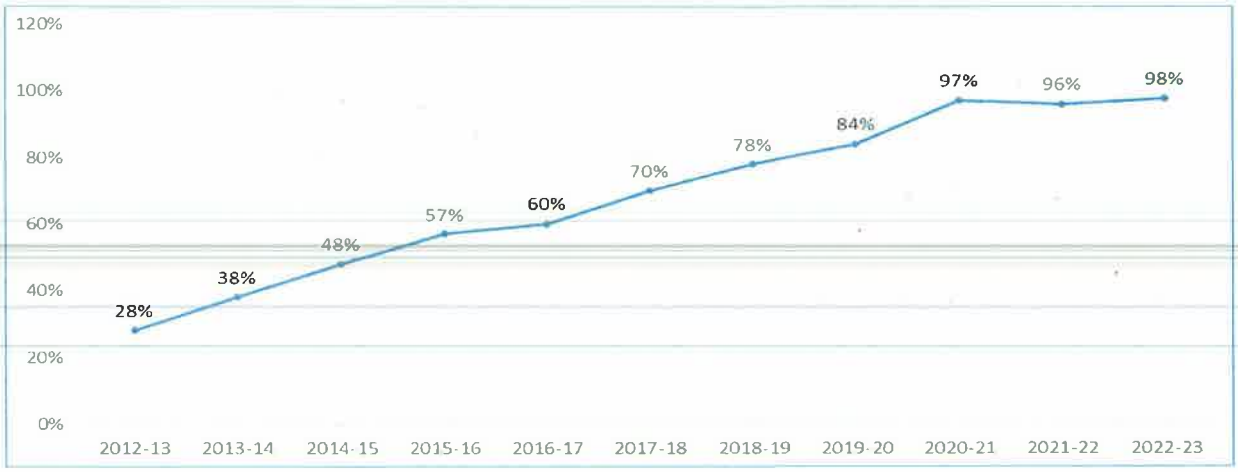


Figure 21: % children <5 years treated within IMCI services of those treated in a health facility from FY 2012/2013 - FY 2022/2023 (Source: HMIS)

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

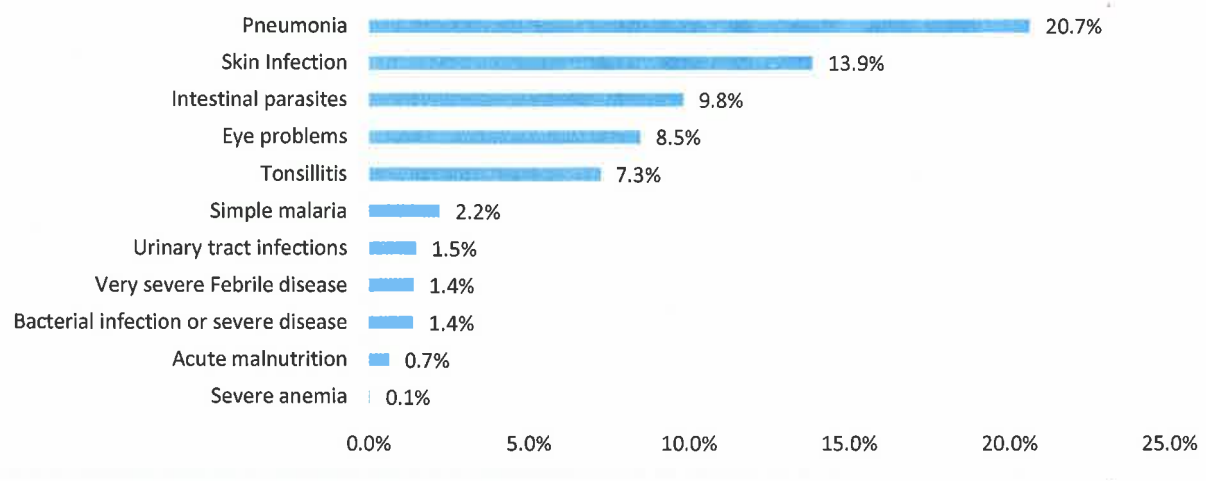


Figure 22: Reasons for attendance at health facility for children under five years of age in the IMCI units in FY 2022/2023 (Source: HMIS)

The number and proportion of children under five years of age who died in FY 2022/2023 are shown in Figure 23. The rate is calculated by using the UNICEF recommendation of using the live births for the year of the death as a denominator.

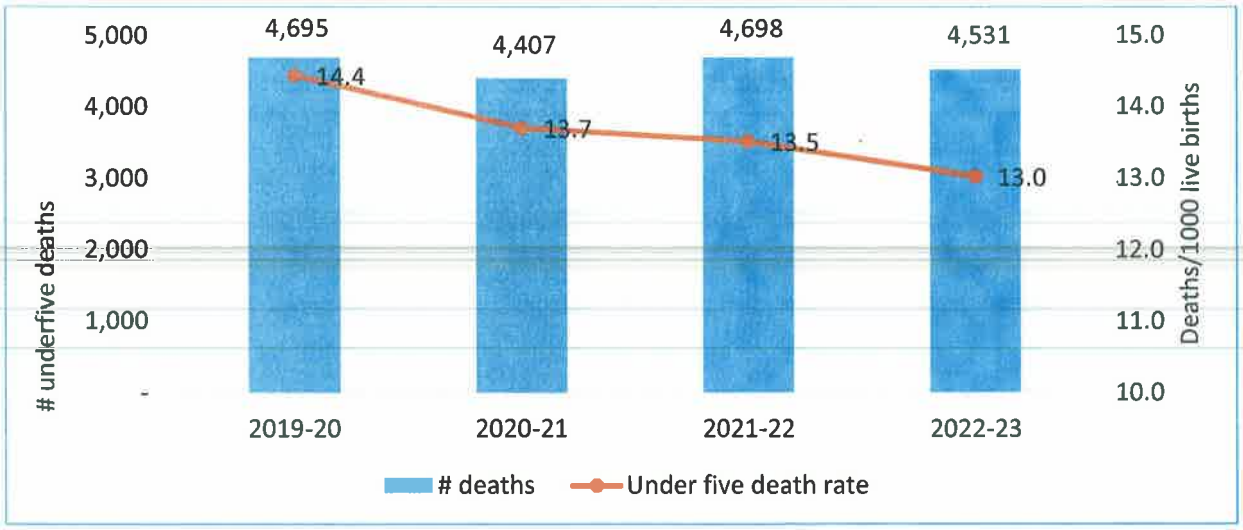


Figure 23: Number of deaths of children under five years of age and Under five death rate from FY 2019/2020 - FY 2022/2023 (Source: HMIS)

Community-based Maternal and Neonatal Health (CBMNH) and Community Case Management (CCM)

While the total number of deliveries was fairly stable, the CHWs identified and referred less new pregnant women for early ANC, PMTCT and danger signs as compared to the past two years (see figure 24).

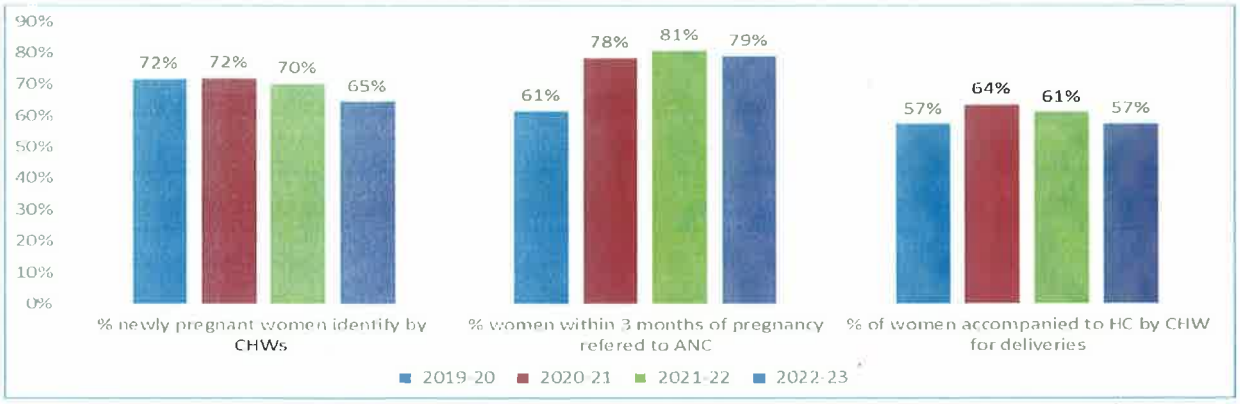


Figure 24: Community-based services for pregnant women from FY 2019/2020- FY 2022/2023 (Source: SISCOM)

However, reported home deliveries were 178 less than last year and referrals to health center during PNC visit increased. The latter is important due to the community maternal deaths being predominantly women who delivered in the health facility but were discharged. Also, among those delivering at home 53% were given misoprostol within the recommended time period compared with only 25% in FY 2021/2022. Early pregnancy testing by CHWs was performed on 7550 more women than in FY 2021/2022 and the positivity rate fell from 62% to 47% (see tables 4, 5 & 6).

Table 5: Community based maternal health indicators in FY 2022/2023 (Source SISCOM)

Data Element	2019-20	2020-21	2021-22	2022-23
Number of home deliveries	6,839	5,543	4,390	4,212
% of women who delivered at home and received misoprostol to prevent Post-Partum Haemorrhage	41%	35%	25%	53%
% of women accompanied to postnatal visit within 24 hours of home delivery	98%	83%	66%	88%
Number of mothers identified with danger signs upon the visit by the Community Health Workers	1,347	1,441	1,244	1,049
Number of mothers referred to the health center for danger signs in post-partum period after receiving home visits	2,304	1,139	931	1,312
Number of mothers referred to the health centre after miscarriage	1,891	3,262	1,361	2,360
Number of pregnant women who have been referred to the health center for any danger sign	9,689	10,285	9,375	6,024
Number of pregnant women with MUAC < 21cm	1,932	7,962	6,712	1,894
Number of breastfeeding women with MUAC < 21cm	9,284	5,007	6,069	4,586
Number of women tested pregnancy by CHWs using urine pregnancy test		37,628	32,398	59,028
Number of women tested pregnancy by CHWs using urine pregnancy test Positive		21,280	19,996	27,546
UPT positivity rate		57%	62%	47%

Table 6: Community based newborn health indicators from FY 2019/2020 – FY 2022/2023 (Source SISCOM)

Data Element	2019-20	2020-21	2021-22	2022-23
Number of newborns who received home visits on the third day after birth	215,750	230,904	243,391	235,449
Number of newborns who received home visits between 7 and 14 days after birth	198,199	216,496	230,176	223,334
Number of newborns who received home visits on 28th day after birth	54,119	34,143	30,936	24,022
Number of newborns identified with danger signs upon the visit by the Community Health Worker	4,334	2,804	2,405	1,527
Number of newborns referred to the health facility for danger signs	1,958	5,619	1,654	1,247
Number of children under Kangaroo mother care in the village	2,054	2,055	1,986	1,821
Number of children < 2 months referred to a health facility due to danger signs	2,868	2,563	2,736	2,347

Table 7: Integrated Community Case Management health indicators from FY 2021/2022 - FY 2022/2023 (Source SISCOM)

Indicator	2021-2022	2022-2023
Total cases received: Children and adults	1,309,148	1,373,185
Malaria cases (6-59 months)	312,089	283,374
Malaria cases (Adults and children > 5 years)	884,077	999,189
Diarrheal cases (2-59 months)	60,858	78,282
Pneumonia cases (2-59 months)	52,124	144,663
Total cases treated: Children and adults	643,773	578,126
Malaria cases (6-59 months)_treated	100,740	71,619
Malaria cases (Adults and children > 5 years)_treated	452,921	366,427
Malaria cases (6-59 months) presenting within 24 hrs treated	94,649	66,547
Malaria cases (Adults and children > 5 years) presenting within 24 hrs treated	418,140	331,688
Diarrheal cases treated	54,390	70,470
Pneumonia cases treated	35,722	131,975
% cases treated: Children and adults	*49%*	42%
% Malaria cases (6-59 months)	*32%*	36%
% Malaria cases (6-59 months) presenting within 24 hrs_treated	*94%*	93%
% Malaria cases (Adults and children > 5 years)	*51%*	37%
% Malaria cases (Adults and children > 5 years) presenting within 24 hrs treated	*92%*	91%
% Diarrheal cases (2-59 months)	*89%*	90%
% Pneumonia cases (2-59 months)	*69%*	91%
Number of RDTs (all) carried out	1,213,754	1,002,930
Number of RDTs (all) carried out_positive	553,350	365,215
Proportion of total malaria cases received vs RDTs carried out	99%	100%
Proportion of malaria cases treated vs positive RDTs	100%	100%

All CHWs are trained and equipped to provide screening and treatment for malaria, diarrhea 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 (see figure 25) for pneumonia and diarrhea. There was an increase in cases of pneumonia and malaria treated by CHWs and little change for diarrheal cases in FY 2022/2023.

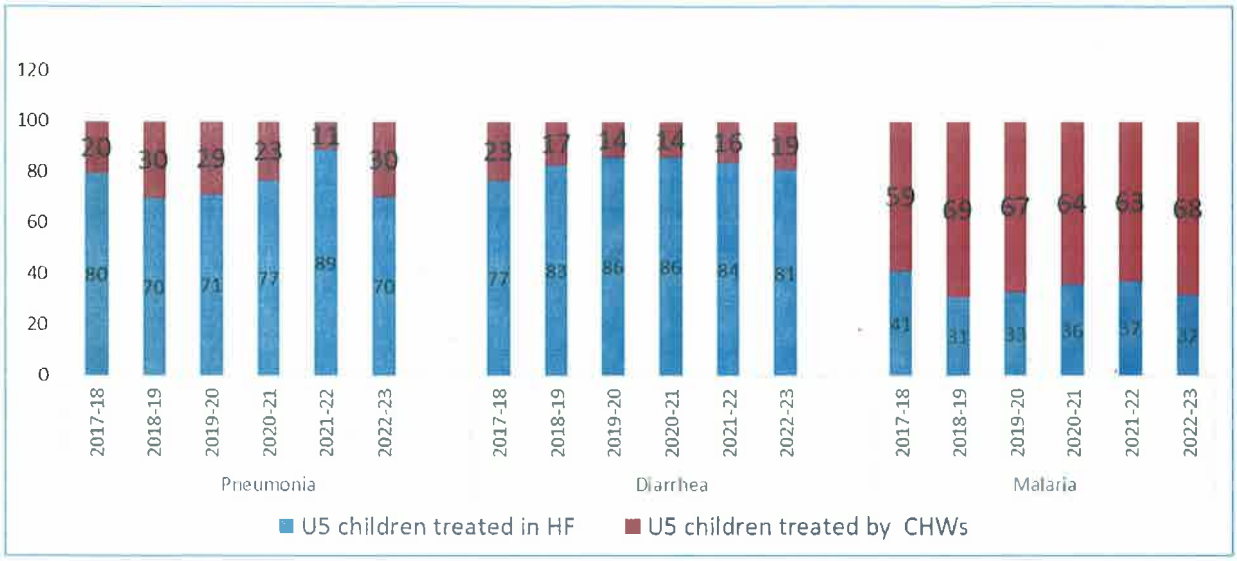


Figure 25: Proportion of children under 5 years treated for pneumonia, diarrhea and malaria between Community Health Workers and Health Centres from FY 2017/2018 – 2022/202023. (Source: HMIS/SISCOM)

User fees for treatment of diarrhoea and pneumonia were removed in March 2023. Figure 26 shows the impact of this policy change on service utilization.

