Republic of Rwanda
Ministry of Health

Rwanda Biomedical Centre
Healthy People, Wealthy Nation

Tuberculosis and other respiratory communicable Diseases Program Annual Report

2025/2026



August 2026

Contents

Foreword 13
Executive summary 13
CHAPTER 1: TB SCREENING AND DIAGNOSTIC 19
1.1. TB Screening and diagnostic 19
1.2. Active case finding screening 20
1.3 Increase access to rapid and molecular tests 22
1.4. Reach the universal access to DST 22
1.4.1. Culture techniques 22
1.4.2. Drug susceptibility for first line drug 23
1.4.3. Drug susceptibility for second line drug at NRL 24
1.4.4. Access to universal drug susceptibility testing 25
1.5. Strengthening the quality of laboratory services 26
1.5.1. Smear microscopy quality control 26
1.5.2. GeneXpert External Quality Control 26
CHAPTER 2: TUBERCULOSIS NOTIFICATION 27
2.1. Notification and CHWs contribution 27
2.2. TB notification by sex and age groups 29
2.3. Geographical distribution of TB notification 30
2.4. Notification of TB cases according to WHO classification 34
2.5. TB notified among high-risk groups 37
2.6. TB notified among children 40
2.7. Drug resistant TB notification 41
2.7.1. DR-TB notification by province 42
2.7.2. DR-TB notification by gender and HIV status 43
CHAPTER 3: TUBERCULOSIS PREVENTION 45
3.1. Tuberculosis infection prevention and control 45
3.2. Tuberculosis preventive treatment among TB contacts 46
3.2.1. Cascade of TB contacts investigation 46
3.2.2. TB prevention therapy among TB contacts under 5 years 47
3.2.3. TB preventive therapy among TB contacts above 5 years 48

3.2.4. TB preventive therapy among PLHIV 50
3.2.5. TB preventive therapy among inmates 51
CHAPTER 4: TUBERCULOSIS TREATMENT OUTCOME 54
4.1. National TB Treatment Success for Drug-Susceptible TB: Five-Year Trend 54
4.2. Treatment Outcomes by Clinical and Demographic Characteristics 56
4.3. Treatment Outcomes by Age Group 56
4.4. Treatment Outcomes by HIV Status 57
4.5. Treatment Outcomes by Disease Site and Diagnostic Classification 57
4.6. Treatment Outcomes for Drug-Resistant TB 57
4.7. Treatment Outcomes by Sex 58
4.8. Subnational Variation in TB Treatment Outcomes 59
4.8.1. Variation in Treatment Outcomes Across Hospital Catchment Areas 59
4.8.2. Variation in Treatment Outcomes at District Level 60
4.8.3 Sector and Health Facility-Level Variation 62
4.9. Programmatic synthesis 63
4.10. TB treatment outcome by nutritional status among patient ≥15years of age 63
4.11. Treatment Outcomes Among Malnourished TB Patients Receiving Nutritional Support, 24-25 FY 64
4.12. Treatment Outcome for TPT among Contacts of index TB cases 66
4.13. Treatment outcome for TPT among PLHIV 66
4.14. TB death audits in the context of TB control in Rwanda 67
4.14.1. Characteristics of TB Deaths 68
4.14.2. TB/HIV Co-infection and Immunosuppression 68
4.14.3. Nutritional Status 68
4.14.4. Programmatic Implications 69
Chapter 5. TUBERCULOSIS PROGRAM MANAGEMENT 70
5.1. Health Promotion, Community, and Stakeholder Engagement 70
5.1.1. Community outreach activities 71
5.2. World Tuberculosis Day (WTBD 2026) 72
5.3. Civil Societies Organization in TB Control 75
CHAPTER 6: SUPPLY PLAN CHAIN MANAGEMENT AND COMMODITIES 77

6.1. Coordinated Procurement and Distribution system 77
6.2. Procurement status of TB products at end of June 2026 78
6.3 Forecasted accuracy of TB medicines 79
6.5.1 Active drug-safety monitoring and management(aDSM) 80
6.5.2 Adverse Events Reported through the eTB System 82
6.5.3 Pharmacovigilance Reporting through VigiMobile 83
6.5.4 Summary and Programmatic Implications 85
CHAPTER 7: TUBERCULOSIS MONITORING, EVALUATION AND RESEARCH . 86
7.1. Data review: Quarterly Data Quality Checking, Validation, and Performance Review 86
7.2. TB &ORD assessment (RSQA) 86
7.3. Digital Adherence Technology (DAT) 88
7.4. e-BUZIMA Implementation for Tuberculosis Services 89
7.5. Annual evaluation meeting with District Hospitals and stakeholders 89
7.6. Strengthening TB research, Innovation and implementation 90
7.7. Capacity Building Activities Conducted During FY 2025–2026 92
7.8. National Strategic Plan (NSP) 93
7.8.1. NSP development, process and costing 93
7.8.2. Challenges considerations during NSP development 94
7.8.3. NSP current status 95
7.8.4. Way Forward to implementation of NSP 95
CHAPTER 8: STRENGTHENING LEPROSY SURVEILLANCE AND RESPONSE 97
8.1. Improve the leprosy surveillance system 97
8.2. Programmatic shifts in leprosy control strategies in endemic zones 98
8.3. Leprosy screening and case-finding 99
8.4. Leprosy notification 100
8.5. Leprosy treatment outcome 101
8.6. Disability Assessment — Beginning vs. End of Treatment 102
8.7. Healthcare Providers' Mentorship on Leprosy, Contact Tracing, and Post-Exposure Prophylaxis (PEP) 105
CHAPTER 9: FINANCING THE NSP TB 107

9.1. Introduction 107
9.2. Funding Sources for TB Expenditures in Rwanda FY 2025-2026 107
9.3. Public and external funding sources for TB NSF 107
9.3. 1. Government contribution to TB National Strategic Plan 108
9.3.2 The Global Fund contribution 110
CHAPTER 10: CONCLUSION 112

List of tables

Table 1: HIV testing among presumptive TB 20
Table 2: Positivity rate in CFs and other high-risk group during active case finding . 21
Table 3: First line DST results, fiscal year 2025-2026 23
Table 4: Processed samples for second line DST: fiscal year 2025-2026 24
Table 5: Summary of slides retesting for smear microscopy 26
Table 6: Diagnostic of TB among HRG mutually exclusive, July 2025- June 2026 .. 38
Table 7: Screening of health care providers and CHWs per district, July 2025-June 26. 46
Table 8. Treatment success rate per fiscal year 55
Table 9. Detailed treatment outcomes by shorter and longer DR-TB regimens are presented in the subsequent section..... 58
Table 10: Forecast accuracy for TB medicines 80
Table 11: Severity grading of adverse events reported in eTB..... 82
Table 12. Most frequently reported adverse events in eTB 83
Table 13. Anti-TB medicines associated with ADR reports in VigiMobile 84
Table 14. Summary of adverse drug reactions reported through VigiMobile..... 85
Table 15: Rapid Service Quality Assessments per selected indicators in Western Provinces, August 2025.....87
Table 16. Leprosy notification, FY 20 25-2026 101
Table 17: Leprosy treatment outcome cohort July 2023-June 2024 for MB and July 2024 to June 2025 for PB cases.....102
Table 18: Disability Grade Transition, Multibacillary Cohort (2023-2024) 102
Table 19. Disability Grade Transition, Paucibacillary Cohort (2024-2025).....103
Table 20: Source of Fund for TB NSP for the Financial Year 2025-2026 108
Table 21: GoR TB NSP budget and expenditure per MTEF chapter for the year ended 30 June 2026.....109
Table 22: GoR TB NSP budget and expenditure per Budget agencies for the year ended 30 June 2026.....109
Table 23: GF TB NSP budget and expenditure per MTEF Chapter for Fiscal Year 2025-2026 110
Table 24: GF TB NSP budget and expenditure per Budget agencies for Financial Year 2025-2026 111

List of figures

Figure 1. TB screening in Rwanda by level 19
Figure 2: Result of primary TB culture 23
Figure 3: Trend of Drug susceptibility testing among TB Bacteriologically confirmed over seven Fiscal years. 25
Figure 4: Summary of slides retesting for smear microscopy 27
Figure 5: Contribution of CHWs on the national TB notification during 2025-2026 FY 28
Figure 6: TB notification trend in the last ten years in Rwanda 29
Figure 7: Age-pyramid of notified TB cases during 2025-2026 fiscal year 30
Figure 8: Notification (number and proportion) of TB cases by province in 2025-2026 FY 31
Figure 9: Map of TB notification per district 32
Figure 10: Notification rate by districts during the 2025-2026 fiscal year 33
Figure 11: TB cases by WHO classifications 35
Figure 12: Extrapulmonary TB localization 36
Figure 13: Trend of TB-HIV co-infection from July 2015-June 2026 36
Figure 14: Diagnostic of TB among HRG mutually inclusive, July 2025- June 2026 38
Figure 15: Map of TB cases under 15 years per district 40
Figure 16: Trend of DR-TB notification during the last 11 years 42
Figure 17: DR-TB notification by province from July 2025 to June 2026 43
Figure 18: Drug resistance TB notification by gender and HIV status in 2025/2026 FY 44
Figure 19: TB contact investigation cascade for FY 2025-2026 47
Figure 20: Under 5 years initiated on tuberculosis preventive therapy, 2025- 2026 48
Figure 21: TPT initiation among TB contacts above 5 YO. 2025-2026 49
Figure 22: TPT Coverage among HIV + newly initiated on ART ,25/26 FY 50
Figure 23: TPT in Correctional facility from 12-28 November 2025 52
Figure 24: Trend of TB treatment outcome by fiscal year, 2020-2021 to 2024-2025. 55
Figure 25: Treatment outcomes by patient subgroup, FY 2024-2025. 56