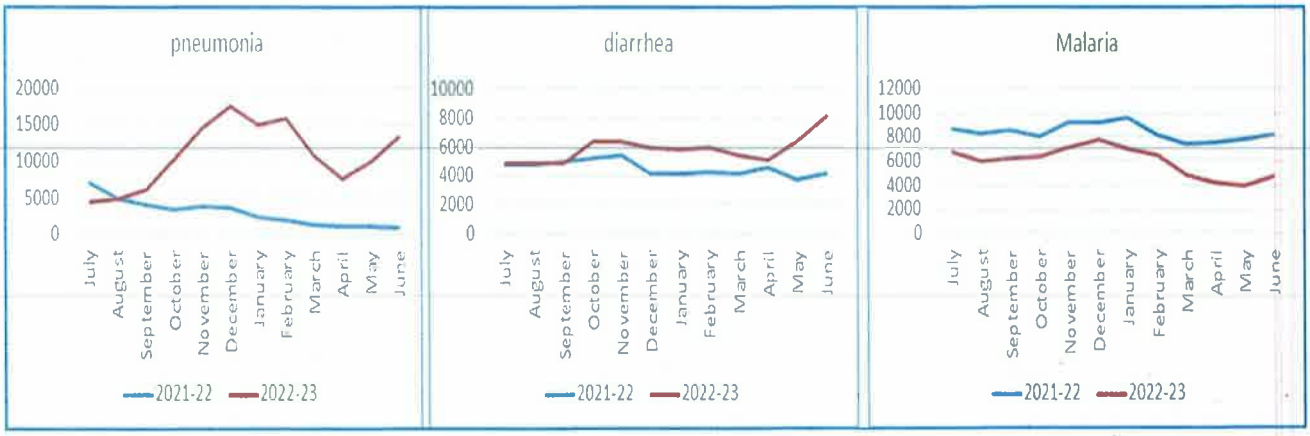


Figure 26: Number of children under 5 years of age treated for pneumonia, diarrhoea and malaria by Community Health Workers on monthly basis in FY 2022/2023 (Source: SISCOM)

I.2 VACCINATION

Childhood vaccines have contributed to the reduction in mortality of children under five years of age in Rwanda. The current expanded vaccine program includes vaccines for pregnant women; babies at birth; babies in the first year of life and young girls among others. The vaccine schedule is shown in Table 8:

Table 8: Rwanda Vaccination schedule

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

Routine vaccination

Immunization coverage is calculated based on 2022 national census projections for children under the age of one year. In FY 2022/2023, 99% of expected children received a BCG vaccine, 93% received polio 0, 101% of children have been vaccinated for penta 1 and other vaccines for the same age, 101% children have been vaccinated for penta 2 and other vaccines for the same age, 100% children have been vaccinated for penta 3 and other vaccines for the same age, 100% were vaccinated for MR 1 at 9 months of age and 90% received MR 2 at 15 months of age (see figure 27).

As a result of the successful vaccination programme there have been no reported cases of polio, rubella or diphtheria. There were 33 cases of measles hospitalised and nine deaths and three suspected cases of neonatal tetanus in FY 2022/2023.

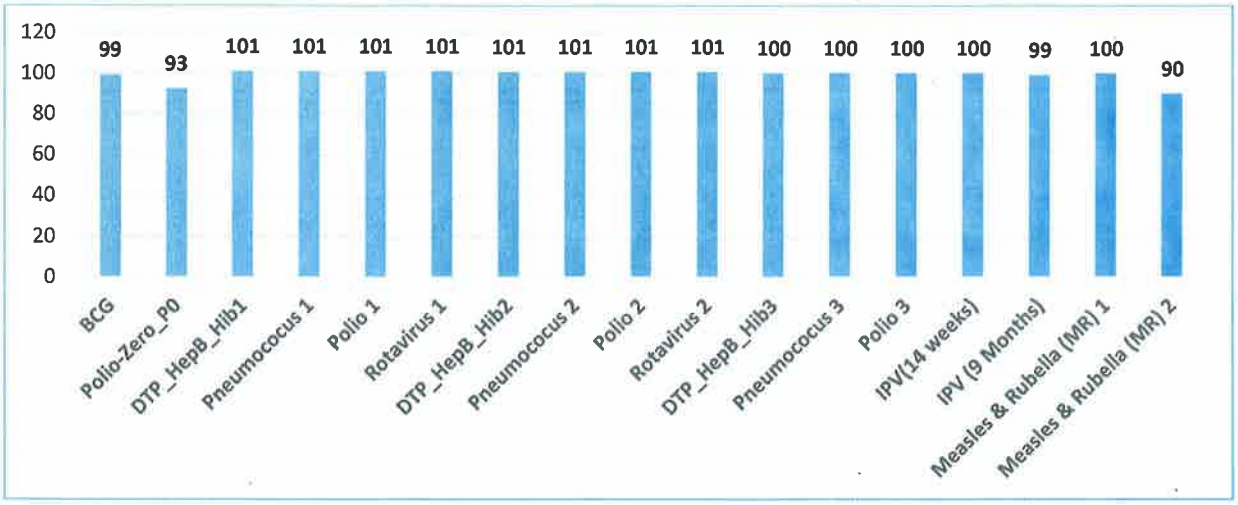


Figure 27: Proportion of children under one year of age vaccinated per vaccine in FY 2022/2023 (Source: HMIS)

The trend over the last ten years shows an increase in vaccination coverage for the last fiscal year (see figure 28). FY 2022/2023 rates were calculated using the 2022 census population projections as denominator, while previous years used BCG as a proxy denominator.

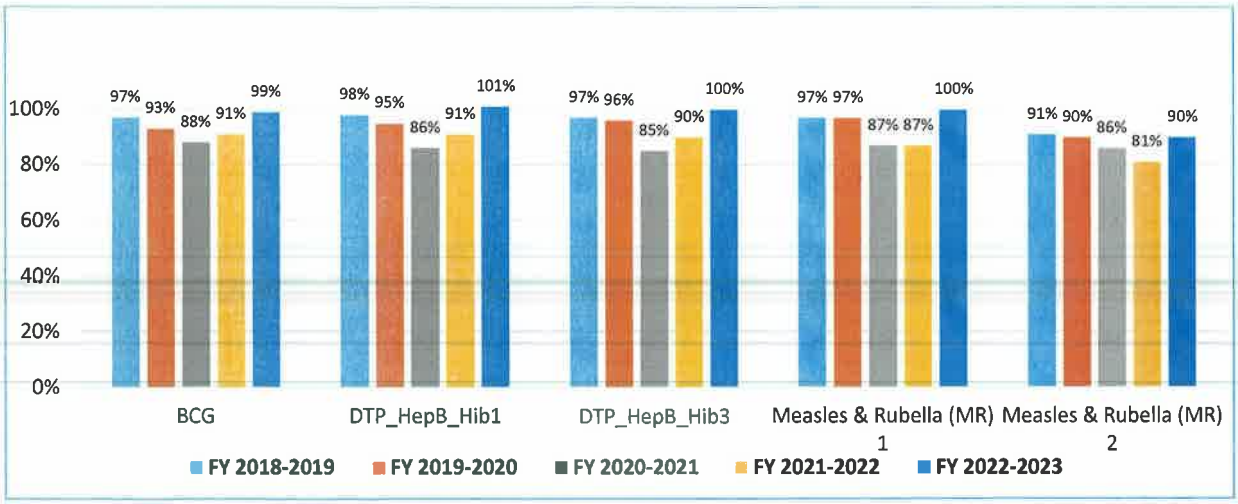


Figure 28: Proportion of children under one year vaccinated by type of vaccine from FY 2018/2019 – 2022/2023 (Source: HMIS)

The vaccination coverage and dropout rates vary between Districts as shown in Table 9. Gakenke and Kamonyi have lower than expected coverage rates while Gasabo, Kamonyi, Kicukiro, Nyabihu and Rutsiro have higher dropout rates. Dropout rates are affected by migration from rural areas for delivery, where BCG and Polio 0 are given before discharge.

Table 9: Routine Immunization coverage and dropout rate in FY 2022/2023 (Source: HMIS)

	Vaccination coverage FY 2022-2023																	Dropout rate		
District	BCG	DTP_HepB_Hib1	DTP_HepB Hib2	DTP_HepB Hib3	IPV (9 Months) July 2022	IPV(14 weeks)	Measles & Rubella (MR) 1	Measles & Rubella (MR) 2	Pneumococus 1	Pneumococus 2	Pneumococus 3	Polio 1	Polio 2	Polio 3	Polio-Zero_P0	Rotavirus 1	Rotavirus 2	Dropout rate (Penta 1&3)	Dropout rate (Penta 1&MR1	Dropout rate (MR1&2)
Bugesera	102%	106%	108%	107%	107%	107%	108%	100%	106%	108%	107%	105%	107%	106%	94%	106%	108%	-1%	-2%	7%
Burera	99%	101%	101%	99%	95%	99%	95%	86%	101%	101%	99%	101%	101%	99%	92%	101%	101%	2%	6%	5%
Gakenke	89%	91%	90%	91%	93%	91%	93%	89%	91%	90%	91%	91%	90%	91%	83%	91%	90%	1%	-2%	5%
Gasabo	100%	105%	103%	102%	96%	102%	99%	84%	105%	103%	102%	105%	103%	102%	93%	105%	103%	2%	6%	15%
Gatsibo	99%	100%	100%	101%	103%	101%	103%	94%	100%	101%	101%	100%	101%	101%	95%	100%	101%	-1%	-2%	8%
Gicumbi	94%	95%	95%	95%	97%	95%	97%	95%	95%	95%	95%	95%	95%	95%	88%	95%	95%	0%	-2%	2%
Gisagara	107%	109%	108%	107%	105%	107%	105%	96%	109%	108%	107%	109%	108%	107%	97%	109%	108%	1%	3%	9%
Huye	96%	100%	99%	98%	98%	99%	98%	91%	100%	99%	98%	100%	99%	98%	91%	100%	99%	2%	2%	7%
Kamonyi	86%	88%	87%	86%	86%	86%	86%	76%	86%	87%	86%	86%	87%	86%	76%	86%	87%	-1%	0%	10%
Karongi	101%	99%	98%	97%	96%	98%	95%	84%	99%	98%	97%	99%	98%	97%	88%	99%	98%	2%	4%	12%
Kayonza	101%	102%	102%	101%	103%	101%	103%	90%	102%	102%	101%	102%	102%	101%	77%	102%	102%	1%	-1%	13%
Kicukiro	102%	100%	99%	97%	93%	98%	96%	82%	100%	99%	98%	100%	99%	97%	85%	100%	99%	2%	3%	15%
Kirehe	102%	102%	102%	103%	103%	103%	102%	92%	102%	102%	103%	102%	102%	103%	86%	102%	102%	0%	0%	10%
Muhanga	95%	97%	97%	95%	97%	95%	97%	93%	97%	97%	95%	97%	97%	95%	84%	97%	97%	2%	0%	4%
Musanze	98%	102%	102%	101%	102%	101%	102%	91%	102%	102%	101%	102%	102%	101%	93%	102%	102%	0%	0%	11%
Ngoma	98%	102%	102%	100%	103%	100%	103%	93%	102%	102%	100%	102%	102%	100%	81%	102%	102%	2%	-1%	9%
Ngororero	102%	96%	94%	92%	87%	92%	88%	76%	96%	94%	92%	96%	94%	92%	96%	96%	94%	4%	8%	14%
Nyabihu	107%	103%	105%	104%	96%	105%	102%	85%	103%	105%	104%	103%	105%	104%	104%	103%	105%	-1%	1%	17%
Nyagatare	105%	107%	107%	106%	109%	106%	109%	92%	107%	107%	106%	107%	107%	106%	84%	107%	107%	1%	-1%	15%
Nyamagabe	92%	92%	90%	90%	90%	90%	89%	87%	92%	90%	90%	92%	90%	90%	84%	92%	90%	2%	2%	3%
Nyamasheke	90%	95%	95%	95%	96%	95%	96%	92%	95%	95%	95%	95%	95%	95%	84%	95%	95%	-1%	-1%	4%
Nyanza	93%	96%	96%	94%	97%	94%	97%	90%	96%	96%	94%	96%	96%	94%	81%	96%	96%	2%	-2%	8%
Nyarugenge	138%	117%	116%	113%	105%	113%	113%	101%	117%	116%	113%	117%	116%	113%	126%	117%	116%	4%	4%	10%
Nyaruguru	98%	99%	99%	100%	99%	100%	99%	92%	99%	99%	100%	99%	99%	100%	94%	99%	99%	-2%	0%	7%
Rubavu	107%	112%	111%	111%	104%	111%	105%	90%	112%	111%	111%	112%	111%	111%	92%	112%	111%	2%	6%	14%
Ruhango	94%	100%	99%	100%	99%	100%	101%	101%	100%	99%	100%	100%	99%	100%	89%	100%	99%	0%	-1%	-1%
Rulindo	93%	97%	98%	97%	94%	97%	95%	89%	97%	98%	97%	97%	98%	97%	88%	97%	98%	0%	2%	6%
Rusizi	108%	111%	110%	110%	112%	110%	116%	104%	111%	110%	110%	111%	110%	110%	101%	111%	110%	1%	-4%	11%
Rutsiro	95%	100%	100%	98%	96%	98%	95%	77%	100%	100%	98%	100%	100%	98%	74%	100%	100%	2%	5%	19%
Rwamagana	95%	101%	101%	101%	105%	102%	101%	89%	101%	101%	102%	101%	101%	102%	84%	101%	101%	0%	0%	12%
National	99%	101%	101%	100%	99%	100%	100%	87%	101%	101%	100%	101%	101%	100%	90%	101%	101%	1%	1%	13%

Figure 29 is a map showing that no Districts had a vaccine coverage for Penta 3 under 80% in FY 2022/2023. The majority were above 94%.