Figure 26: Treatment outcome by sex, FY 2024-2025.....59

Figure 27: Treatment outcome for the TB cohort, FY 2024-2025, ranked by hospital catchment area, against the 90% national target. 60

Figure 28: Treatment success rate by district, Rwanda, FY 2024-2025, with the lowest-performing district (referral) hospitals ranked alongside the map. 61

Figure 29: Health facilities below 90% treatment success rate, FY 2024-2025..... 62

Figure 30: Nutritional outcome Among TB Patient with baseline BMI <18.5 receiving nutrition support, FY 2024-2025. 64

Figure 31: Treatment Outcomes Among DS-TB Patients Receiving CHW Follow-Up, FY 2024–2025.....65

Figure 32: CHW follow up and DS-TB Treatment outcome 66

Figure 33: Procurement status of TB products, FY 2024-2025.....78

Figure 34: Execution rate for the supply chain plan 79

Figure 35. Coverage of active drug safety monitoring.....81

Figure 36. Leprosy screening and case-finding.....100

Figure 37. Disability Grade Transition, Beginning vs End of Treatment (Both Cohorts).....103

Figure 38. Household Contact Screening to PEP Cascade (Cumulative from July 2021 to June 2026) 104

List of Abbreviations and Acronyms

The following abbreviations and acronyms are used throughout this report.

Abbreviation	Full Term
ACF	Active Case Finding
ADR(s)	Adverse Drug Reaction(s)
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
BMI	Body Mass Index
CAD	Computer-Aided Detection
CDC	Centers for Disease Control and Prevention
CDT	Centre de Diagnostic et Traitement (TB Diagnosis and Treatment Center)
CF(s)	Correctional Facility (Facilities)
CFR	Case Fatality Ratio
CHUK	Centre Hospitalier Universitaire de Kigali (University Teaching Hospital of Kigali)
CHW(s)	Community Health Worker(s)
CNR	Case Notification Rate
DAT	Digital Adherence Technology
DH	District Hospital
DOT	Directly Observed Treatment
DQA	Data Quality Audit
DR-TB	Drug-Resistant Tuberculosis
DS-TB	Drug-Susceptible Tuberculosis
DST	Drug Susceptibility Testing

Abbreviation	Full Term
EID	Early Infant Diagnosis
EPTB	Extrapulmonary Tuberculosis
EQA	External Quality Assessment
FDA	Rwanda Food and Drugs Authority
FY	Fiscal Year
GF / GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoR	Government of Rwanda
HFN	High False Negative
HFP	High False Positive
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRG(s)	High-Risk Group(s)
HRTT	Health Resource Tracking Tool
HSSP	Health Sector Strategic Plan
IC	Infection Control
IEC	Information, Education, and Communication
IFMIS	Integrated Financial Management Information System
IGRA	Interferon-Gamma Release Assay
IPC	Infection Prevention and Control
L2TH	Level Two Teaching Hospital
LEMT	Leprosy Elimination Monitoring Tool
LFN	Low False Negative
LPA	Line Probe Assay

Abbreviation	Full Term
LTBI	Latent Tuberculosis Infection
MB	Multibacillary (leprosy classification)
MDR-TB	Multidrug-Resistant Tuberculosis
MDT	Multidrug Therapy (leprosy treatment)
MoH / MINISANTE	Ministry of Health
MTB	Mycobacterium Tuberculosis
MTEF	Medium-Term Expenditure Framework
NCD	Non-Communicable Disease
NGOs	Non-Governmental Organizations
NRL	National Reference Laboratory
NSP	National Strategic Plan
NTDs	Neglected Tropical Diseases
NTP	National Tuberculosis Program
ORD	Other Respiratory (Communicable) Diseases
PB	Paucibacillary (leprosy classification)
PEP	Post-Exposure Prophylaxis
PLHIV	People Living with HIV
QE	Quantification Error
QEM(s)	Quarterly Evaluation Meeting(s)
RBC	Rwanda Biomedical Centre
RBF	Results-Based Financing
RMS	Rwanda Medical Supply
RR-TB	Rifampicin-Resistant Tuberculosis

Abbreviation	Full Term
RSQA	Rapid Service Quality Assessment
RWF	Rwandan Franc
SDR-PEP	Single Dose Rifampicin Post-Exposure Prophylaxis
TB	Tuberculosis
TB&ORD	Tuberculosis and other Respiratory Communicable Diseases (Division)
TPM+	Smear-Positive Pulmonary Tuberculosis
TPT	Tuberculosis Preventive Therapy / Treatment
TST	Tuberculin Skin Test
USD	United States Dollar
USG	United States Government
WHO	World Health Organization
XDR-TB	Extensively Drug-Resistant Tuberculosis

Rwanda Biomedical Centre
Healthy People, Wealthy Nation

Doc Number: RBC/DG/26038/2026
Date: 23-9-2026 06:20:06

Foreword

The Tuberculosis and other Respiratory Communicable Diseases (TB&ORD) Division of the Rwanda Biomedical Centre is pleased to present the Annual Report for the Fiscal Year 2025–2026, documenting the progress, achievements, and challenges of Rwanda's national response to tuberculosis over the reporting period.

During FY 2025–2026, Rwanda notified 8,274 TB cases of all forms, sustaining the national case notification trend observed over the past three fiscal years, while high-risk group and childhood TB case-finding both exceeded their national targets. The country maintained a national treatment success rate of 91%, meeting the ≥90% target and reflecting a sustained, multi-year decline in TB mortality. TB prevention services also recorded notable gains, with TB preventive therapy coverage remaining high among children under five, contacts aged five and above, and people living with HIV on antiretroviral therapy, alongside continued strengthening of infection control across health facilities. Strengthened laboratory quality assurance, expanded molecular diagnostic capacity, and improved death audit reporting further reflect the Division's ongoing investment in the quality and reliability of the national TB programmer's data and services.

These achievements were made possible through the sustained commitment of Community Health Workers, health facility staff, district and hospital teams, and technical and financial partners, whose combined efforts continue for Rwanda's TB response at community and facility level.

Looking ahead, the TB&ORD Division remains committed to consolidating these gains and addressing the identified gaps through evidence-based planning, strengthened partnerships, and innovative community-based approaches. We extend our sincere gratitude to all partners, implementers, and frontline health workers whose dedication continues to drive Rwanda closer to its goal of ending the TB epidemic by 2035.

Digitally Signed By Claude Mambo MUVUNYI
Director General
Date : 23-9-2026 06:20:06

Executive summary

1. TB Screening and Diagnostics

During FY 2025–2026, Rwanda continued to strengthen TB screening and diagnostic services through targeted active case finding, rapid molecular diagnostics, sputum pooling, TB-LAM testing, DST, and laboratory quality assurance. Active screening among high risk and vulnerable populations contributed to improved identification of presumptive and confirmed TB cases, with CXR supported by computer aided detection playing an important role in these activities.

A total of 81,775 samples processed using GeneXpert, 28,703 (35.1%) were reported through DataToCare; however, only 2,715 (44.4%) of 6,103 GeneXpert positive samples were processed through the system. Universal DST coverage reached 95% among bacteriologically confirmed TB cases, compared with 95.6% in the previous fiscal year, mainly due to cartridge stock outs, supply chain challenges, and delays in specimen transportation.