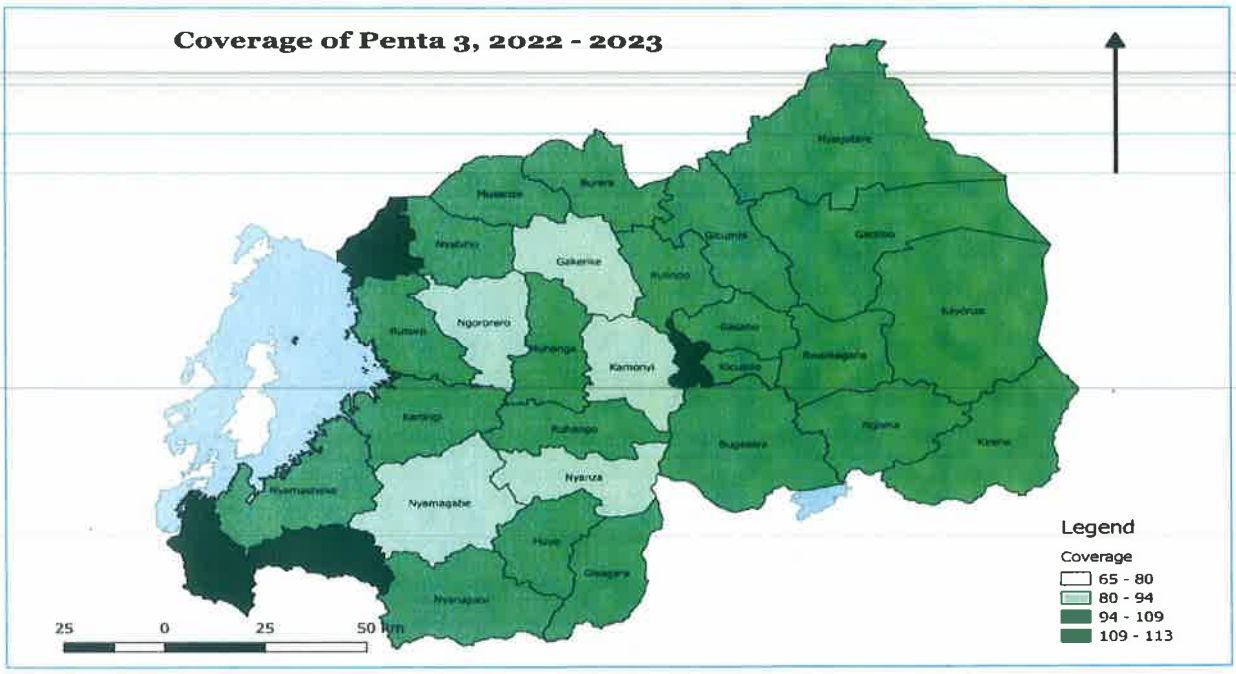


Figure 29: Vaccine coverage for Penta 3 by District in FY 2022/2023 (Source: HMIS)

Human Papilloma Virus vaccination

Vaccination against the Human Papilloma Virus (HPV) was introduced in 2021 for girls aged 12 years of age. The coverage rates are 83% for first dose, a decrease from 88% in FY 2021/2022 and 79% for

the second dose, an increase from 78% in FY 2021/2022. The dropout rate between 1st dose and 2nd dose was 4% compared with 10% last fiscal year, partially due to the high coverage of HPV 1 (see figure 30).

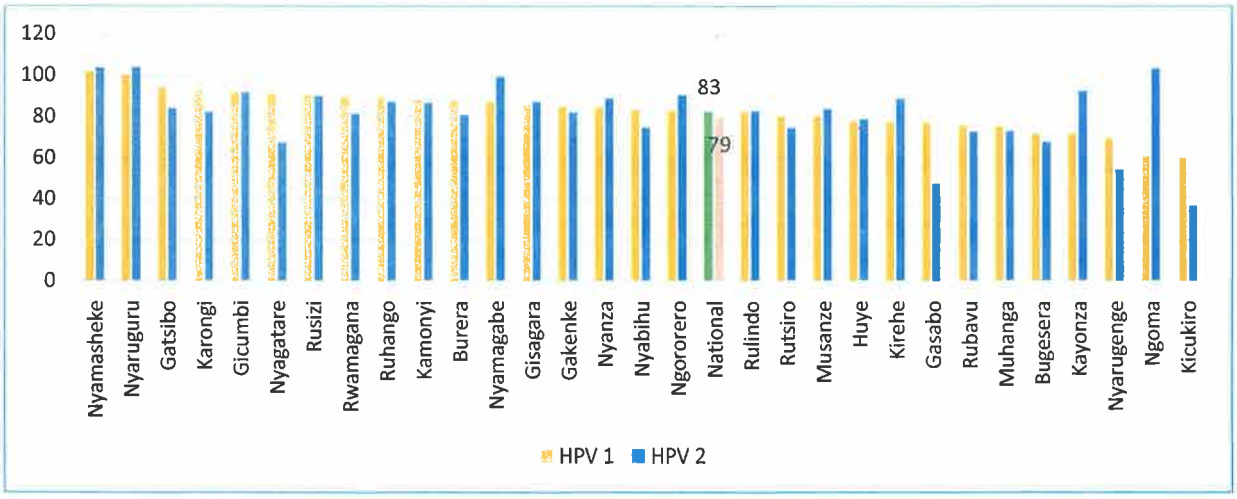


Figure 30 : Proportion of girls aged 12 receiving HPV 1 and HPV 2 vaccine in FY 2022/2023 (Source: HMIS)

I.2.3 COVID-19 vaccination

Covid vaccines were introduced in Rwanda in May 2021. By the end of June 2023, 85% of total population had received 1st dose of COVID-19 vaccine; 80% had received the second dose while 44% people had received a booster dose (see figure 31).

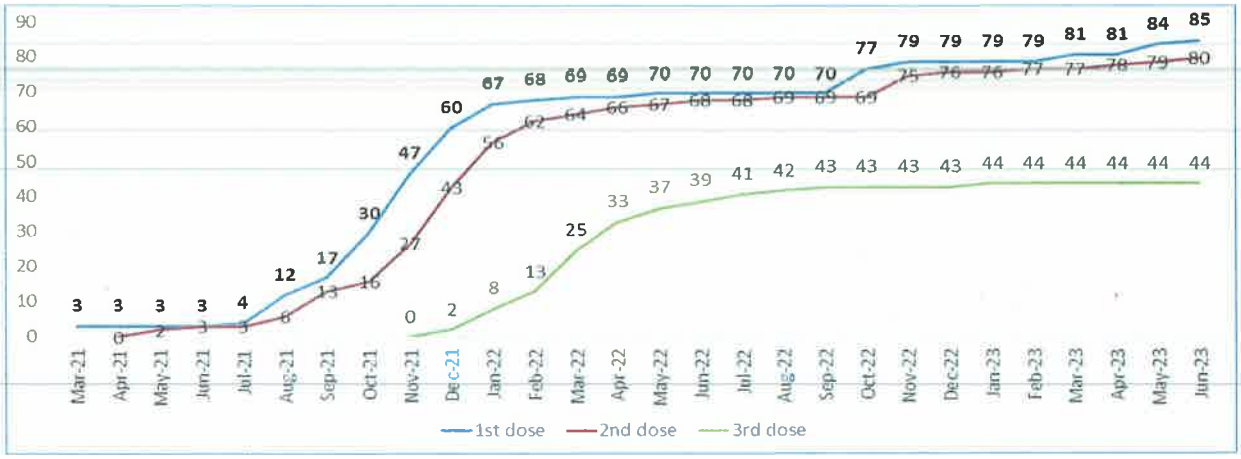


Figure 31: COVID-19 vaccination coverage of total population from May 2021 to June 2023

I.3 NUTRITION

The screening for nutritional status of children under five years of age using weight-for-age measurement increased to 91% in June 2023 compared with 84% in June 2021. Screening coverages are lower in highly urbanized areas compared with rural areas while in three Districts it was below

70% (Kamonyi: 62%, Muhanga: 68% and Nyanza: 69%) (see figure 32). Children who are screened and found to have malnutrition should be referred to health centers for nutrition rehabilitation.

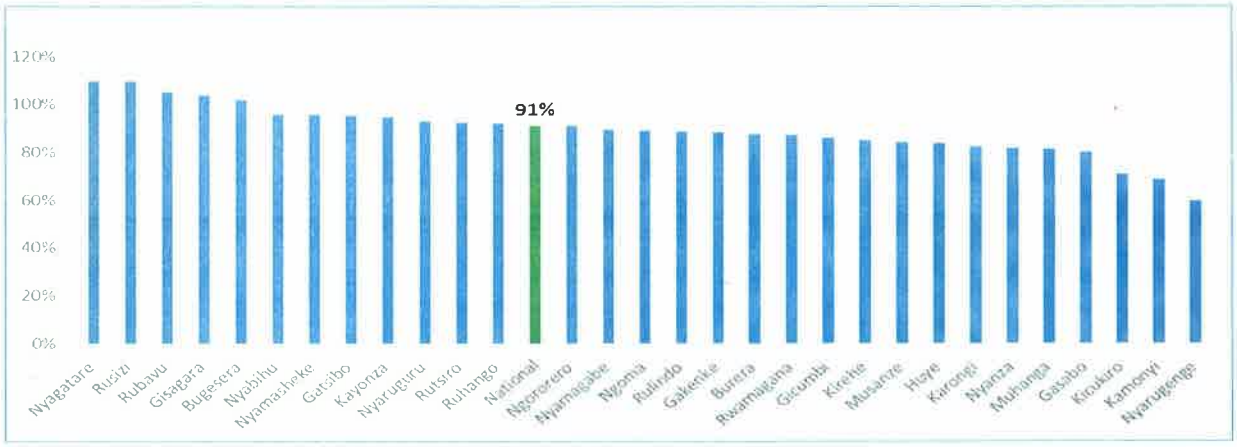


Figure 32: Proportion of expected children 6-59 months screened for malnutrition (Weight for age) by CHWs by District in FY 2022/2023 (Source: SISCOM)

Over the past ten years the Government of Rwanda has put a focus on prevention and reduction of malnutrition across the country in children under five years of age. CHWs were equipped to enable them to provide services and screen children at village levels. All these interventions resulted into an increase in screening for acute malnutrition from 72% to 91% (see figure 33).

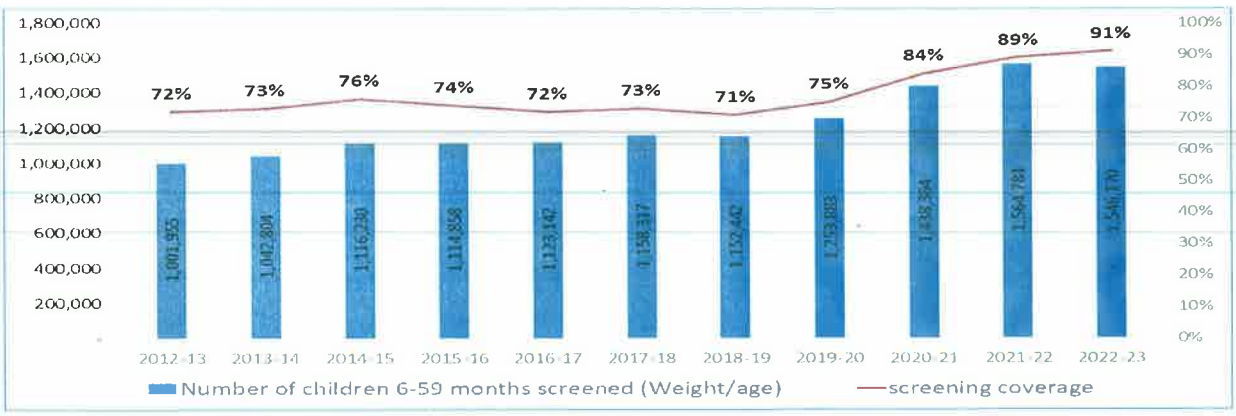


Figure 33: Number and proportion of children 6-59 months of age screened for malnutrition (Weight for age) by CHWs from FY 2012/2013 – FY 2022/2023 (Source: SISCOM)

The number of children who were admitted into the nutrition rehabilitation program at health facilities increased by over 3000 in the past two years (see figure 34).

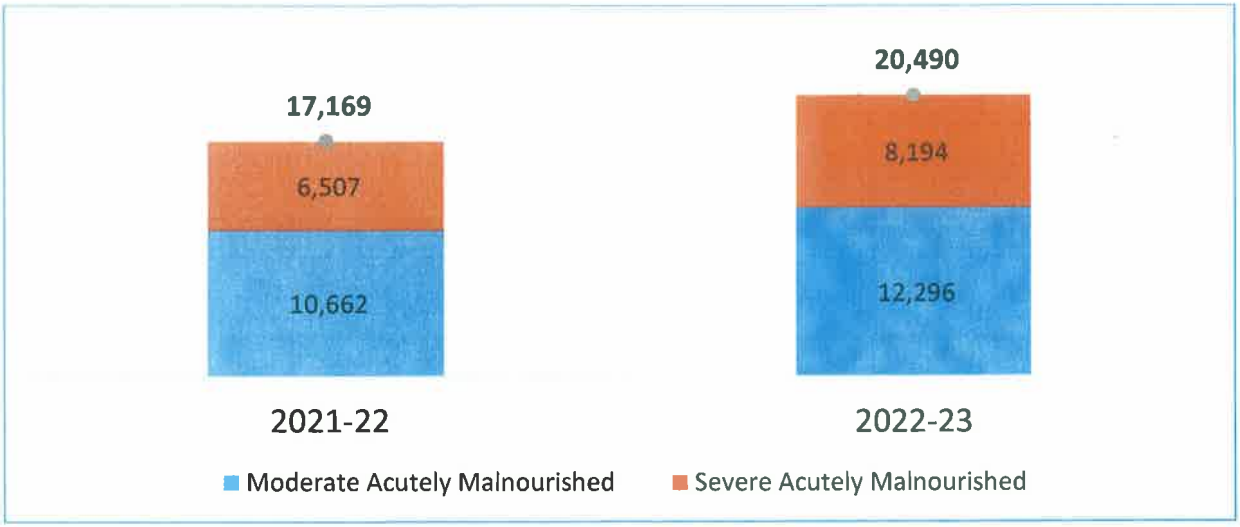


Figure 34: Number of moderate and severe acute malnutrition cases admitted in nutrition rehabilitation program at health facilities from FY 2012/2013 – FY 2022/2023 (Source: SISCOM)

I.4 FAMILY PLANNING SERVICES

By the end of June 2023, the national average Contraceptive Prevalence Rate (CPR) was at 55% for all methods combined. Thirteen districts were below the national average and only two districts - Nyarugenge and Kicukiro- have a CPR below 40% but with improvement compared to the previous reporting period: Nyarugenge increased from 24% to 37% and Kicukiro increased from 35% to 37% (see figure 35).

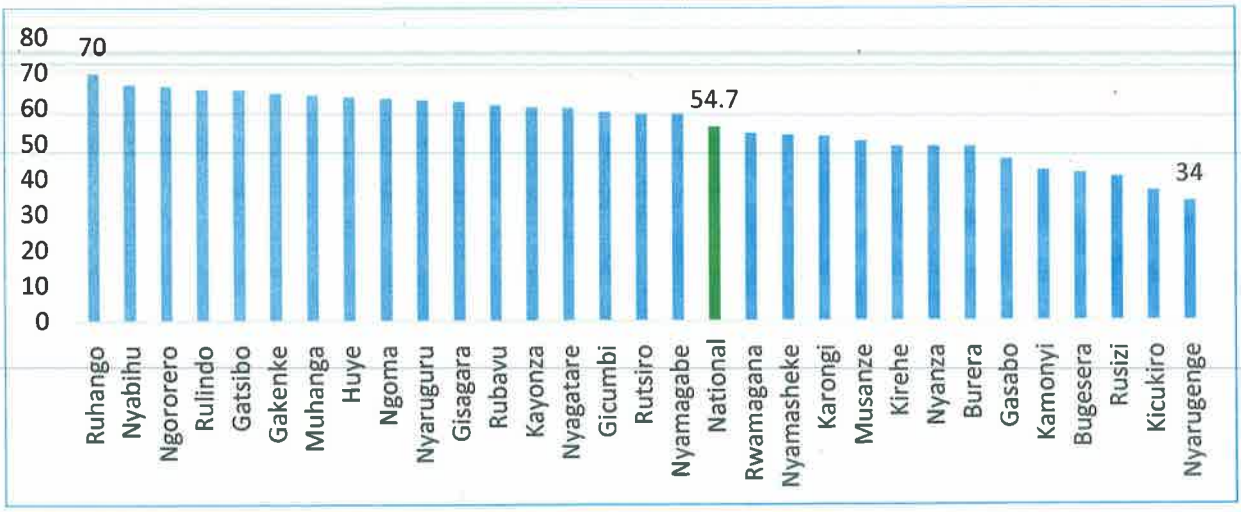


Figure 35: Contraceptive Prevalence Rate (CPR) (all methods) in health facilities by District vs. projected women of reproductive age as of end June 2023 (Source: HMIS).

The CPR, based on expected women of reproductive age (WRA), increased from 40% in 2012/13 to 55% in 2022/23. However, the contribution of CHWs in follow up of FP users decreased from 74% to 12% 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, see increase from 17% in FY 2017/2018 to 67% in FY 2022/2023 (see figure 36).

Recommendations from a study on the improvement of PPFP rates in hospitals were introduced in all hospitals in FY 2022/23, resulting in a further increase of 9% in the past twelve months.

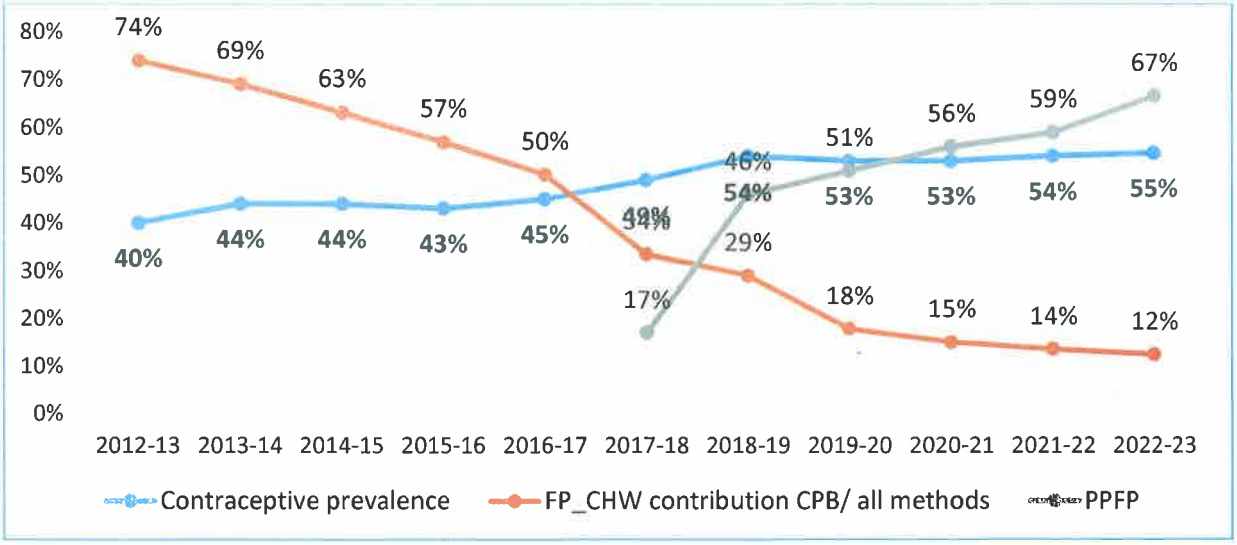


Figure 36: Post-Partum Family Planning, Contraceptive Prevalence Rate and contribution of CHWs in FP services from FY 2012/2013 – FY 2022/2023 (Source: HMIS & SISCOM)

Of the women who gave birth in a health facility, 67% received a family planning method before discharge. PPFP is highly impacted by the sensitization sessions held during ANC visits and intra- and post-partum education of mothers (see figure 37). Possible causes of low performance in PPFP for different districts are some faith-based health facilities that do not provide modern family planning services and low reporting rate of private health facilities particularly in Kigali City.

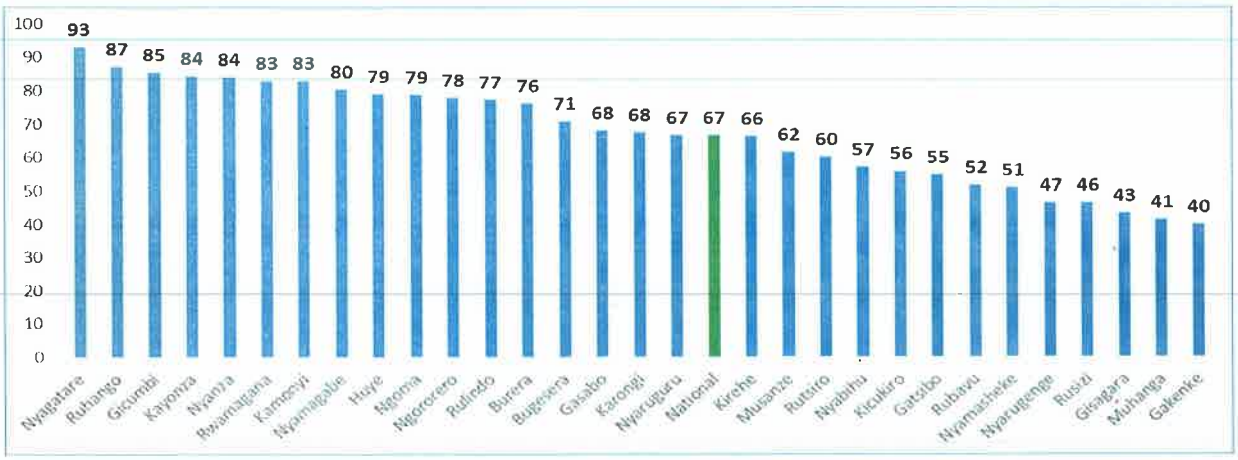


Figure 37: Post-partum family planning of all deliveries per District in FY 2022/2023 (Source: HMIS)

The demand for implants as a family planning method is increasing over time while the demand for injectable family planning methods is declining. Demand for implants started increasing in 2017 when PPFP program was introduced and scaled up across country. By June 2023, the commonly preferred method implants were implants at 42%, injectables at 33%, and pills 18%.

This change mix can explain the decline of clients receiving methods from CHWs as seen in figure 38.

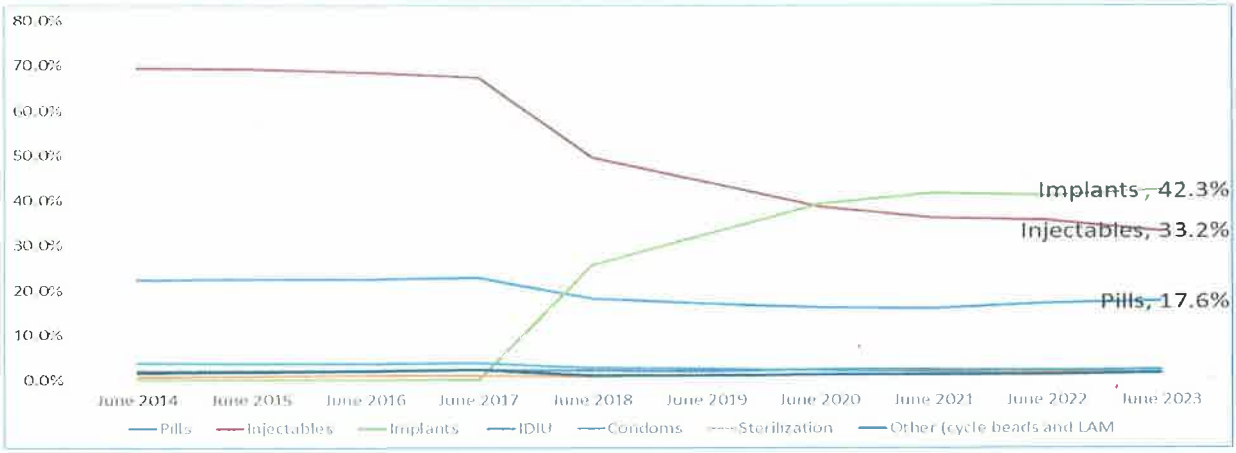


Figure 38: Proportion of preferred Family Planning methods from June 2014 to June 2023

I.6 STRATEGIC INFORMATION

I.6.1 Routine data systems

All Maternal and Child health programme performance is monitored through DHIS2 platform that utilises standard data collection tools. The completeness and timeliness during this reported period were 99.6% and 94% respectively. Different data is collected from registers at service delivery point level mainly by health centre data managers and entered into the DHIS2 platform. Data at community level are collected by CHWs and the compilation is made by the health centre data managers, who enter the data into SISCOM. Monthly review and validation of data is conducted at the level of district hospitals with all heads of health centres.

MCCH Division also conducted regular data quality checks using WHO data quality tool to identify outliers and inconstancies and provided feedback to data managers of health facilities. In addition, use of the WHO outlier tool was promoted in various workshop and formative supervision sessions with district data managers. Health Centre data managers were trained in FY 2022/23 in seven districts. Weekly data use sessions with individual programs allowed data inconsistencies to be easily identified by each program. The programs were able to identify actions to improve both data quality and key indicators. The number of requests to M&E Unit for data from HMIS more than doubled compared with FY 2021/2022. Data was presented and discussed at all TWG meetings attended by MCCH program implementers.

In March 2023, MCCH M&E team conducted data quality review in 41 health facilities including 11 hospitals and 30 health centres attached to these hospitals (Gihundwe DH, Kaduha DH, Kibagabaga DH, Kibuye RH, Kigeme DH, Kirinda DH, Mibilizi DH, Byumba DH, Mugonero DH, Nyamata DH, Ruhengeri RH).The objectives were to cross-check the HMIS reported data versus data sources, conduct a triangulation for some correlative data elements, identify possible reasons for discrepancies

and to propose and implement recommendations to address the identified gaps. The findings showed a low level of data discrepancy for most of the assessed indicators. Data discrepancies were observed for deliveries at health facilities (0.7%), mothers in labour referred to higher level for delivery (2%), DTP_HepB_Hib3 (5%), SGBV (4%) and family planning new acceptors (1%). However, higher discrepancies between information in registers and data reported in HMIS were observed for Family planning users at the end of the month (40%). The discrepancy for this data element is difficult to rectify in the current paper-based system. The key recommendation is to speed up the digitalization of FP reporting system.

I.6.2 Surveillance and Research

Maternal and Child Death Surveillance

Maternal deaths are reported through the HMIS and a community-based system of death notification. The data in the two systems were reconciled on a weekly basis in FY 2022/2023. This improved the quality of maternal death data compared to the past fiscal year.

All maternal, neonatal and child deaths are subject to audit/review under the framework of Maternal, Perinatal and Child Death Surveillance and Response (MPCDSR) both at health facility and community levels. Data are analysed by health facility-based MPCDSR committees, as well as at the national level.

One of the recommendations of the Joint Health Sector Review (JHSR) and an activity in the roadmap for the *'No woman should die giving life'* campaign was for immediate communication by hospitals following a maternal death. A further recommendation of the JHSR was to explore the accuracy of HMIS data for calculating maternal mortality and its use to track MMR in Rwanda on an annual basis. A question was added to the vaccine tracking tool to ask if a child's mother is still alive at six weeks. The ANC tracker to identify and follow-up at-risk women will identify maternal deaths during pregnancy and childbirth.

Adverse Event Following Immunization (AEFI) Surveillance

Rwanda has a system for surveillance of adverse events related to immunization: health facilities report the cases and severe cases are reviewed by the national committee of Adverse Event Following Immunization (AEFI).

AEFI surveillance training was provided for 1,900 health care workers. The training was conducted to close gaps in areas of awareness and ownership of health care workers around AEFI reporting. The aim is to reach required performance indicators of minimum of 10 AEFI cases /100,000 doses.

Research

Integrated management of childhood illness survey

Early in 2002, the Rwandan government adopted and began putting into practice the Integrated Management of Newborn and Childhood Illnesses (IMNCI) in health facilities across the country. Since then, the IMNCI guidelines were utilised as a best practice for diagnosing and treating sick children who visit primary healthcare institutions, as well as for counselling and educating parents about their children's medical conditions.