Laboratory quality assurance showed performance, with 154 of 205 CDTs (75.1%) covered by smear microscopy quality control and 67 of 69 evaluated GeneXpert laboratories (98.6%) achieving satisfactory proficiency testing results. Overall, the reporting period demonstrated continued progress in strengthening TB diagnostic capacity, although challenges remain in optimizing GeneXpert utilization, ensuring uninterrupted diagnostic supplies, achieving universal DST coverage, and expanding quality assurance to all testing sites

2. TB Notification

In FY 2025–2026, Rwanda notified 8,274 TB cases of all forms, including 34 rifampicin-resistant TB (RR-TB) cases, with 0.9% increase over FY 2024–2025 that confirms a plateau in national case notification over the past three fiscal years. CHWs contributed 1,995 cases (24.1%), slightly under the 25% national target, as CHW-referred notifications declined by 10.5% relative to the previous year. The majority of cases occurred among males (71.9%, ratio 2.5:1) and the economically active 25–44 age group (45.1%). Kigali City reported the highest proportion of cases (29.6%), followed by the Eastern (23.9%) and Southern (19.5%) provinces, with the Northern Province recording the lowest share (10.5%). Bacteriologically

confirmed cases comprised 71.6% of notifications, with pulmonary TB representing 87.4%. TB-HIV co-infection rose to 15.6% from 13.0% the previous year, an increase driven mainly by improved case detection following the scale-up of TB-LAM testing rather than a true rise in burden. High-risk groups accounted for 73.7% of notified cases, exceeding the 70% national target, with malnourished individuals the most affected group. Childhood TB cases made up 14% of the total, double the 7% national target. DR-TB notifications declined by 29.2% to 34 cases; this trend should not be interpreted as programmatic evidence of a reduced DR-TB burden.

3. TB Infection Control and Preventive Therapy (TPT)

Rwanda has made strong progress in TB prevention, with 90% of 580 health facilities meeting all six minimum TB infection control (IC) standards. Screening reached 87% of health facility staff (23,684/27,268), identifying 13 TB cases, while 99% of CHWs were screened, detecting six cases. Household contact tracing also remained high at 99% (15,605/15,800), with 273 contacts (2%) diagnosed with TB. TPT initiation was similarly strong, reaching 99% among children under five, 95% among those aged five years and above, and 99.1% among PLHIV already on ART.

Despite these achievements, some gaps still need attention. Screening coverage among health facility staff is declining, infection control practices remain below expectations in some sub-districts, and TPT coverage among newly enrolled ART patients is only 73.6%. Addressing these gaps will require continued mentorship and supportive supervision, stronger follow-up at facility and sub-district levels, and improved data recording and reporting to ensure that TB prevention services consistently reach everyone who needs them.

4. Tuberculosis treatment outcome

Rwanda maintained strong TB treatment outcomes, achieving 91% treatment success among patients treated in FY 2024–2025, meeting the national target of ≥90% and improving from 90% in the previous cohort. The improvement was mainly driven by a sustained reduction in TB mortality, from 8% in FY 2020–2021 to 5% in FY 2024–2025. However, treatment success remained below target among TB/HIV co-infected

patients (81.8%), patients with extrapulmonary TB (86.8%), and adult men (90%). Nutritional recovery and CHW follow-up were associated with better treatment outcomes and lower mortality.

In FY 2025–2026, TB death audit reporting reached 100% completeness, a substantial improvement from 29% in FY 2019–2020. Most audited deaths occurred during the early period following diagnosis, with 76.6% within the first month and 87.7% within the first two months, underscoring the need to strengthen early identification, clinical management, and follow-up of patients at high risk of death

5. Health Promotion and Stakeholder Engagement

TB prevention and control was strengthened through 18 radio talk shows, 8 TV programs, social media campaigns, community outreach in 13 districts, and stakeholder engagement, including sensitization in 13 prisons and 6 refugee camps. These activities mobilized 3,182 peer educators in high-risk settings and 4,823 peer educators across 547 health facilities, reaching 165,911 PLHIV, conducting 27,677 home visits, and referring 2,971 people for TB screening, resulting in 75 PLHIV diagnosed and linked to TB treatment. Overall, these interventions strengthened TB awareness, early detection, referral, treatment adherence, and stigma reduction, although data quality and referral tracking remain areas for improvement.

6. Supply plan chain management and commodities

During FY 2025–2026, the TB&ORD Division maintained continuity of TB commodity supply through coordinated forecasting, procurement, distribution, and supply monitoring. Of the 181 items in the annual supply plan, 67 (37%) were fully received, while 41 (22%) were ordered and awaiting delivery, 32 (18%) remained at the planning stage, and 41 (23%) were cancelled following reassessment of needs. Despite procurement challenges, no nationwide stock-outs of TB medicines were reported. Demand exceeded forecasts for adult first-line TB treatment (113%) and pediatric formulations (172%), requiring forecast adjustments and emergency procurement. For drug safety monitoring, 6,913 of 8,274 TB patients (83.6%) had documented aDSM

follow-up, with 118 adverse events recorded in eTB and 55 adverse drug reactions reported through VigiMobile.

7. Monitoring, Evaluation, and Research

Rwanda's efforts during FY 2025–2026 to strengthen the quality, use, and effectiveness of TB program data and services. Quarterly Evaluation Meetings and Rapid Service Quality Assessments were used to identify weaknesses in data quality, reporting, diagnosis, infection control, active case finding, and treatment monitoring. The overall RSQA performance averaged 62%, with particularly low performance in active cases finding among high-risk groups (33%), diagnostic functionality and timely results (43%), leprosy control (16%), and active drug safety monitoring (44%). The chapter emphasizes the need for more accurate and timely reporting, stronger laboratory and GeneXpert services, improved infection-control monitoring, increased screening of high-risk populations, better TB/HIV integration, and continuous availability of medicines and diagnostics. Rwanda's increasing use of digital technologies, research, and capacity building to improve TB control. Digital Adherence Technology (DAT) was introduced in 46 high-burden facilities to support treatment adherence, although its implementation was limited by SMS interruptions, inadequate funding, and training delays. The e-BUZIMA TB module was developed to improve electronic patient management and reporting

8. Strengthening leprosy surveillance and response

Programme performance in FY 2025–2026 remained strong on treatment outcomes, with 97% of multibacillary (MB) and paucibacillary (PB) patients completing therapy, and no new disabilities recorded during treatment. Fifteen cases were notified (10 new, 5 relapse), 70% of new cases via ACF, with 20% presenting Grade 1 disability and none with Grade 2, suggesting reasonably timely diagnosis. Contact tracing coverage improved, with 88% of registered contacts screened this year and 75.6% initiated on post-exposure prophylaxis (PEP), though cumulative PEP uptake since 2021–2022 (66.3%) indicates room for further gains.

Surveillance systems were also strengthened. Rwanda continued to operate an electronic, case-based reporting platform and began piloting the WHO Leprosy Elimination Monitoring Tool (LEMT), including a review of historical data dating back to 2003 to harmonise paper- and web-based records ahead of integration with DHIS2. In parallel, the Division is preparing to migrate individual surveillance data to the e-Buzima platform in line with the Ministry of Health's move to a fully paperless health system from August 2026, while continuing to rely on paper tools in areas where e-Buzima is not yet operational.

9. TB Financing

Tuberculosis National Strategic Plan (NSP) remains a key instrument for guiding TB control and prevention activities in Rwanda in alignment with the latest World Health Organization (WHO) guidance. The implementation of the TB NSP is financed through domestic government resources and external development partner contributions, principally the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

For the 2025–2026 financial year, the TB NSP had a revised total budget of USD 6,640,791, comprising USD 2,652,747 from the Government of Rwanda (GoR) and USD 3,988,044 from the Global Fund. Total expenditure amounted to USD 6,539,395, representing an overall budget execution rate of 98%, with an unspent balance of USD 101,396.

CHAPTER 1: TB SCREENING AND DIAGNOSTIC

1.1. TB Screening and diagnostic

In Rwanda, TB screening combines passive and active approaches. Passive screening is applied to people seeking care at health facilities who are not in high-risk groups, while active screening targets populations more vulnerable to TB. Community Health Workers (CHWs) support the process by detecting individuals with TB symptoms and directing them to health centers for further checks. In addition, chest X-rays are particularly used in correctional facilities, transit sites, rehabilitation centers, and other high-risk settings.

During the fiscal year (FY) 2025/2026, a total of 115,211 presumptive TB cases were screened. Of these, 72,907 (63.3%) were identified by health facilities (HFs), while 42,304 (36.7%) were identified through Community Health Workers (CHWs).

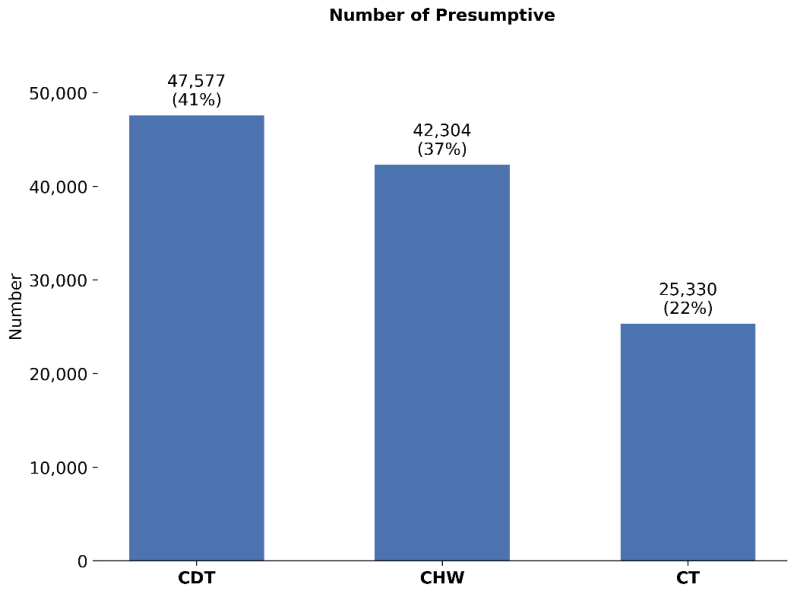


Figure 1. TB screening in Rwanda by level

Among all presumptive TB, 9.2% (10,546) knew their HIV-positive status and 97.8% (102,367) of unknown HIV status had been tested during the TB diagnosis. Overall, 11,243 (9.8%) of the presumptive TB cases tested positive for HIV.