Regular monitoring and evaluation are crucial for the systematic tracking of the implementation of the IMNCI and its effects on the quality of care provided to ill children visiting healthcare facilities. To assess the quality of care provided to sick children under the age of five at primary health facilities and health centers in accordance with IMNCI guidelines, RBC in collaboration with WHO conducted the Second National IMNCI Health Facility Survey. The survey revealed gaps in services delivery including insufficient equipment and gaps in knowledge and skills of health care providers at health centres. The survey recommended training of health care providers and provision of necessary equipment.

In addition, during FY 2022/2023, research was conducted in the areas of maternal, child and community health through formal surveys, action research and specific research on a particular topic. Separate reports capturing findings from these studies will be availed.

PART II: MCCH UNIT ACTIVITIES

The activities conducted by each of the 3 units within the Maternal, Child and Community (MCCH) Division – Health Facilities Programs Unit, Vaccine Programs Unit and Community Programs Unit– during the FY 2022/2023, are presented in this section. The full details of all activities are available in the individual unit reports for FY 2022/23. The activities are presented in categories such as governance/strategies/guidelines, capacity building and other relevant categories. Wherever possible, the impact of the activities is linked using the HMIS data presented under different chapters in Part I of this report.

II.1 Health Facilities Programs Unit

II.1.1 Maternal and Newborn Health

The Maternal, Newborn and Child Health (MNCH) activities included guideline development and technical meetings as well as key capacity building activities. In addition, key equipment was procured and distributed. Details of these activities are shown below.

Governance/guidelines:

- Safe abortion guidelines were updated based on the new World Health Organisation (WHO) guidelines where the title changed from "*Safe Abortion Guidelines*" to "*Guidelines for Termination of Pregnancy*". The new guidelines were validated by the MCCH Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Technical Working Group (TWG).
- A sub technical working group to RMNCAH named *Comprehensive Abortion Care* was established to review all documents related to abortion before its validation by the RMNCAH TWG.

Capacity Building:

- Training of nurses and midwives from health centres on the new Antenatal Care (ANC) guidelines in Gakenke, Nyarugenge and Rulindo Districts.
- Training of nurses and midwives (two from each health centre) on basic obstetric ultrasound from Gakenke, Musanze, Nyarugenge, Rusizi and Nyamasheke Districts in May, 2023.
- Training of health providers from health centres in Kirehe District on basic ultrasound use.
- On site validation on MVA for health providers trained previously in PAC/Safe abortion / FP and refresher training on VCAT (Values clarification and attitudes transformation). This activity was organized in collaboration with RSOG with financial support from

IMBUTO Foundation in six districts (Rusizi, Nyamasheke, Rubavu, Karongi, Nyaruguru, Nyamagabe and Gicumbi).

Mentorship and supervision:

- Mentorship of staff in maternity and neonatology units was provided on a continuous basis using different models. The mentorship is likely to have impacted on the maternal and perinatal mortality rates, stagnation of C/S rate, the proportion of newborns with asphyxia and the increase in babies born not breathing who were resuscitated (see Part I for details).
- Mentorship of healthcare providers from health centres on basic obstetrics ultrasound in Ruhango, Kamonyi, Kayonza, Rwamagana, Gakenke and Rusizi Districts. The mentorship sessions aimed at providing strong basis for competencies and hands on skills in obstetric ultrasound for safe management of pregnancy and to integrate screening Ultrasound efficiently into routine antenatal care.
- Mentorship and supervision of health care providers in provision of comprehensive abortion care through on-site validation of MVA services by health providers previously trained in PAC/Safe abortion/ FP was conducted. In addition, refresher training on VCAT (Values clarification and attitudes transformation) was provided in seven Districts (Rusizi, Nyamasheke, Rubavu, Karongi, Nyaruguru, Nyamagabe and Gicumbi).

Equipment procured:

The following equipment were procured and distributed to different hospitals.

- Oxygen concentrators: 100
- Portable Patient monitors: 110
- Finger pulse oximeters: 912
- Hand held pulse oximeters (for Health Centers and Hospitals): 597
- Infant Incubators: 34
- CPAP machines: 12
- Infant Radiant Warmers: 12
- Infusion Pumps: 61
- Phototherapy Lamps: 12
- CTG Machines: 12
- Foetal Heart Doppler (Foetoscope): 15
- Ultrasounds: 57
- Anaesthesia machines: 35
- Laptops provided in Kirehe district to be used for teleconsultation in service provision using telemedicine: 18

II.1.2 Child Health

The Child Health program consists of the Integrated Management of Neonatal and Childhood Illnesses (IMNCI); Child Care Development (CCD); Emergency, Triage, Assessment, Treatment and Admission; and Paediatric Development Clinics. The activities are presented under the headings of governance/survey and capacity building.

Governance:

- IMNCI survey conducted and disseminated. The results of the survey indicated that more attention is needed for malnutrition screening, referral systems and counselling of mothers on when they should return for review.

Capacity Building:

Trainings:

- Training of 33 nurses from 16 health centres in IMCI / CCD was conducted in Kirehe District in February 2023.
- Training of doctors and nurses (4) on ETAT+ from Kirehe, Burera and Rwinwavu District Hospitals was conducted
- Workshop organized to develop MCCH Division National Scorecard linked to the ALMA RMNCAH scorecard and identified its potential use. The ALMA Scorecard for Accountability and Action is a new model for global health. Each quarter and on annual basis, the Ministry of Health, through RBC/MCCH Division, prepares and submits reports to ALMA Secretariat.

Supervision:

- Field supervision to ensure implementation of death audit recommendation according to new MPCDSR guidelines and mentorship on near miss reporting was conducted in May 2023. Hospitals selected reported the highest number of deaths of children under five years of age (Ruhengeri, Kinihira, Rutongo, Remera Rukoma, Nyamata, Rwamagana, Gihundwe and Mibilizi).

II.1.3 Maternal, Perinatal and Child Death Surveillance and Response (MPCDSR)

The activities implemented are presented under the governance and capacity building headings. Full details of the activities are found in the MPCDSR annual report FY 2022/2023.

Governance:

- Bi-annual coordination meeting of the National MPCDSR Committee was held attended by 18 members.

- National Workshop was conducted to review Maternal and Child Health (MCH) data including deaths that occurred between July 2022 and February 2023 as well as results of MPCDSR supervisions. Various recommendations and strategies were put in place to reduce maternal, perinatal and child mortality.
- Maternal near-miss audit tool was digitalized and is now ready to use.
- Maternal, neonatal and child death audit tools are also being digitalized and will be ready by Q1 FY 2023/2024.
- Digital maternal tracking system to track and trace high risk pregnancies and deliveries was designed, developed and piloted in Musanze District from May to July 2023. The conception and the design of the project resulted from a recommendation of the Joint Health Sector Review held in August 2022.

Capacity Building:

- Training on neonatal and adult resuscitation skills to improve quality of care and decrease maternal and neonatal mortality was held in December 2022. The topics covered various aspects such as: recognize the sick obstetric patient, recognize and effectively prepare for life-threatening loss of airway or respiratory function, peri-operative & post-operative vomiting, aspiration & airway compromise, pulse oximetry & intra-operative monitoring, hypoxia management & recognition and effective preparation for risk of high blood loss. Communication and preparation for delivery and neonatal resuscitation of high-risk pregnancy was also covered in the training.
- Workshop of peer-learning for the review of MPCDSR guidelines implementation to avoid preventable deaths was held in November 2022 and March 2023.
- Workshop for review of cases, monitoring of performance and strengthening quality and timeline of response was conducted in April 2023.

Supervision:

- Supportive supervision on implementation guidelines for MPCDSR was conducted in five District Hospitals (Shyira, Gisenyi, Kabgayi, Gitwe, Kabutare) and Bigogwe Medicalized Health Centre in Rubavu District.

II.1.4 Family Planning

Family Planning activities during the FY 2022/23 are presented under three headings, Governance/guidelines, Capacity Building and demand generation. Full details of all activities can be found in the Family Planning annual report FY 2022/2023. The impact of these activities can be seen in the increase in deliveries, PPFP and mCPR as compared to last fiscal year.

Governance/guidelines:

Conducted activities included: Data Quality Review, Inventory Spot-Check Review, development of key FP strategic documents and World Contraception Day (WCD) celebrations.

- Data quality review was conducted to compare different sources of data (patient files, FP registers, HMIS hard copy reports and HMIS online cards). The selection of districts to visit was based on the performance of districts: over-reporting and under reporting. The indicator showing family planning users at the end of the month proved difficult to track and accuracy was around 50%. Recommendation to set up a digital tracking system using DHIS2 to track family planning clients was made to respond to this finding. Full details of the report are found in the section below on Strategic Information.
- An inventory spot-check review for UNFPA and USAID-donated programme supplies made through Karongi and Rwamagana Rwanda Medical Supply Ltd branches and its Service Delivery Points was conducted in September 2022 for the period from January 1, 2021 to June 30, 2022. The Last Mile Assurance (LMA) process is designed to provide visibility and assurance on the safeguarding, management, and use for intended purposes of the supplies. Findings showed that all commodities were received at each level, were recorded in the inventory system – eLMIS – and bin cards and all receiving and inspection controls were in place and working at all levels.
- Development of key Family Planning strategic documents including: FP 2030 Commitments Country Implementation Plan (2021-2025), Family Planning booklet for religious and local leaders, Family Planning Flipchart and Family Planning training manual.
- World Contraception Day was celebrated on 30th September 2022 together with the launch of ANC Guideline of 8 contacts. Prior to this, World Contraception Day celebrations included an outreach for Family Planning in Rusizi district where 2,212 clients received different Family Planning methods.

Capacity Building:

Capacity building used both training, mentorship and supportive supervision approaches.

Trainings:

- Quality family planning (all methods) training with a focus on long acting reversible contraceptives (LARCs), was provided to 218 nurses and midwives working especially in health posts from Rubavu (36), Rutsiro (35), Musanze (29), Burera (36), Ngororero (47) and Nyanza (35) Districts.
- Cascade on-job training on provision of hormonal intra-uterine device (H-IUD) for Family Planning providers from Karongi, Nyamasheke, Rusizi, Rulindo, Gakenke, Gisagara, Nyarugenge, Kirehe, Kayonza and Burera Districts resulting in 24 master trainers, 103 national

trainers, 554 onsite trainers in May 2023; service data recorded by HMIS show 3,780 H-IUD insertions performed.

- Integrated competence-based community health workers' package (polyvalent model) was provided for Community Health Officers and Family Planning focal points.

Mentorship:

Family Planning clinical mentorship is a routine and integrated activity conducted at District and National levels. In addition to trainings, the mentorship looks at quality of FP services provided, quality of data reported, teamwork and collaboration between CHWs at the community level and health care providers at the Health Facility level.

- Family Planning clinical mentorship was conducted by national level mentors quarterly in 145 health facilities (18 district hospitals, 100 health centres and 27 secondary health posts) in Nyarugenge, Rulindo, Gakenke, Gisagara, Karongi, Rusizi and Nyamasheke Districts. During this mentorship, 260 health care providers were reached, and 515 clients received family planning services.
- Family Planning Clinical mentorship was conducted by 52 district-based mentors quarterly to 167 mentees on 14 Family Planning technical competencies in 112 health centers; Gakenke (17), Rulindo (17), Rusizi (16), Karongi (9), Nyarugenge (5), Nyamasheke (6), Gisagara (4) Kayonza (11), Kirehe (20) and Burera (7) Districts, respectively.

Supportive supervision:

The main objective of the supportive supervision was to strengthen the provision of FP services in private health facilities; increase the quality of data reported in HMIS; and encourage reporting on monthly basis.

- Supportive supervision was conducted in 28 private health facilities: Gasabo (7), Nyarugenge (7), Kicukiro (8), Kamonyi (2), Muhanga (1), Kayonza (2), and Musanze (1). This supportive supervision showed that (i) in the majority of private clinics, FP is integrated in gynaeco-obstetric services; (ii) all long-acting methods are provided by gynaeco-obstetrician or other medical doctors, (iii) the source of products used is the public sector supply (RMS Ltd); (iv) updated Family Planning registers are not available or not well used, and (v) data reporting into Health Management Information System (HMIS) is not consistent.

Demand generation:

- In line with FP2030 commitments, Rwanda Biomedical Centre (RBC), through the Rwanda Health Communication Centre (RHCC), conducted different demand generation and community awareness campaigns targeting hard-to-reach communities such as national radio and TV talk shows, public campagins/rallies, as well as airing live talk shows, short

spots/jingles, DJ mentions, sketch / role plays in all 46 bus parks and market place radio stations countrywide. The objectives of these activities were to increase the knowledge of women and providers about FP methods available incountry; improve the quality and availability of FP information for both men and women to address existing myths and misconceptions, especially on the methods' side effects; to generate demand on newly introduced FP methods and; ensure full integration into national FP mass media campaign in line with national FP communication strategy.

- MCCH/RHCC also conducted different FP outreach sessions in different districts targeting remote health facilities to increase efforts in decreasing the unmet need for contraception and expand access to FP methods. This activity included community mobilization campaigns, clients counselling, and FP provision at local sites and health facility levels.

II.1.5 Gender Based Violence

The Gender-Based Violence (GBV) activities were implemented under governance/technical guidelines and Capacity Building categories.

Governance/ guidelines:

The activities included provision of technical support for development and/or revision of key policies, standard operating procedures (SoPs), and communication strategies.

- Isange One Stop Centre standard operating procedures were reviewed and updated.
- Safe Abortion Ministerial Order was reviewed.
- GBV Clinical Management Protocol and register were revised.
- A Guide for Health Providers Training on the Clinical Management Protocol was developed.
- GBV and Drug Abuse Communication Strategy and Communication booklet for disabled were developed.
- Common GBV action plan for FY 2023/2024 was prepared.
- Technical input and guidance was provided in the Steering Committee Meeting.

Capacity Building:

Capacity building took the form of mentorship and orientation.

- Mentorship was conducted in all District Hospitals with IOSC in the management of GBV cases and victims. The mentees were newly recruited medical doctors and nurses. The Ministerial Order for Safe Abortion was discussed and HMIS data reviewed in reference to improving the services provided at IOSCs.
- Training on revised GBV Clinical Case Management Guidelines was provided to 78 staff from 26 Hospital IOSC centres.

II.2 Vaccine Programs Unit

The activities in this unit included routine immunization, COVID-19 vaccination, vaccine supply chain, vaccine management and international travellers' vaccination. The activities are presented under the following headings: governance, capacity building, vaccination services and supply chain. The full details of these activities are found in the Vaccine Programs Unit annual report FY 2022/2023.