Table 1: HIV testing among presumptive TB

Table 1: HIV testing among presumptive TB

Total # of presumptive TB	Known as HIV+	Unknown HIV status			Total tested	Total # of HIV+ presumptive TB
		# to be tested	# and % of Tested	# and % of HIV+		
115,211	10,546	104,665	102,367	697	112,913	11,243
	9.2%		**97.8%**	**0.7%**	**98.0%**	**9.8%**

1.2. Active case finding screening

During the 2025–2026 fiscal year, active case finding (ACF) activities were carried out in areas with high TB notification, using data to identify villages with a high burden of TB cases, including slum areas. Hotspots and slums were identified across 25 health centers; the intervention targeted 15 health centers with high TB notification rates and 10 low-notification health centers located within sectors reporting a high TB burden. The selected health centers were distributed as follows:

12 health facilities in Kigali City: Gasabo District (2), Kicukiro District (5), and Nyarugenge District (5);

5 health facilities in the Northern Province: Rulindo District (2), Musanze District (1), Gicumbi District (1), and Gakenke District (1);

4 health facilities in the Southern Province: Muhanga District (1), Kamonyi District (1), Nyanza District (1), and Nyaruguru District (1);

4 health facilities in the Western Province: Rubavu District (1), Nyabihu District (1), Ngororero District (1), and Rusizi District (1).

The ACF was also implemented using mobile digital chest X-ray (CXR) equipped with computer-aided detection (CAD) technology in seven correctional facilities: Gicumbi, Nyamagabe, and Ngoma for the third round of screening; Nyanza, Muhanga, and Musanze for the fourth round; and Rwamagana Correctional Facility for the fifth round. Furthermore, ACF using Mini-X-ray machine equipped with CAD was also carried out at Rubavu

correctional facility, performed by Gisenyi hospital staff, targeting TB symptoms screened positive and/or close contacts of confirmed TB cases.

In addition, ACF was conducted among trainees in the Nyamagabe and Gitagata Rehabilitation Centres, miners at the Musha Trinity Metals mining site, and populations in high-risk community settings, including Gisozi-Agakiriro, Batsinda and Kimironko market.

As a result of ACF in hot spot/slums, corrections services, rehabilitation centers, mining site and markets, a total of 62,684 people were eligible for TB screening and 85,5% (53,583) were screened symptomatically and 58.6% (36,735) were screened by CXR with computer aided diagnostic. Of the people screened, 14.5% (7,744/53,583) were TB presumptive and 58.8% were identified by symptoms only, 38.8% by chest x-ray only and 2.4% by both symptoms and CXR. The low proportion identified through CXR and symptoms is mainly attributable to the fact that a significant proportion of the population in hotspots was screened using symptom-based screening only. Among them 665 (8.6%) TB cases were diagnosed and 54.6% had symptoms only, 37.0% had abnormal CXR suggestive TB and 8.4% had both symptoms and abnormal CXR. The following shows detection by high-risk groups:

In hotspots/slum areas, a total of 16,846 people were screened, of whom 4,339 (25.3%) were identified as TB presumptive through symptom screening alone and 360 (8.3%) were diagnosed with TB.

Table 2: Positivity rate in CFs and other high-risk group during active case finding

ACF		Hotspots & slums	Correctional facilities	Rehabilitation Centers	Mining site	Markets
Population		**16,846**	**33,534**	**2,253**	**1,980**	**8,071**
Screening	Symptoms	16,846 (100%)	32,260 (96.2%)	2,148 (95.3%)	1,750 (88.4%)	579 (7.2%)
	CXR	0 (0.0%)	32,260 (96.2%)	2,148 (95.3%)	1,750 (88.4%)	577 (7.1%)
TB presumptive	Symptoms	4,339 (25.8%)	45 (0.1%)	0 (0.0%)	60 (3.4%)	107 (18.5%)
	CXR	0 (0.0%)	2,809 (8.7%)	56 (2.6%)	113 (6.5%)	29 (5.0%)
	Symptoms and CXR	0 (0.0%)	120 (0.4%)	4 (0.2%)	19 (1.1%)	43 (7.4%)
	Total	**4,339 (25.3%)**	**2,974 (9.2%)**	**60 (2.8%)**	**192 (11.0%)**	**179 (30.9%)**
TB cases	Symptoms	360 (8.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (1.7%)
	CXR	0 (0.0%)	236 (7.9%)	8 (13.3%)	1 (0.5%)	1 (0.6%)
	Symptoms and CXR	0 (0.0%)	46 (1.5%)	0 (0.0%)	0 (0.0%)	10 (5.6%)
	Total	**360 (8.3%)**	**282 (9.5%)**	**8 (13.3%)**	**1 (0.5%)**	**14 (7.8%)**

* Rubavu CF: the ACF targeted only TB symptoms screened positive and/or close contacts of confirmed TB cases (846 out of 6110 inmates).

**Gisozi-Agakiriro,Batsinda and Kimironko markets: three days of ACF covered only 7% of the population.

1.3 Increase access to rapid and molecular tests

Access to molecular diagnostic testing remains a key priority for strengthening early detection, accurate diagnosis, and appropriate treatment of tuberculosis and other priority diseases.

In total, 81,775 GeneXpert tests were performed as initial diagnostics and drug susceptibility testing (DST) for smear positive cases, representing an average GeneXpert utilization rate of 24.7% (81,775 /330,260) for TB testing. In addition to TB testing, GeneXpert platforms were also utilized for early infant diagnosis (EID) of HIV and hepatitis testing across all GeneXpert testing sites. Among the total of 81,775 samples processed using GeneXpert between July 2025 and June 2026, 28,703 (35.1%) were processed through the DataToCare system. However, following the implementation of sputum pooling on GeneXpert from January 2026, the use of DataToCare was affected because only samples tested individually were eligible for processing through the DataToCare system. Therefore, it was expected that all GeneXpert-positive samples would be processed through DataToCare, as individual testing is required to accurately identify and report positive samples. Nevertheless, of the 6,103 GeneXpert-positive samples processed during the reporting period, only 2,715 (44.4%) were processed and reported through DataToCare.

1.4. Reach universal access to DST

In Rwanda, three techniques are used to assess the access to the universal drug susceptibility testing (DST): LPA (Line Probe Assay), phenotypic testing, and GeneXpert molecular testing. LPA and phenotypic testing for first-line drugs are conducted at the National Reference Laboratory while the GeneXpert is performed for all positive samples for Rifampicin DST. As mentioned earlier, we have already started using Xpert XDR cartridges for second-line drug testing at 10 hospitals.

1.4.1. Culture techniques

To interpret culture results, we analyzed all samples received and processed between April 2025 and March 2026. A total of 2302 samples were processed for primary culture, of which

720 (31%) were from new cases, 1303 (57%) from patients with unknown TB history, 260 (11%) from drug-resistant TB (DR-TB) follow-up patients, and 19 (1%) from previously treated patients.

Overall, 508 (22%) of samples were culture-positive, 77% (1768) were negative, and 26 (1%) were contaminated. Furthermore, culture positivity was highest among patients with unknown TB history (42%), followed by patients with unknown TB history (29%) while the positivity was at 13% for samples from MDR follow-up and new cases respectively. Conversely, negative results were most frequent among new patients (87%), followed by MDR follow-up (86%) and patients with unknown history (70%).

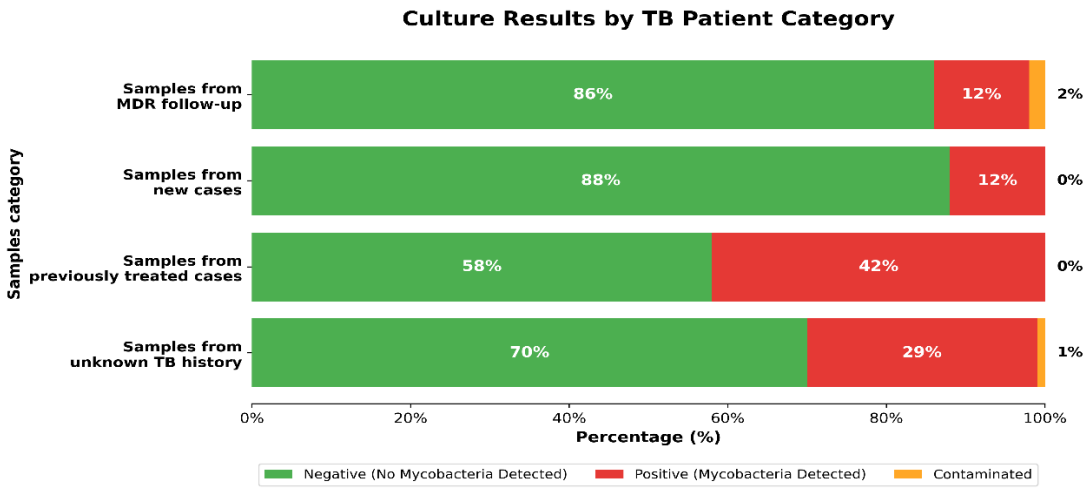


Figure 2: Result of primary TB culture

1.4.2. Drug susceptibility for first line drug

From April 2025 to March 2026, a total of 508 (22%) samples were culture-positive, of which 473 were eligible for first-line drug susceptibility testing (DST).The total of 395 (84%) TB samples underwent first-line drug susceptibility testing. Of these, 68 (17%) were new cases, 8 (2%) previously treated, and 319 (81%) with unknown treatment history. Overall, 313 samples (79%) were fully susceptible to rifampicin and isoniazid, while 15 (4%) showed isoniazid mono-resistance, 7 (2%) rifampicin mono-resistance, and 38 (10%) multidrug-resistant TB (MDR-TB). Most MDR-TB cases 87% (33/38) were detected among patients newly diagnosed for Tuberculosis, suggesting early detection of MDR-TB among patients with TB-suggestive symptoms. Additionally, 21 samples (5%) were not detected or

contaminated. These findings underscore the need to strengthen DST among eligible culture-positive samples.

Table 3: First line DST results, fiscal year 2025-2026

Samples received during the quarter previous to the quarter of evaluation		Number registered	Drug Susceptibility Testing (DST)	
			LPA 1st line	DST 1st line
History of previous TB treatment	New cases	68	20	48
	Previously treated cases	8	8	0
	Unknown history	319	318	0
		New cases	Previously treated cases	Unknown history
1st Line DST Results	Susceptible to both R and H	19	6	288
	Resistance to H but not R	11	0	4
	Resistance to R but not H	3	0	4
	Resistance to both H and R (MDR-TB)	33	2	3
	Not detected/Contaminated	0	2	19

1.4.3. Drug susceptibility for second line drug at NRL

From April 2025 to March 2026, 76 culture-positive samples from patients receiving second-line TB treatment were eligible for second-line DST. Among these, 53 (69.7%) samples were processed for the second line DST. Both processed samples for the second line DST (100%) were fully susceptible to all second-line drugs, including fluoroquinolones, second-line injectables, bedaquiline, clofazimine, delamanid, and linezolid. No resistance was detected, confirming the absence of Pre-XDR and XDR-TB among the tested cases. Efforts should be strengthened to ensure that all eligible culture-positive samples undergo second-line DST to enable timely detection of drug resistance and guide appropriate treatment management.

Table 4: Processed samples for second line DST: fiscal year 2025-2026

Samples received during the quarter previous to the quarter of evaluation		Number registered	Drug Susceptibility Testing (DST)	
			LPA 2nd line	DST 2nd line
History of previous TB treatment	New cases	51	0	51
	Previously treated cases	2	0	2
	Unknown history	0	0	0
2nd Line DST Results		New cases	Previously treated cases	Unknown history
2nd Line DST Results	Number of samples susceptible to all 2nd line drugs (FQ, 2LI, Bdq, Cfz, Dlm, Lzd)	51	2	0
	Number of samples with any resistance to FQ (PreXDR-TB)	0	0	0
	Number of samples with any resistance to 2LI (PreXDR-TB)	0	0	0
	Number of samples with resistance to Bdq (PreXDR-TB)	0	0	0
	Number of samples with resistance to Cfz (PreXDR-TB)	0	0	0
	Number of samples with resistance to Dlm (PreXDR-TB)	0	0	0
	Number of samples with resistance to Lzd (PreXDR-TB)	0	0	0
	Not detected/Contaminated	8	0	0

1.4.4. Access to universal drug susceptibility testing

WHO recommends universal drug susceptibility testing (DST) for all TB patients. To achieve this target, in addition to TB cases diagnosed with GeneXpert as the initial diagnostic test, Xpert testing should be performed on all smear-positive TB cases for rifampicin susceptibility testing. According to the new WHO TB surveillance guidelines, universal DST should be considered only for bacteriologically confirmed TB cases. The figure below shows that the access to the universal DST was 95.0% among bacteriologically confirmed TB cases. This coverage has been stable for the last four years.

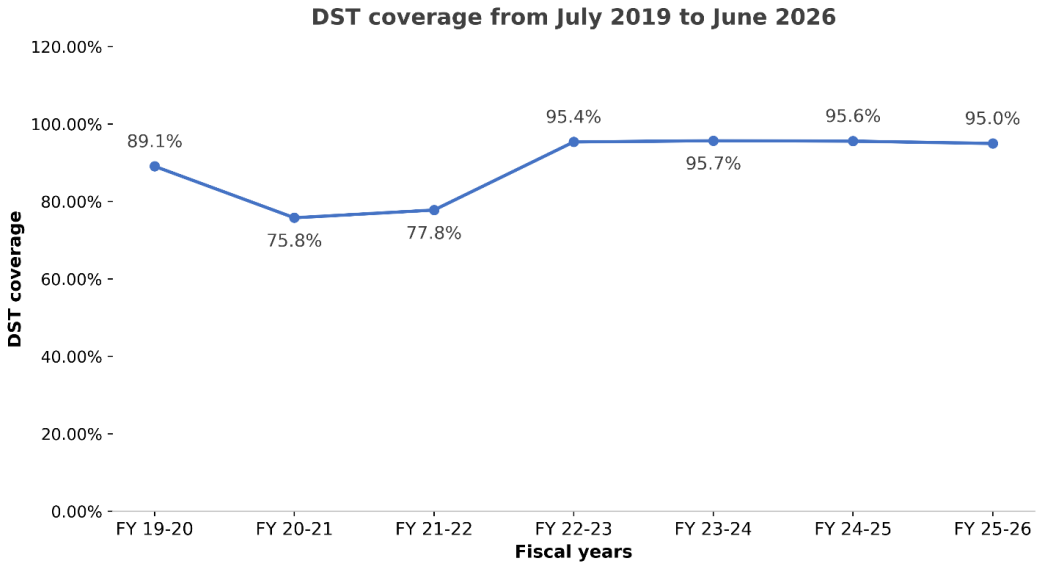


Figure 3: Trend of Drug susceptibility testing among TB Bacteriologically confirmed over seven Fiscal years.

1.5. Strengthening the quality of laboratory services

1.5.1. Smear microscopy quality control

From July 2025 to June 2026, 154 of 205 CDTs (75.1%) were controlled at least three times, with 8124 slides reviewed (431 positive, 140 with 1–9 AFB, and 7,553 negative). High false positives (HFP) were detected in 17 samples, 4 high false negatives (HFN), 7 low false negatives (LFN), and 135 quantification errors (QE). Major errors including either HFP or HFP were identified in 7 Health Facilities (Nemba DH, Kabutare DH, Kayenzi Cs, Kinyinya Cs, Gatunda DH, Kirehe DH, Munini DH. These findings emphasize the importance of strengthening quality assurance and targeted corrective measures in underperforming CDTs as well as strengthening capacity building.

Table 5: Summary of slides retesting for smear microscopy

Slide Control and Error Summary

	Number of slides controlled				Number of Errors				
	Total	Pos	1-9AFB	Neg	HFP	HFN	LFP	LFN	QE
Values	8124	431	140	7553	17	4	0	7	135

1.5.2. GeneXpert External Quality Control

During the fiscal year 2025–2026, out of 85 GeneXpert sites, 69 (81.1%) received proficiency testing panels provided by CDC-Atlanta as part of external quality assessment (EQA). Among the 69 laboratories enrolled in GeneXpert proficiency testing, 1 of them named Rukoma-Sake was not evaluated as the machine was not available at time, 67 (98.6%) achieved satisfactory scores of 80% and above, while 1 (1.4%) did not meet the standard (Kirinda DH). Considering all 85 GeneXpert sites, the overall satisfactory performance for the 2025–2026 fiscal year was 78.8% (67/85). Efforts should be strengthened to enroll all GeneXpert testing sites in the proficiency testing (PT) program to ensure comprehensive external quality assessment and enable an objective evaluation of national GeneXpert testing performance.