II.2.1 Routine vaccination

Rwanda routine vaccination has 12 antigens, to be administered to all infants under two years olds age to protect them from the following vaccine-preventable diseases: tuberculosis, poliomyelitis, diphtheria, neonatal tetanus, pertussis, hepatitis B, haemophilus influenza type b, measles, streptococcus pneumonia, rotavirus infections and rubella.

In addition, all the young adolescent girls of 12 years of age are targeted to be protected from cervical cancer with human papilloma virus (HPV) vaccine and pregnant women to be protected from tetanus, during the antenatal care visits, according to the WHO immunization schedule, with toxoid tetanus and diphtheria (TD) vaccine.

Governance/guidelines/strategies:

- The National Immunization Strategy (NIS) for the next five years was elaborated and finalized. The priorities of NIS have been aligned with the strategic priorities of Immunization Agenda (IA) 2030, and HSSP IV, to address the remaining challenges and ensure that immunization achievements contribute to the national targets for achieving Universal Health Care and global targets for control, eradication, and elimination of vaccine preventable diseases.
- Phase-out of paper-based systems for capturing immunization data. The Ministry of Health (MoH) formally notified all institutions implementing vaccination program that from 1st October 2022, capturing of immunization data will no longer use paper-based system but immunization e-tracker only.
- Expanded Programme on Immunization (EPI) guideline was developed. Updates were mainly on IPV and TD vaccines. Adjustments were made to the target (from 97% to 100%) and tools to use including VLMIS were also updated in the guideline.
- The national immunization guideline was developed.
- Meetings of the Inter-Agency Coordinating Committee (ICC) were held. The invitees who attended the meeting were immunization partners of immunization programs such as WHO, UNICEF, EPI Committees (NITAG, NCC), Single Projects Implementation Unit (SPIU) and Rwanda Biomedical Centre (RBC)/MCCH staff. Discussion points were The Rwanda MR Application, CCEOP application and Equity Accelerator Findings application.
- EPI data review and coordination meetings with Districts.

- The NITAG meeting was held and there was participation in the Scientific Advisory Group (SAG).
- Workshop to develop and review immunization key messages for vaccine demand uptake was held with the objective of developing immunization key messages targeting parents and adolescents to achieve desired behavioural change on immunization. The messages will be used to train healthcare providers from health centres, in order to improve their knowledge in social behaviour change communication.

Capacity Building:

- Journalists from 27 media houses were trained on essential aspects of vaccination so they can help their audiences to grasp vaccine information easily and engage in informed evidence on vaccination.
- Supportive supervision on reporting, vaccine management and HPV vaccination was conducted in six Districts.

II.2.2 Vaccinations and supply chain management

- Supply chain was monitored including the cold chain system, development of a procurement and distribution plan, reception and distribution of vaccines as per plans, for the smooth running of the vaccination programme.
- COVID-19 vaccination to adults continued. Vaccination to children 5-11 years olds was introduced.
- Vaccination of special population for Measles and Rubella in response to an outbreak in a refugee camp was provided.
- International vaccination for Yellow Fever continued on a demand driven basis. Total number vaccinated were 20,013.

II.3 Community Programs Unit

II.3.1 Community Health

The Community Health Program continued to support Community Health Workers, including trainings in line with the new polyvalent model. In addition, different activities were conducted in the areas of nutrition, adolescent, sexual reproductive health and community-based service provision. Full details of the activities are found in the Community Programs Unit Annual Report FY 2022/2023. A summary of Community Programs Unit activities is presented below under the headings of governance/guidelines and capacity building.

Governance/ guidelines:

Advocacy for removal of user fees for diarrhoea and pneumonia resulted in increase of diarrhoea and pneumonia cases treated by CHWs compared to last fiscal year (see impact of the user fee removal in Figure 24 b in Part I of this report).

- Integrated Community Case Management (ICCM) and CBMNH TWG meetings were held on quarterly basis during FY 2022/2023.
- National Community Health Policy Dialogue Meeting was held to gather views from different key stakeholders to guide the ongoing community health reforms.
- Development & updating community health policy and strategic plan
- A study tour in Ghana was organized to share experiences about the Child Scorecard
- The quantification exercise for MCCH commodities was conducted
- The Implementation of Procurement and Supply Plan
- Monthly Stock Status Analysis
- Registers, CHW tools and training manuals were printed and distributed.
- Study on demand for community health worker services for diarrhoea and pneumonia in children under 5 years of age was conducted.

Capacity Building:

Capacity building in the Community Health Programme included training and supervision activities.

Trainings:

- Training on Polyvalent Model using Competency Based Approach continued throughout the year. The topics covered were Community-Based Management of Neonatal Health (CBMNH), CBP/Family Planning FP, Integrated Child Case Management (ICCM), Nutrition, First Aid, ESR, MH, HIV, Non-communicable Diseases (NCDs), Behavioural Change Communication (BCC) and reporting. Community Health Workers trained were from Musanze, Rusizi, Rulindo, Huye and Ngororero, Gihundwe, Mibilizi, Kabutare, Kabgayi, Butaro, Remera-Rukoma, Kirehe, and Rwamagana. As of June 2023, 18 districts are trained and remaining 12 districts will be trained in the next fiscal year.
- Three e-learning courses were developed and approved (ICCM, CBMNH, Malaria) and three developed courses will be approved soon (Community Based Provision of Family Planning, Community Based Nutrition Program and drugs management).
- CHW Cell coordinators were trained from Ruhengeri (154), Nyanza (108), Byumba (257), Murunda (50), Kibungo (49), Mugonero (40) Kibuye(79), Kirinda (58) Hospitals on e-Learning.

- Cell coordinators supervised CHWs at the cell level and are responsible for supervising their peers, facilitating the supply of community drugs, and compiling reports.

Supervision:

- Community Health Workers from Nyabihu, Rubavu, Gakenke, Rutsiro, Ngororero, Karongi and Nyamagabe Districts were supervised from October 2022 to May 2023 to assess the implementation CHWs polyvalent model.

II.3.2 Adolescent Health

Adolescent Sexual and Reproductive Health (ASRH) activities were capacity building activities including training, supervision, mentorship, and awareness-raising. Full details of all activities can be found in the ASRH annual report FY 2022-23.

Trainings:

- A training of trainers on the content of adolescent health training manual was given in February 2023 to healthcare providers (74) from Health Centres and district hospitals of Burera, Gakenke, Kayonza and Kirehe, to increase knowledge on the provision of comprehensive adolescent and youth health services to appropriately respond to their health needs.
- Cascade training was conducted on ASRH peer education for out-of-school peer educators to establish a network of young people at community level with sound knowledge on adolescent sexual reproductive health, who can influence positively their peers by providing correct information on sexual reproductive health so that they can take an informed decision. A total number of 7094/7262 (97.6%) youth Nyagatare, Gatsibo, Kayonza, Ngoma, Bugesera, Rulindo and Musanze districts were trained.

Supervision/mentorship/awareness raising:

- Supervision was conducted in 65 Health Centres in Nyarugenge (10), Rulindo (18), Gakenke (23) and Gisagara (14) Districts. The supervision focused on how to practically improve ASRH service provision by healthcare providers especially at Health Centre level and during outreach activities.
- Mentorship was conducted in Health Centres of Nyarugenge and Rulindo Districts in November/December 2022 and in Health Centres of Rusizi, Gihundwe, Nyamasheke and Karongi Districts in December 2022. The mentorship focused on the provision of IEC on ASRH in schools, HIV services to adolescents and the provision of ASRH services in youth corners. Key recommendations were made.

II.3.3 Nutrition

Nutrition activities are presented in the following categories: governance and guideline development, capacity building and Maternal Child Health week. Full details of these activities are available in the Nutrition Unit annual report FY 2022-23.

Governance and guideline development:

The activities to improve governance and implementation of nutrition activities included Elaboration of Rwanda Nutritional Ricket Guideline, Improvement in Data quality and use and introduction of a new approach to chronic malnutrition management.

- Elaboration of Rwanda Nutritional Rickets Guideline was made in October 2023 to prevent rickets among children and to assist health care providers to diagnose and provide quality services to children and young adolescents affected by nutritional rickets. The guidelines include information on (i) Clinical manifestations and diagnosis of Rickets (ii) Rickets prevention and treatment; (iii) Delivering interventions through existing programme and (iv) Monitoring and evaluation of nutrition rickets status.
- Workshops to evaluate the performance of nutrition indicators were conducted in September and November/December 2022 in Muhanga and Musanze districts to evaluate the progress and impact of nutrition interventions in the health facilities and community. Recommendations were made Dissemination of PBF SPRP revised indicators and tools was held in March 2023 for stakeholders involved in health sector from community up to hospital and district levels and to on review of pending PBF SPRP invoices as per the updated tools and guidelines.
- New approach of chronic malnutrition management will be introduced in FY 2023-24. In this year the new approach was developed with orientation to key partners

Capacity Building and Training:

- Training of hospital and health centre data managers and nutritionists on nutrition data management was conducted in February 2023 to improve the quality of routine nutrition health facility and community data. Data managers and nutritionists were the participants of the training in ten Districts.

Supervision:

- Supportive supervision of MAM & SAM with the purpose of strengthening the capacity of health care providers and community health workers at health facility and community level to care for children with moderate and severe acute malnutrition, and documenting strength and weaknesses to inform future capacity building interventions. The supervision was conducted in 44 hospitals in two sessions, one in August 2022 and one in March 2023.
- Supervision of growth stunting monitoring integrated in immunization was conducted in Ruhango District in December 2022 to provide support to improve performance against nutrition indicators and the reporting system.

- Supportive supervision of the essential community health services and nutrition was conducted in seven Districts in May 2023. The purpose of the supervision was to assess the implementation CHWs polyvalent model, readiness for MCH week campaign and support emergency response to disasters in the affected districts.

Mother Child health week campaign

- This important activity was conducted in November 2022 and June 2023. During these weeks the following services were provided
  - ✓ Vitamin-A supplementation among the children aged 6-59 months,
  - ✓ de-worming for the children aged 12 to 59 months and children between 5-15 years and adults from 16 years and above in districts with high prevalence of intestinal worms
  - ✓ Provision of micronutrient powder/ONGERA for children aged 6-23 months
  - ✓ Malnutrition screening through anthropometric measurements. Additionally, sensitization on malaria prevention, family planning, hygiene and sanitation promotion were also implemented.

Table 10: National coverage for interventions conducted during MCH week in June 2023

Interventions		Target population	Served	Coverage (%)
Vitamin A supplementation	Provision of Vitamin A (100.0000UI and 200.0000UI) _6-59 months	**1,688,902**	1,598,762	95%
De-worming	Provision of Mebendazole or Albendazole_12-59 months	**1,511,041**	1,447,718	96%
	Provision of Mebendazole or Albendazole_5-15 years	**3,652,460**	3,658,198	100%
	Provision of Mebendazole or Albendazole_16 years and above	**3,839,385**	3,279,258	85%
	Provision of Praziquantel_5-15 years	**1,753,424**	1,461,995	83%
	Provision of Praziquantel_16 years and above	**1,776,747**	1,553,888	87%
Malnutrition screening	Malnutrition screening_using MUAC 6-59 months	**1,688,902**	1,589,257	94%
	Malnutrition screening by Weight for Age 6-59 months	**1,688,902**	1,570,950	93%
	Malnutrition screening by Height for Age 6-23 months	**500,690**	403,005	80%
	Identification of children with oedema (6-23 months)		16	
MNP (Ongera) powder distribution	Provision of MNP powder (ongera) products	**500,690**	410,973	82%

Identification and vaccination of defaulters	Children vaccinated for BCG		265	
	Children vaccinated for Penta 1		323	
	Children vaccinated for Penta 2		308	
	Children vaccinated for Penta 3		292	
	Children vaccinated for Rotavirus 1		208	
	Children vaccinated for Rotavirus 2		209	
	Children vaccinated for MR 1		629	
	Children vaccinated for MR 2		711	
	Children vaccinated for IPV_14 weeks		238	
	Children vaccinated for IPV_9 months		443	
Family Planning	Provision of FP methods		20,342	

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

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

During FY 2022-2023, the total budget allocated to activities under MCCH Division was RWF 41,735,268,161 where RWF 31,725,440,507 was spent representing a 76% budget execution.

Table 11: MCCH budget allocation according to source of funds and Funding source for program expenditures

Funding source	Planned budget	Proportion of source of fund	Budget spent	Budget execution rate
Barame Project	1,143,623,798	2.7%	1,132,326,196	99%
Bloomberg	52,351,200	0.1%	12,636,760	24%
GAVI	232,487,788	0.6%	223,166,325	96%
GAVI - VIG	1,509,024,184	3.6%	108,775,562	7%
Ordinary budget	2,194,091,329	5.3%	2,191,344,483	100%
Own revenues	174,988,180	0.4%	82,680,804	47%
RBF HIV	24,133,363	0.1%	24,133,363	100%
RBF-Enabel MCCH	6,785,136,317	16.3%	6,779,322,496	100%
UNFPA	552,745,060	1.3%	506,104,712	92%
UNICEF	454,434,284	1.1%	418,681,750	92%
WB-COVID-19	19,968,934,356	47.8%	19,057,380,563	95%
WHO	198,353,740	0.5%	169,680,081	86%
World Bank - SPRP	2,690,018,220	6.4%	1,019,207,412	38%
ENI FOUNDATION	5,754,946,342	13.8%	-	0%
Total	**41,735,268,161**		**31,725,440,507**	**76%**

The contribution of some partners through direct implementation, as well as costs covered by the GoR related to HRH (payment of salaries in health facilities) and investment in infrastructure, are not captured in this table.

ENI Foundation and GAVI–VIG did not provide funding as committed since planned activities were postponed to FY 2023/2024.

III.2 Results Based Financing (RBF Enabel Support)

III.2.1 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 Bank Account during FY 2022-2023

Instalment	Disbursed amount in Euros	Period
Instalment 7	5,234,001	25th Oct 2022
Instalment 8	1,458,002	26 May 2023
Total	**6,692,003**	

Table 13: RBF ENABEL budget and expenditure per MTEF chapter for the year ended 30 June 2023

MTEF Chapter	Budget in EUR	Expenditures in EUR	Variance in EUR	Performance in %
22 Use of goods and services	928,992	739,615	189,378	79.6%
34 Acquisition of fixed assets	2,395,534	1,959,952	435,582	81.8%
26 Grants	305,412	305,412	0	100.0%
28 Other expenditures	2,485,470	2,472,870	12,600	99.5%
Total	**6,115,407**	**5,477,848**	**637,559**	**90%**

As per the table above for FY 2022-2023, Enabel is contributing to RBF Enabel expenditures the total budget of EUR 6,115,407 with Expenditures by budget activities of EUR 5,477,848 representing 90 % of total budget planned for FY 2022/2023.