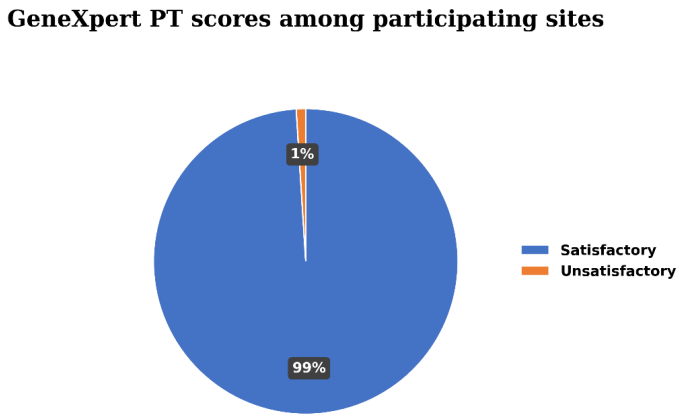


Figure 4: Summary of GeneXpert proficient testing

CHAPTER 2: TUBERCULOSIS NOTIFICATION

2.1. Notification and CHWs contribution

In FY 2025–2026, the National Tuberculosis and Other Respiratory Diseases (TB&ORD) Division notified 8,274 TB cases of all forms, including 34 rifampicin-resistant TB (RR-TB) cases. Community Health Workers (CHWs) contributed 1,995 cases (24.1% of total notifications), falling short of the 25% national CHW-contribution target set under the Extended TB National Strategic Plan (NSP) 2019–2027. Compared to FY 2024–2025, overall case notification increased marginally by 0.9%, while CHW-referred notifications declined by 10.5%, reflecting a reduced contribution of community-based case-finding to overall notification this fiscal year.

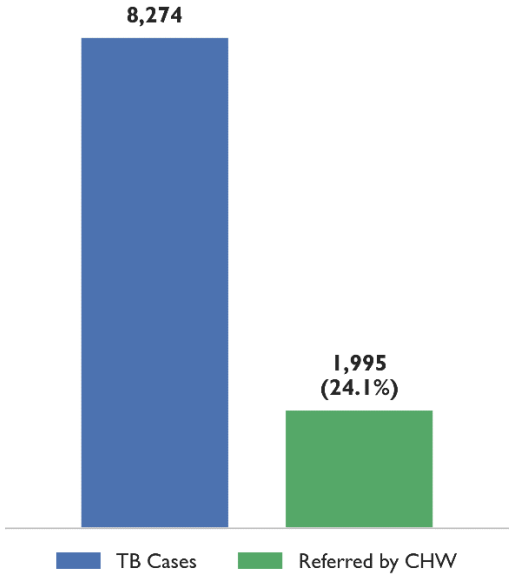


Figure 5: Contribution of CHWs on the national TB notification during 2025-2026 FY

The ten-year trend in TB case notification remained relatively stable between FY 2015–2016 and FY 2021–2022, before rising sharply to 9,422 cases in FY 2022–2023. Notifications subsequently declined to 8,551 cases in FY 2023–2024, 8,196 in FY 2024–2025, and 8,274 in FY 2025–2026, indicating a plateau in case notification over the past three fiscal years. The peak observed in FY 2022–2023 was largely associated with the recovery of TB services following the COVID-19 pandemic, as intensified case-finding activities and the restoration of routine health services led to the identification of cases that had been missed or delayed during the pandemic period.

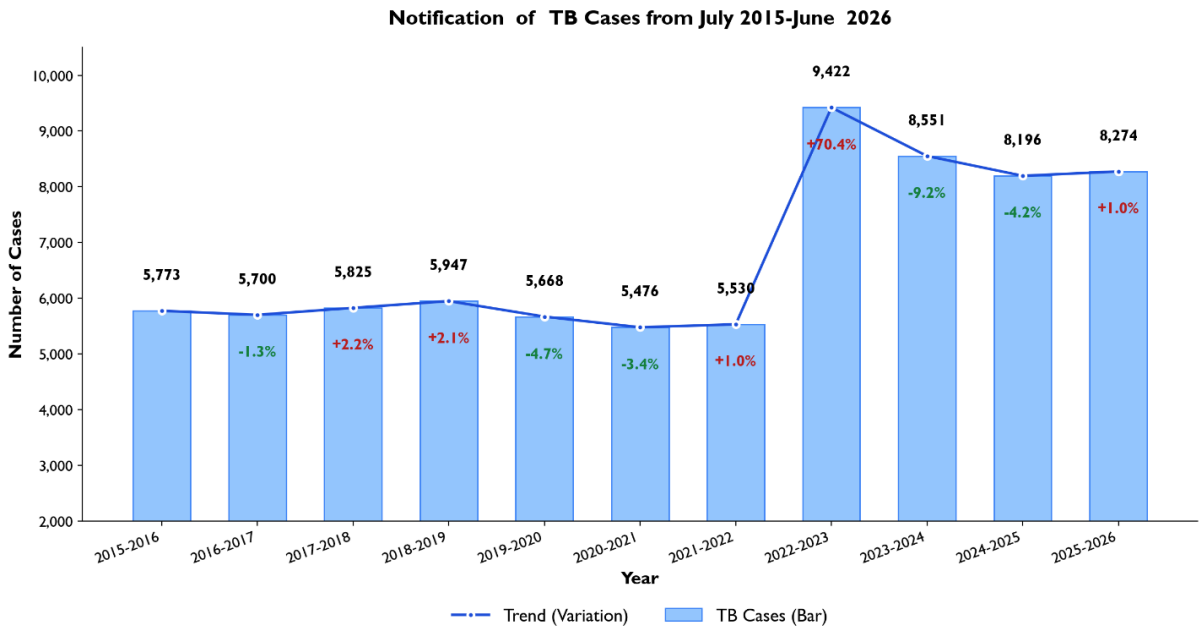


Figure 6: TB notification trend in the last ten years in Rwanda

2.2. TB notification by sex and age groups

In FY 2025–2026, 5,950 (71.9%) of notified TB cases were among males, corresponding to a male-to-female notification ratio of 2.6:1. This ratio remained unchanged from FY 2024–2025 (2.5:1) but was narrower than the 2.8:1 ratio recorded in FY 2023–2024. The economically active population (ages 25–44 years) accounted for 3,733 (45.1%) of all notified cases, consistent with the age distribution typically observed in TB epidemiology. Children aged 0–4 years accounted for 966 (11.6%) of all notified cases, underscoring the continued importance of childhood TB screening and contact investigation.

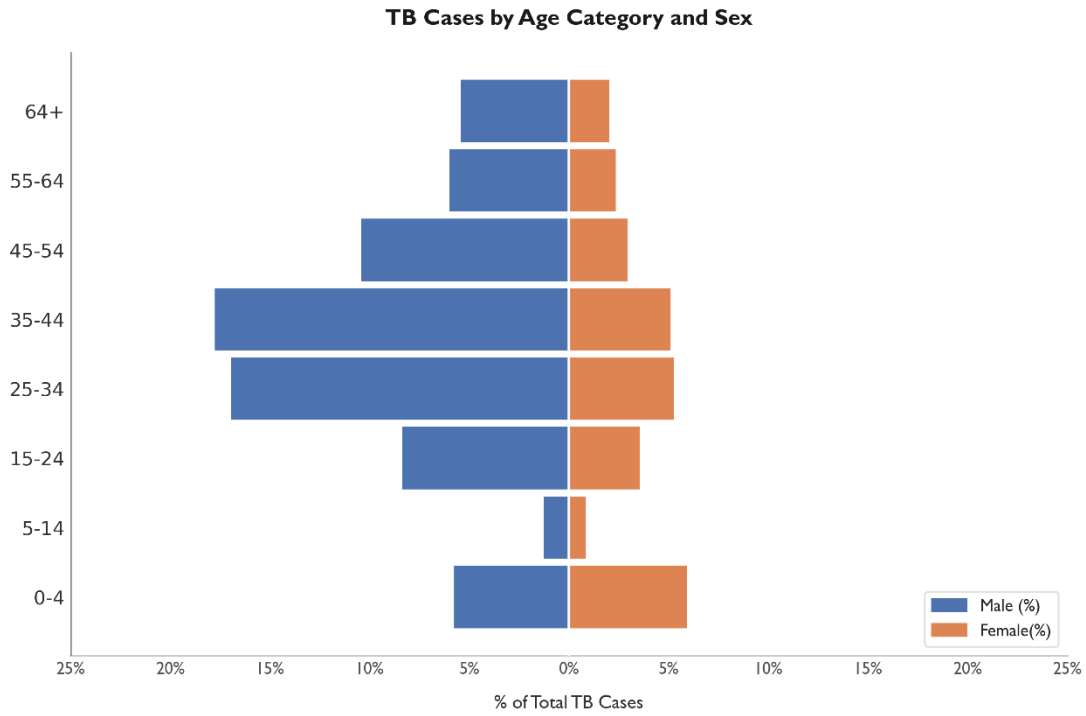


Figure 7: Age-pyramid of notified TB cases during 2025-2026 fiscal year

2.3. Geographical distribution of TB notification

TB case notification varied considerably across Rwanda's provinces and Kigali City. Kigali City reported the highest proportion of notified cases, 2,447 (29.6%), followed by the Eastern Province with 1,937 cases (23.9%) and the Southern Province with 1,615 cases (19.5%). The Western Province accounted for 1,406 cases (16.9%), while the Northern Province recorded the lowest proportion, 869 cases (10.5%). Kigali City and the Eastern Province together contributed more than half of the national TB burden, flagging these as priority areas for continued intensification of case-finding and treatment support. Conversely, the comparatively low burden reported in the Northern Province warrants programmatic scrutiny: it may reflect an actual epidemiological difference, or it may point to under-detection driven by insufficient case finding intensity a distinction with direct implications for whether the province requires strengthened active case-finding efforts or continued monitoring at current levels

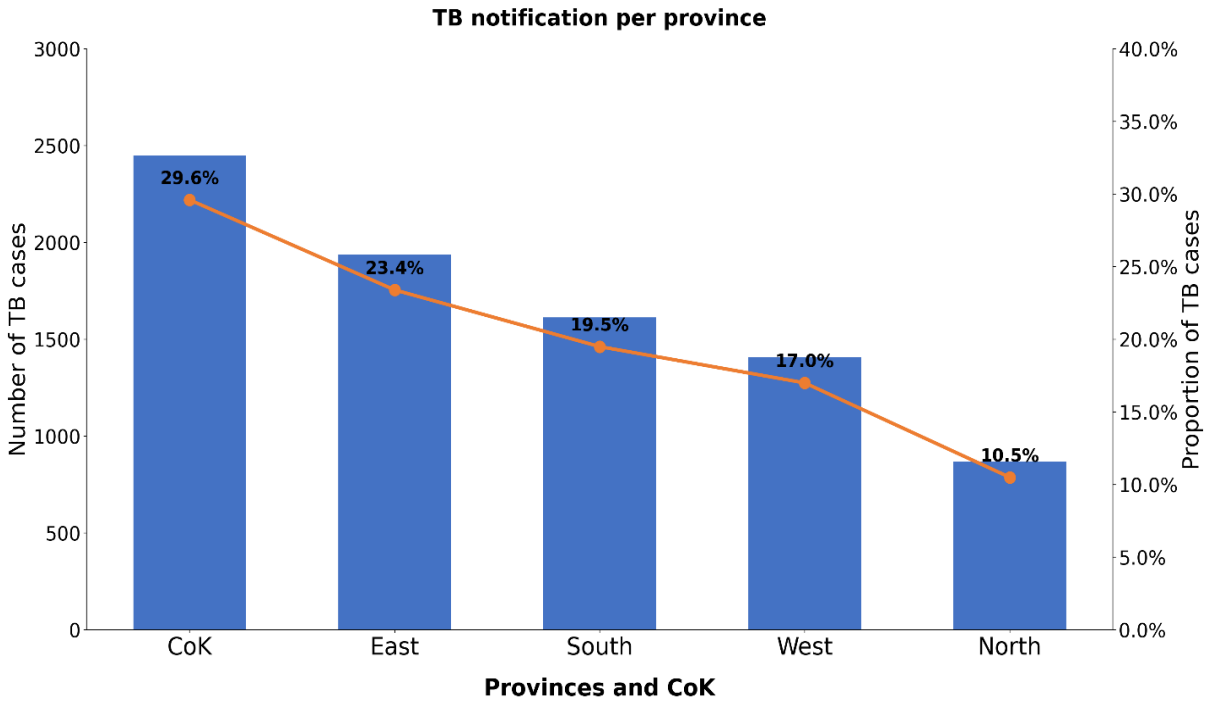


Figure 8: Notification (number and proportion) of TB cases by province in 2025-2026 FY

The district-level map presents the geographic distribution of TB notifications across Rwanda's 30 districts, with a total of 8,274 cases. Darker shading denotes districts with a higher proportion of the national caseload, while lighter shading indicates a lower proportion. The highest burden is concentrated in Gasabo, Kicukiro, and Nyarugenge, Rwamagana, Rubavu, and Huye. Other districts with comparatively high cases include Kayonza, Muhanga, Musanze, Bugesera and Karongi. while most northern, southern, and eastern districts reported lower counts. Nyamasheke and Nyaruguru notified the fewest cases nationally

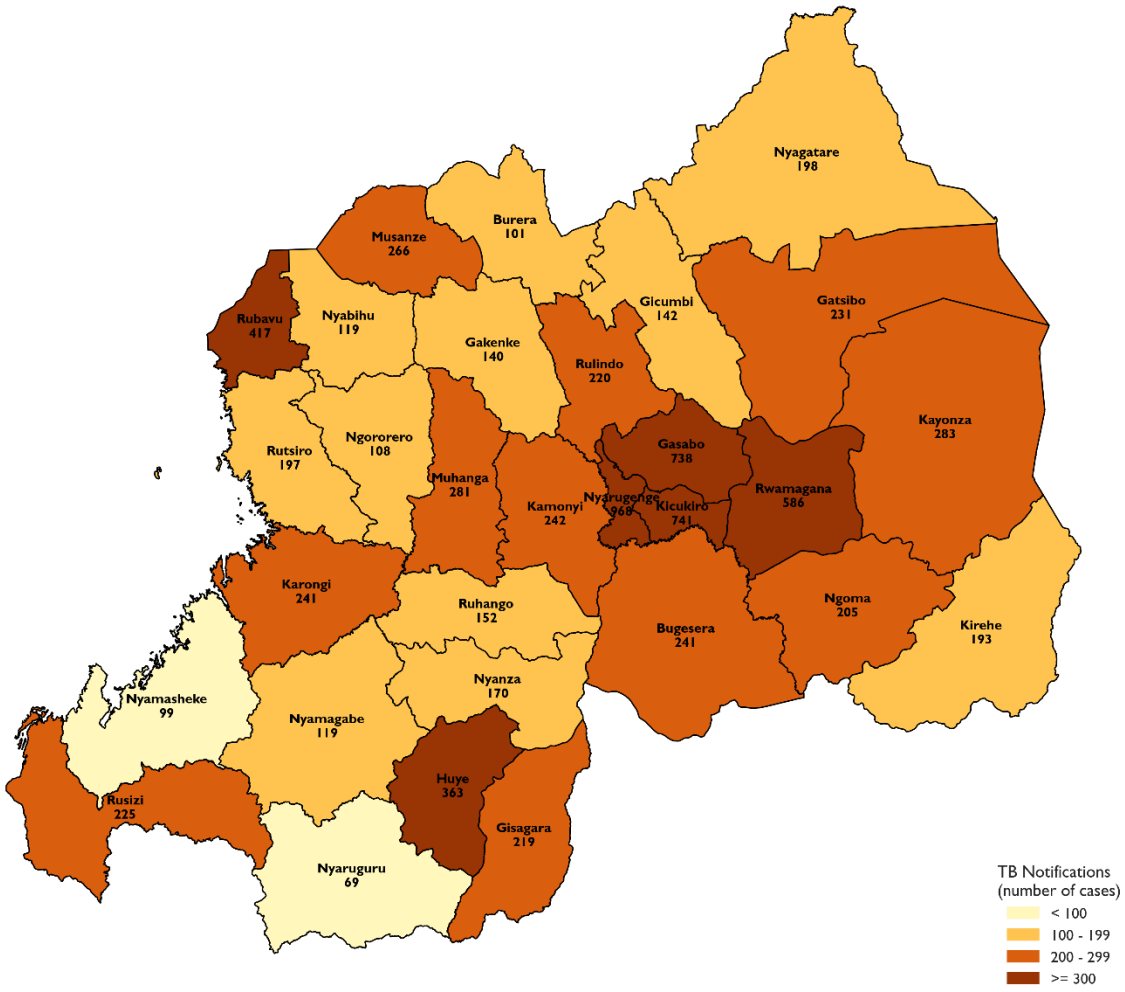


Figure 9: Map of TB notification per district

District-level TB case notification rates ranged from 19.6 to 235.2 per 100,000 population, against a national average of 56.9 per 100,000. Nyarugenge District recorded the highest CNR (235.2 per 100,000), followed by Kicukiro (136.0), Rwamagana (111.5), and Huye (86.8). Muhanga, Rubavu, Gasabo, Karongi, districts also reported notification rates at or above the national average.

Rulindo District entered the top 10 districts by CNR for the first time this fiscal year. This increase is largely attributable to active case finding (ACF) conducted at mining sites, which accounted for 26% (57/220) of all cases notified in the district.

This pattern underscores the continued importance of targeted case-finding interventions including active case finding among occupational risk groups such as miners and strengthened clinical mentorship to improve TB case detection across districts.