Table 14: Reproductive, Maternal, Neonatal, Child and Adolescent Health – RBF Enabel Annual Budget Execution rate FY 2022/2023

RBF- Enabel Annual budget Execution rate FY 2022/2023					
BNR Exchange rate, annual average 2022/2023 =1126.599480					
Planned activities	**Approved budget in EUR**	**Commitment in EUR**	**Budget Balance in EUR**	**Budget execution rate**	**Comments on budget execution rate**
RBF-Enabel MCCH	**6,115,407.34**	**5,477,848.47**	**637,558.869**	**90%**	
Administrative And Support Services	**92,737.84**	**92,730.91**	**6.93**	**100%**	
Organise regular meetings with implementing institutions	4,445.07	4,438.14	6.93	100%	This activity was successfully implemented
Provide Communication airtimes	6,231.13	6,231.13	0	100%	This activity was successfully implemented
Pay salaries to SPIU project staff	82,061.64	82,061.64		100%	This activity was successfully implemented
MATERNAL AND CHILD HEALTH IMPROVEMENT	**5,568,543.43**	**5,097,244.06**	**471,299.374**	**92%**	

RBF- Enabel Annual budget Execution rate FY 2022/2023					
BNR Exchange rate, annual average 2022/2023 =1126.599480					
Planned activities	**Approved budget in EUR**	**Commitment in EUR**	**Budget Balance in EUR**	**Budget execution rate**	**Comments on budget execution rate**
Support to C-PBF focusing on indicators not financed in current model	273,945.30	273,945.30	0	100%	This activity was successfully implemented
Support to HF PBF focusing on indicators not financed in current model	31,466.45	31,466.45	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	873,657.04	873,657.04	0	100%	This activity was successfully implemented
Conduct monthly coordination meeting	853,139.23	853,139.23	0	100%	This activity was successfully implemented
Increase FP uptake in catholic church affiliated HF	724,267.85	724,267.85	0	100%	This activity was successfully implemented

RBF- Enabel Annual budget Execution rate FY 2022/2023					
BNR Exchange rate, annual average 2022/2023 =1126.599480					
Planned activities	**Approved budget in EUR**	**Commitment in EUR**	**Budget Balance in EUR**	**Budget execution rate**	**Comments on budget execution rate**
Kibagabaga Hospital Maternity construction and equipment	1,959,951.87	1,959,951.87	0	100%	This activity was successfully implemented
Supervision works of construction for Kibagabaga Hospital Maternity	35,969.73	35,969.73	0	100%	This activity was successfully implemented
Procure equipment's for maternity and neonatology units in health facilities	745,002.66	273,703.29	471,299.36	36.7%	The variance is derived from the purchase of hydraulic delivery beds for various hospitals already committed in FY 2022-2023 but the delivery was not yet done by 30th June 2023 because it is planned to be done in August 2023.
Mentorship of health providers/health professionals (including teachers and youths Clubs) at all level to offer youths friendly services in and out of schools	71,143.30	71,143.30	0	100%	This activity was successfully implemented

RBF- Enabel Annual budget Execution rate FY 2022/2023					
BNR Exchange rate, annual average 2022/2023 =1126.599480					
Planned activities	**Approved budget in EUR**	**Commitment in EUR**	**Budget Balance in EUR**	**Budget execution rate**	**Comments on budget execution rate**
FAMILY PLANNING	**454,126.06**	**287.873.51**	**166,252.55**	**63.39%**	
Procurement of ICCM commodities (Misoprostotol, UPT, Zn and ORS)	287,341.65	287,341.65	0	100%	This activity was successfully implemented
Procurement of FP Drugs and Consumables	166,784.41	531.86	166,252.55	0.32%	The variance is derived from the purchase of Condom adult male (to be supplied by THAI NIPPON RUBBER INDUSTRY PCL PO 113684) and Levonorgestrel microlut (to be supplied by BAYER AG PO 113999). The budget was already committed in FY 2022-2023 but the delivery was not yet done by 30th June 2023 because it is planned to be done in July and August 2023 respectively.

III.2.2 Key achievements registered during FY 2022/2023 under RBF Enabel Project

1. **Kibagabaga Maternity ward construction**

The construction project for the new maternity ward at Kibagabaga Hospital was awarded to SEEGEC Ltd for construction and Prisma Ltd for supervision. Constructions works are on track and current progress is about 25%. The revised timeline for the completion is March 2024. Important to note is that the RBF Enabel contribution to construction works is Frw 4.5 billion on track to be all used by December 2023.

2. **Procurement of Family Planning Drugs and Consumables**

RBC purchased microluts and condoms through Rwanda Medical Supply (RMS) Ltd. Distribution is using existing channels based on requests submitted to RMS by health facilities.

3. **Procure equipment for maternity and neonatology units in health facilities**

Maternity and neonatology equipment was procured using existing contract frameworks. Equipment purchased included 312 delivery beds to be distributed to health centres and hospitals.

4. **Mentorship of Health providers/Health Professionals (including teachers and Youths clubs) at all levels to offer youths friendly services in and out of schools**

Mental health professionals have visited three hundred twenty-three (323) schools. Among them, one hundred (100) schools conducted training of school staff while two hundred twenty-three (223) schools conducted awareness of students on mental health and ASRH.

5. **Increased Family Planning uptake in catholic church affiliated Health facilities**

RBC supported CARITAS Rwanda to organize awareness mass campaigns using community radio talk shows and Jingles to spread FP messages in low performing Districts.

6. **Ensured Quarterly coordination meetings of Community Health Workers**

RBC supported Access to Health, to support community health workers' organisation of quarterly coordination meeting with the moderation of the Head of health centres and the Community Environmental Health Officer (C-EHO).

PART IV. GOVERNANCE MECHANISMS

Maternal, Child and Community Health is governed through a pyramid of governance and technical committees. The Health Sector Committee organises Joint Health Sector Reviews (forward-looking and backward looking) each year. The MCCH is an active participant in these reviews. The National Strategy for Transformation I (NST1), Health Policy (2021-2030) and the 4th Health Sector Strategic Plan (HSSP IV) provide direction to the national reviews. In FY 2022-2023, the Mid Term Review of the HSSP IV was conducted. Development of the HSSP V will begin in FY 2023/2024.

IV.1 National Coordination of RMNCAH Interventions

All interventions as well as principles guiding interventions are directed by the Reproductive, Maternal, Neonatal, Child and Adolescent Health Policy and its two 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, coordination of partners/donors, monitoring & evaluation of programs. The Division of Maternal, Child and Community Health of the Rwanda Biomedical Centre (RBC) is responsible for implementation of the RMNCAH programme in collaboration with divisions under the department of HIV/AIDS, Disease Prevention and Control, the Rwanda Health Communication Centre and the Research, Innovation and Data Sciences (RIDS) 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 RMNCAH) Technical Working Group (TWG). Feeding into this TWG are the sub-Technical Working Groups of Family Planning, Safe motherhood, Child Health, ASRH and Neonatal. The Community Health TWG is housed in the Ministry of Health. Additional TWGs that MCCH staff participate in are digitalisation, FDA and Quality Assurance.

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.

Forward-Looking Joint Sector Review: MoH, Rwanda Biomedical Centre, Development Partners (DPs), Civil Society Organisations (CSOs), Academia and the private sector meet regularly to monitor key performance indicators, review implementation of previously agreed recommendations and report to the Health Sector Working Group (HSWG) which is chaired by the MoH with co-Chair coming from among Development Partners. In FY 2022/2023 the '*No woman should die giving life*' campaign was conceived during the Joint Health Sector review, a roadmap designed for implementation and the campaign launched in February 2023.

For all decisions 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 requires 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 Decentralized / 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 of the Republic of Rwanda, 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 (CSOs)

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 TWG.

IV.4 Private sector

Private sector invests 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

For the fiscal year 2022-2023, MCCH division successfully implemented planned activities and challenges identified during implementation courses were responded with available resources to ensure smooth implementation.

V.2 Challenges, contributing factors/root causes and recommendations of MCCH Division FY 2022/23

Table 15: Challenges, contributing factors/root causes and recommendations of MCCH Division FY 2022/23

Challenges	Contributing factors/root causes	Recommendations
General		
While MMR, Perinatal Mortality and Child mortality continue to decrease rates remain too high.	Many factors including community behaviour, health system factors and financing.	Prioritise implementation of evidence-based interventions as per Roadmap towards *'No woman should die giving life'*
Routine data does not capture all information required to identify effective interventions	Some data elements are aggregated and others are missing in the HMIS	Review and revise data elements and introduce into HMIS
Reporting of some data elements is not complete or standardised, such as home deliveries, maternal deaths outside the maternity units, measurement of PPH	Data definitions not adequately understood and followed	Revise definitions, disseminate and follow up
Stock out of RMNCAH commodities	Lengthy procurement processes at RMS Ltd; Delay in ordering and recording the consumptions in eLMIS by health facilities leading to underestimation of needs	Speed up procurement processes at RMS Ltd Stock status to be analysed and alert leadership level for advocacy/ or support Mentorship and supervision at all levels

Challenges	Contributing factors/root causes	Recommendations
Shortages of essential equipment and (preventive) maintenance of the equipment	MEMMS not in use to monitor equipment inventory and maintenance; Shortage of key equipment Preventative maintenance plan not implemented in all hospitals	Upgrade MEMMS; Identify key equipment shortages; Ensure all hospitals have budget and plan for preventive maintenance of equipment Prioritise equipment as per roadmap
Continuity and quality of mentorship	Several models 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	Evaluate the current mentorship models Agree on one national model
Health Facility Programs Unit		
Safe motherhood		
Utilisation rates are high for many indicators but outcome of care remain a challenge to achieving national MNH targets	Quality of care in health facilities	Align and strengthen mentorship models/programmes. Provide necessary staff and equipment
Stagnation of ANC1 and ANC4 over the past ten years and quality of services not according to guidelines	Mothers are not presenting early for ANC, reducing the number of visits overall; Cultural beliefs and norms linked to early disclosure of pregnancy; Not all HC conduct daily ANC clinics; Not all services are provided to all pregnant women attending ANC	Implement new ANC guidelines of 8 contacts and early identification of pregnancy.
Death audits (maternal, perinatal, child) and verbal autopsies of community deaths are not all conducted and uploaded into HMIS.	Electronic systems not performing well, preventing uploading from hospitals Some audits not conducted due to lack of prioritisation and staff time (especially perinatal death audits)	Implement MoH digitalisation plan; DGs of hospitals to prioritise death audits; CHW supervisors to facilitate verbal autopsies; Close collaboration with NISR on civil

Challenges	Contributing factors/root causes	Recommendations
		registrations and death records.
No much change in proportion of under 20 of all age groups ANC visits	Adolescents are sexually active; Cultural beliefs and societal norms affect access to family planning even at youth corners	Continue efforts in awareness raising (including peer educators), CSE, provision of youth friendly services, legal frameworks
Deaths occurring post C/S and as a result of previous C/S	High numbers of C/S conducted while quality is not assured; Inadequate information on nature of and reason for C/S complications	Conduct Monitor justification of C/S using Robson Classifications; Mentor and train GPs on conducting C/S; Ensure all women with previous C/S are adequately monitored during late pregnancy and delivery; Conduct clinical audits on C/S cases
PPH high contributor to MMR rate	Reporting of PPH not using guidelines in all hospitals and health centres; Poor of monitoring and management during and immediately after delivery	Conduct clinical audits PPH; Continue mentorship on reporting PPH, delivery monitoring, post-partum C-section and management of PPH
Programmes are concerned with shortages of trained staff and rotation of staff trained in service on various topics	Movement of staff within hospitals irrespective of experience and training	Hospital leadership to take into account skills and experience in
Contraceptive Prevalence Rate affected by declining services provided by community, PPFP in Districts with Catholic-administered hospitals	Few secondary health posts near religious health facilities to provided PPFP Demand for implants insufficient equipment at Health Posts	Continue training of CHWs in polyvalent model; Increase number of secondary health posts to provide PPFP; Equip Health Posts
Data quality of CPR at 40%	Complex paper-based system between CHWs, Health Centres and hospitals.	Introduce an electronic system for FP (e-FP) service with *unique identifier system*
Low coverage of HPV second dose compared to first dose	HPV vaccination conducted in different school calendar	Timely planning HPV vaccination during same school calendar

Challenges	Contributing factors/root causes	Recommendations
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	Prioritise Nutrition equipment and commodities
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
User fees for US in HC is not covered by CBHI and not standardised across Districts.	User fees for ultrasound at health centre is not covered by mutuelle insurance	Continue to evaluate the efficacy of US in HCs Conduct CBA of US in HC for inclusion in CBHI
Lack of equipment desktop, laptops and internet to support the scale up of implementation of digital tool for tracking high risk pregnancy	Limited budget	Advocate to avail equipment to support implementation of digital tool for tracking high risk pregnancies
Training on CHWs polyvalent model: only 18 districts are currently	Limited budget	Training of remaining 12 districts on polyvalent model

V.3 KEY PRIORITIES FOR 2023-2024

For the year 2023-2024, MCCH Division priorities are in line with the Roadmap for 'No woman should die giving life'; newborns and child health are summarized as follows:

Governance, Leadership and Finance:

- Central level to review maternal deaths with hospital leadership within 24 hours of the death
- Monitor the implementation of key recommendations from the policy dialogue
- To include Vacuum extraction(VE) and Manual vacuum aspiration(MVA) in essential services provided by Health centers and hospitals
- Support to C-PBF Focusing on indicators not financed in the current model
- Finalize community health workers reform
- Approve the newly developed community health policy and strategic plan and related ministerial order

Human Resources:

- Using WISN advocate for additional staff in high workload facilities using WISN as advocacy tool

Health Information and M&E:

- Revise data elements to remove gaps in information from HMIS
- Review existing mentorship models and approve one national model
- DQA of key RMNCAH data elements
- Conduct research to address critical gaps in knowledge to allow for evidence-based planning
- Criteria based clinical audits for C-section and PPH at hospital level
- Conduct maternal, perinatal and child death audits and upload into DHIS2 a
- Conduct near miss audits

Service Delivery including community demand generation

- MCH week twice annually
- Training, rotation to high volume units and continuous mentorship of Healthcare providers on essential EmoC skills (C/S, Vacuum Extraction, management of PPH, hysterectomy)
- Continue the training of CHWs on new competence polyvalent model for remaining 12 Districts and equip all CHWs accordingly
- Monitor C/S through Robson classification in all health facilities conducting C/S
- Strengthen IPC measures especially during pre-operative preparation of C/S to avoid infections.
- Polio vaccine campaign to address outbreaks in neighbouring countries
- Increase FP Uptake in Catholic church affiliated HFs
- Community (including Schools and Universities) outreach theatres and production broadcast of FP/ASRH and MNH information to address barriers to FP/ASRH
- Provision of ultrasound machines to remaining 270 health centre to support implementation of ANC new guidelines of 8 contacts

Supplies and medicines:

- Improve procurement of essential RMNACH commodities to avoid national stockouts
- Mentorship to HF staff for ordering and use of dLMIS
- Improve health system issues (RMS/eLMIS etc)
- Improve adherence by clients (e.g. iron tablets for pregnant women

Equipment and Infrastructure:

- Procure equipment for maternity and neonatology units in health facilities including cold chain equipment based on an evidence based digitalized (MEMMS) plan
- Preventive and curative maintenance for medical equipment

- Prioritize facilities with high load of mothers/mortality for expansion of wards and equipping them with enough beds
- To equip health centers that has many referrals and are far from hospitals with an ambulance to speed up referrals/ equip existing ambulances
- Promotion of horizontal referral options for hospitals; identification of provincial referral hub and full investment in terms of HR, infrastructure etc.

In addition to key priorities listed here, MCCH has an entire action plan to be implemented in 2023-2024, which will be revised and add other activities from stated recommendations.

PART VI. CONCLUSION

In the year 2022-23 the MCCH Division has supported the progress towards meeting Rwanda's ambitious goals of economic prosperity and health for women, children and adolescents as a human right. The achievements in improving health outcomes as a human right are evident in the further reduction in maternal and child mortality. The Ministry of Health launched an ambitious campaign titled 'No woman should die giving life', for which a Roadmap was developed towards meeting this goal.

Technical Working Groups have provided strong co-ordination between partners and direction to policy development and intervention implementation. Guidelines and strategies have been developed and introduced. Continuous capacity building, including extensive mentorship coupled with supervision has strengthened the implementation of these policies and guidelines.

Successful new strategies, such as post-partum family planning, have complemented the efforts to improve access to contraceptives. Provision of comprehensive care from pregnancy to childbirth continues to reach the vast majority of women. The new ANC guidelines for eight contacts was launched. As utilisation rates remain high the focus is on the quality of the services provided. The MCCH Division commits to the improvement in quality of services: pre-natal care, closer monitoring during delivery, increasing use of vacuum extraction and high-quality caesarean sections when indicated and attention to hygiene throughout the continuum of care.

In FY 2022-23 children under five years of age 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. Adolescent girls are also protected from cervical cancer through HPV vaccine. The victims of GBV were received and treated as required by guidelines and protocols, Further efforts are required to provide culturally appropriate access to sexual and reproductive and GBV services to adolescents and vulnerable women.

The MCCH division remains committed to contribute to the aim of *'No woman should die giving birth'* and RBC vision of healthy people in a wealthy nation through achieving SDGs, HSSP IV and Rwanda Vision 2050 targets.

Annex 1: RBF-ENABEL Result Framework, FY 2022-2023

Program area	Indicator	Baseline 2017-18	Target 2022-23	Results achieved. 2022-2023	Data source
Maternal and newborn health	•OCI 1: Facility deliveries – percentage of births attended by skilled health professionals – facility based information °HMIS	92%	≥ 90%	94%	HMIS_Routine data
Reproductive Health	•OCI 2: mCPR : utilization rate of modern Contraceptives – facility based ° HMIS	47%	50%	55%	HMIS_Routine data
Reproductive Health	•OPI 1: PPFP uptake : Post-Partum Family Planning within the first 6 weeks after delivery : °HMIS : baseline and target to be agreed on	32%	≥ 45%	67%	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	318,652	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%	94%	HMIS_Routine data

Maternal and newborn health	•OPI 4: First routine ANC within 1st trimester: °HMIS: baseline and target to be agreed on	40%	45.1%	53%	HMIS_Routine data
Maternal and newborn health	•OPI 5: Total of new-born not breathing successfully resuscitated/total of new-born not breathing: °HMIS: baseline and target to be agreed on	58%	≥ 70%	76%	HMIS_Routine data

Annex 2: SPRP Result Framework

PDO-level indicators	Baseline 2017-2018	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	Target FY 2022/23	Results FY 2022/23	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%	45%	49%	HMIS
Indicator 4a: Number of children	-	508,826	515,573	510,326	581,142	511,836	657,784	560,000	686,792	560000	683,178	SISCOM

under 5 were beneficiaries of project interventions												
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		318652	HMIS
IRI 2: Percentage of CHWs who received a quarterly supportive supervision visit from HC	40%	48%	59%	56%	86%	64%	91%	80%	101%	80%	96%	Supervision reports
IRI 3: Percentage of pregnant women who attended the first ANC visit	42%	44%	46%	46%	44%	48%	48%	52%	51%	52%	53%	HMIS

during the first trimester												
IRI 4: Percentage of pregnant women with anemia	1.6%	1.5%	2%	1.40%	1%	1.3%	0.7%	1%	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%	90	82%	HMIS
IRI 7: Percentage of children under five with diarrhea treated with ORS and zinc.	0%	95%	93%	95%	85%	95%	82%	95%	85%	95%	86%	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%	85%	80%	HMIS

IRI 11: Percentage of CHWs with no stock out of Zinc for diarrhea treatment	95%	95%	95%	95%	93%	95%	94%	95%	95%	95%	96%	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	125,000	117,353	HMIS

Annex 3: Maternal and Child Health week results for November 2022

District	Target population			Coverage	Coverage deworming			Coverage screening		Others	
	12-59 months	5-15 years	16+ years	Coverage Vit A_12-59 months	MBZ_12-59 months	ALB_5-15 years	ALB_16 + years	MUAC_6-59 months	Weight_6-59 months	Received MNP 6-12 month	Received FP methods
Bugesera	70,307	158,509	248,250	85%	94%	94%	17%	95%	95%	2,925	455
Burera	42,691	113,892	244,080	99%	100%	98%	97%	98%	98%	3,481	330
Gakenke	39,956	97,066	247,473	100%	99%	99%	93%	98%	98%	4,382	812
Gasabo	91,543	215,848	341,247	99%	100%	100%	8%	88%	86%	11,041	331
Gatsibo	63,901	146,654	302,434	95%	97%	97%	82%	95%	94%	7,012	557
Gicumbi	53,137	108,415	273,151	94%	97%	99%	94%	93%	87%	7,488	346
Gisagara	47,828	112,459	256,587	93%	93%	96%	92%	89%	89%	6,493	147
Huye	42,522	95,292	233,153	100%	100%	100%	100%	99%	99%	7,275	988
Kamonyi	43,332	106,585	228,323	97%	96%	97%	69%	96%	92%	9,623	366
Karongi	42,277	105,563	233,092	91%	96%	98%	93%	92%	92%	5,955	341
Kayonza	50,202	121,928	223,343	97%	98%	97%	92%	97%	97%	6,515	656
Kicukiro	42,311	107,035	190,255	95%	98%	92%	26%	88%	87%	4,347	215
Kirehe	54,018	141,059	277,744	93%	96%	98%	80%	92%	92%	7,918	638
Muhanga	34,321	95,534	240,738	97%	91%	98%	93%	97%	97%	4,155	251
Musanze	52,954	119,693	288,086	77%	99%	99%	93%	82%	84%	8,115	461

Ngoma	42,592	112,037	229,311	100%	100%		100%	81%	100%	100%	10,659	414
Ngororero	45,652	108,512	236,897	90%	93%		98%	96%	91%	91%	3,051	192
Nyabihu	42,438	102,685	196,855	94%	96%		98%	98%	93%	91%	3,173	178
Nyagatare	86,749	193,423	402,946	97%	97%		97%	89%	96%	94%	15,827	892
Nyamagabe	42,163	113,949	238,520	97%	98%		98%	96%	95%	97%	10,173	367
Nyamashek e	56,309	131,681	251,421	96%	99%		95%	95%	96%	97%	6,456	326
Nyanza	35,606	108,476	194,948	99%	100%		98%	97%	99%	99%	9,543	324
Nyarugeng e	37,009	90,721	49,967	100%	100%		100%	75%	100%	100%	10,088	422
Nyaruguru	39,125	101,709	203,059	98%	99%		99%	98%	99%	99%	6,875	330
Rubavu	75,049	158,217	315,697	84%	99%		98%	93%	94%	93%	5,812	523
Ruhango	40,045	102,380	205,750	97%	99%		99%	87%	94%	94%	2,818	503
Rulindo	42,049	95,435	214,810	96%	99%		97%	95%	95%	95%	5,279	275
Rusizi	66,564	135,261	301,390	92%	98%		94%	94%	94%	93%	5,634	342
Rutsiro	44,926	107,031	223,700	100%	100%		99%	99%	100%	100%	6,472	119
Rwamagan a	52,027	117,230	235,396	98%	100%		100%	14%	99%	99%	8,711	373
National	**1,519,60 3**	**3,624,27 9**	**7,328,62 3**	95%	98%		98%	81%	**94%**	**94%**	**207,296**	**12,474**

Annex 4: Maternal and Child Health week results for June 2023

District	Target Pop			Coverage Received Vitamin A	Coverage deworming					Coverage screening			other	
	12-59 months	5-15 years	16+ years		Mbz _12-59 months	Alb _5-15 years	Alb _16+ years	Pzq 5-15 years	Pzq 16+yrs	MUAC 12-59 months	Weight 12-59 months	Height 6-23 months	% Received Onger a	Total FP clients
Bugesera	65,481	151,655	248,250	97%	93%	86%		95%		99%	99%	102%	97%	545
Burera	45,085	108,816	244,080	96%	95%	100%	84%	67%	53%	95%	93%	87%	84%	406
Gakenke	39,506	86,909	247,473	98%	98%	109%		61%		97%	96%	93%	93%	649
Gasabo	102,898	236,586	341,247	89%	94%	100%		95%		84%	84%	42%	40%	1633
Gatsibo	63,050	144,132	302,434	96%	97%	101%	80%	104%	101%	96%	94%	68%	64%	754
Gicumbi	49,817	119,905	273,151	97%	98%	105%		48%		97%	99%	85%	85%	488
Gisagara	42,475	96,514	256,587	99%	99%	116%		95%		97%	95%	99%	98%	272
Huye	41,140	108,545	233,153	99%	99%	101%		75%		99%	101%	87%	86%	411
Kamonyi	47,777	121,277	228,323	90%	93%	106%		65%		82%	91%	72%	72%	513
Karongi	41,983	111,553	233,092	89%	87%	89%	85%	44%	61%	83%	83%	86%	102%	4684
Kayonza	51,355	125,919	223,343	91%	97%	110%	73%	91%	59%	94%	93%	62%	64%	215
Kicukiro	51,920	132,276	190,255	91%	96%	88%		100%		87%	81%	51%	47%	264
Kirehe	50,937	124,335	277,744	99%	97%	110%		64%		99%	99%	99%	100%	652
Muhanga	37,857	86,132	240,738	95%	92%	111%		84%		102%	101%	81%	84%	389
Musanze	54,074	128,184	288,086	97%	99%	97%	94%	77%	87%	96%	87%	85%	108%	741
Ngoma	44,834	115,872	229,311	95%	96%	95%	89%	105%	115%	95%	93%	96%	96%	475
Ngororero	42,650	115,586	236,897	98%	100%	101%	96%	89%	109%	97%	97%	91%	68%	311
Nyabihu	36,320	89,883	196,855	93%	98%	104%	85%	97%	139%	85%	84%	81%	107%	150
Nyagatare	86,258	178,114	402,946	95%	98%	108%		48%		98%	90%	85%	86%	1289
Nyamagabe	43,227	98,047	238,520	96%	99%	94%	91%	36%	46%	97%	97%	88%	87%	334
Nyamasheke	51,263	155,370	251,421	94%	96%	98%	98%	133%	93%	88%	88%	77%	83%	488

Nyanza District	41,183	106,177	194,948	93%	95%	100%		88%		93%	93%	95%	94%	478
Nyarugenge	39,812	97,476	49,967	95%	99%	102%		91%		96%	96%	63%	60%	1088
Nyaruguru	37,057	90,228	203,059	91%	90%	95%	85%	74%	77%	89%	84%	87%	82%	232
Rubavu	64,953	147,058	315,697	96%	89%	95%	71%	102%	94%	102%	102%	80%	81%	618
Ruhango	41,693	103,130	205,750	91%	92%	93%		119%		92%	92%	93%	93%	464
Rulindo	42,118	106,758	214,810	98%	100%	104%	96%	96%	95%	99%	99%	70%	69%	565
Rusizi	58,851	130,712	301,390	90%	95%	99%	83%	97%	125%	94%	95%	79%	102%	581
Rutsiro	41,940	104,156	223,700	98%	100%	94%	77%	42%	44%	97%	95%	84%	79%	76
Rwamagana	53,527	131,155	235,396	99%	100%	101%		110%		98%	98%	88%	92%	387
National	**1,511,041**	**3,652,460**	**7,328,623**	**95%**	**96%**	**100%**	**85%**	**83%**	**87%**	**94%**	**93%**	**80%**	**82%**	**20152**

Annex 5: List of partners: FY 2022-2023

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

Partner	Program of intervention	District(s) where they intervene
PIH	MNH, Child Health, Community Health, ASRH, Family Planning, Mentorship	Kirehe, Burera and Kayonza
World Bank SPRP	Nutrition	Ruhango, Gakenke, Karongi, Rusizi, Kayonza, Nyabihu, Ngororero, Rutsiro, Nyamagabe, Nyaruguru, Rubavu, Bugesera & Huye
Access to Health	Community Health	Countrywide
Rwanda Paediatric Association	Mentorship	Countrywide
RAM	Mentorship	Bugesera, Burera, Gasabo, Karongi, Kayonza, Kicukiro, Kirehe, Ngororero, Nyamasheke, Nyanza, Nyarugenge, Rubavu, Rutsiro and Rusizi
ADRA Rwanda	Child health, Nutrition and mentorship	Nyabihu
CARITAS	Nutrition	Ruhango
Garden for health	Nutrition	Musanze
CRS_Gikuriro Project	Nutrition	Ngoma, Kayonza, Nyarugenge, Kicukiro
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
Humanity& Inclusion	Child Health, Mentorship	Ngororero, Rutsiro and Karongi
IHANGANE Project	Nutrition	Gakenke
Imbuto Foundation	ASRH	Countrywide
KASHA	ASRH	Gasabo & Huye
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