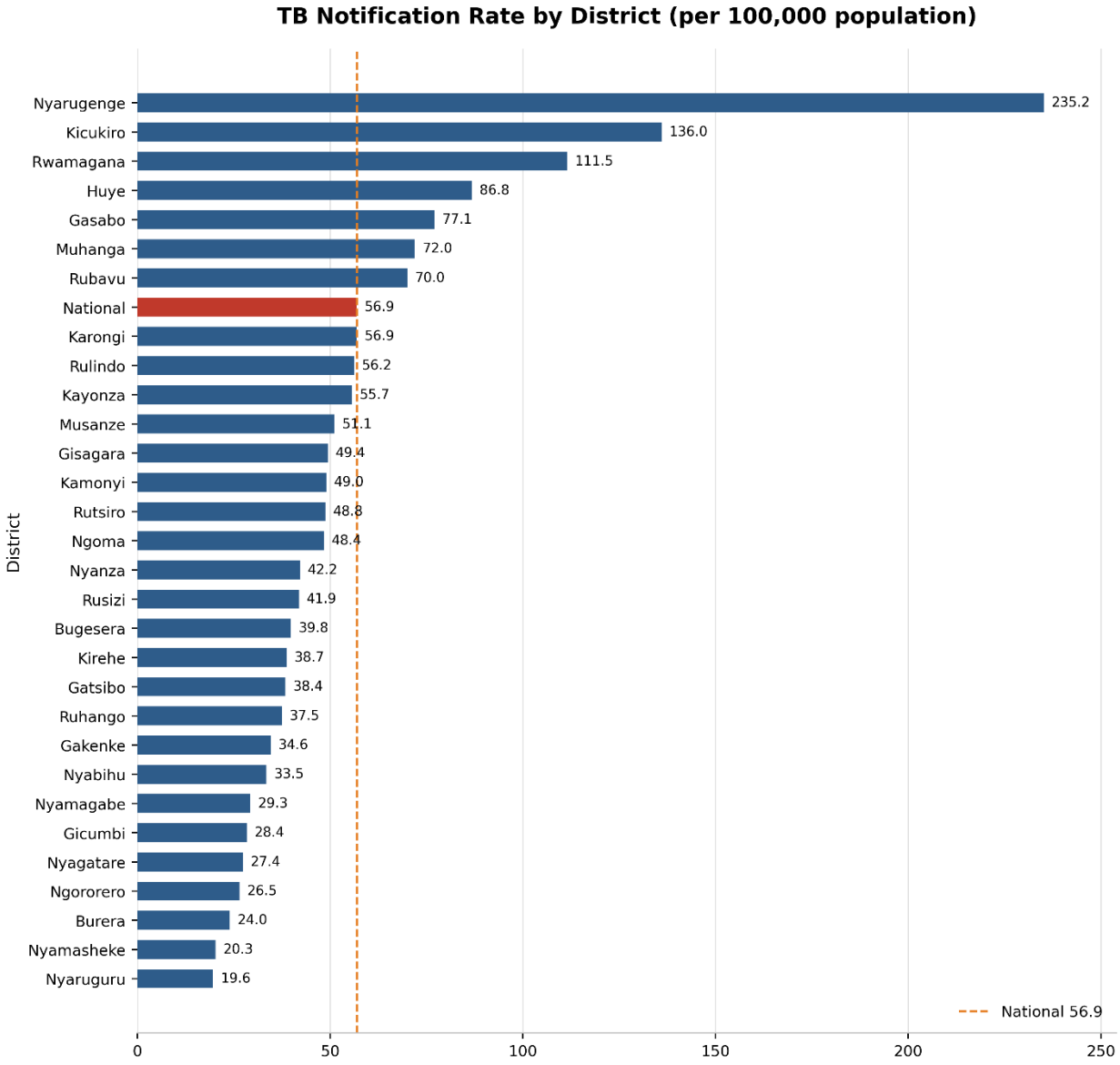


Figure 10: Notification rate by districts during the 2025-2026 fiscal year

2.4. Notification of TB cases according to WHO classification

Case classification by WHO diagnostic category shows that the majority of notified cases, 5,925 (71.6%) were bacteriologically confirmed, while 2,349 (28.4%) were clinically diagnosed. This reflects strong and sustained laboratory diagnostic capacity, although continued reliance on clinical diagnosis in over a quarter of cases underscores the need to further strengthen specialist clinical skills at decentralized levels of care. By site of disease, pulmonary TB accounted for the large majority of notifications, 7,231 (87.4%), with extrapulmonary TB (EPTB) representing 1,043 cases (12.6%). By treatment history, almost all notified cases, 8,108 (97.9%), were new or relapse cases, while 166 (2.1%) were previously treated, indicating early case detection and effective treatment management. Regarding HIV status, 1,294 patients (15.6%) were HIV-positive, while 6,978 (84.4%) were HIV-negative.

The proportion of TB/HIV co-infection increased from 13.0% in FY 2024–2025 to 15.6% in FY 2025–2026. This increase is likely associated with improved TB case detection among people living with HIV following the scale-up of TB-LAM diagnostic testing. The expansion was supported by targeted capacity-building for laboratory technicians in health facilities across 13 districts in the Southern and Northern Provinces, strengthening their competency in TB-LAM testing and enhancing the identification of TB cases among people living with HIV. These findings suggest that the increased TB/HIV co-infection rate reflects improved case detection rather than a true rise in the burden of TB/HIV co-infection.

Among the 8,274 notified TB cases, 8,240 (99.6%) were eligible for first-line DS-TB treatment, while 34 (0.4%) were eligible for second-line treatment; among those eligible for DST treatment, 8,124 (98.5%) started anti-TB treatment, while 33 (97%) of those eligible for second-line treatment started second-line treatment it.

Beyond treatment initiation rates among notified cases, the programme performance can also be assessed against the universal treatment coverage, which measures the proportion of estimated incident TB cases who are successfully reached and initiated on treatment. Using the WHO estimated TB incidence for the reporting period, Rwanda achieved a treatment coverage of 89.4% (7,992/8,943). This performance reflects sustained strengthening of case-finding strategies, including active case finding, contact investigation, and health facility-based screening. However, the remaining 10.6% gap underscores the continued presence of a "missing cases".

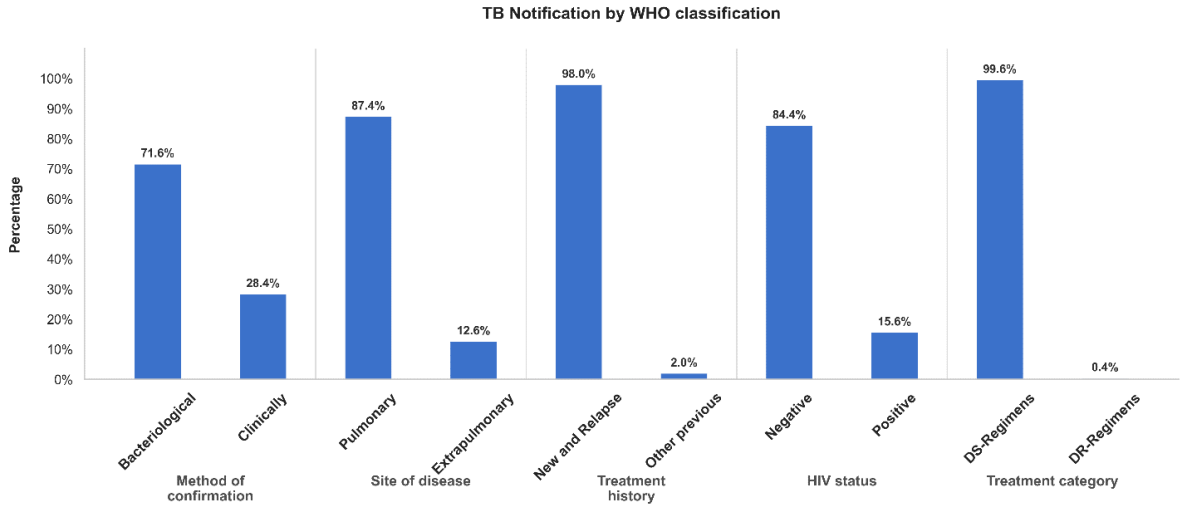


Figure 11: TB cases by WHO classifications

Following the introduction of extrapulmonary TB (EPTB) site-of-disease data collection introduced in FY 2024–2025, a total of 1,043 EPTB cases were reported nationally in FY 2025–2026. Pleural TB, skeletal TB, and tuberculous lymphadenitis were the most frequently reported presentations, together accounting for 629 cases (60%). Peritoneal TB and miliary TB were also common, jointly contributing 208 cases (20%). Pericardial TB accounted for 46 cases (4.4%) and meningeal TB for 40 cases (3.8%). Less frequent presentations included ocular TB (41 cases, 3.9%), genitourinary TB (47 cases, 4.5%), gastrointestinal TB (11 cases, 1.0%), and cutaneous TB (10 cases, 1.0%). Rare forms, breast TB and adrenal gland TB accounted for fewer than 6 cases combined (0.6%). The identification of these rare presentations highlights the broad clinical spectrum of EPTB and reinforces the need for comprehensive diagnostic capacity, particularly imaging, histopathology, and molecular testing, to support timely and accurate EPTB detection.

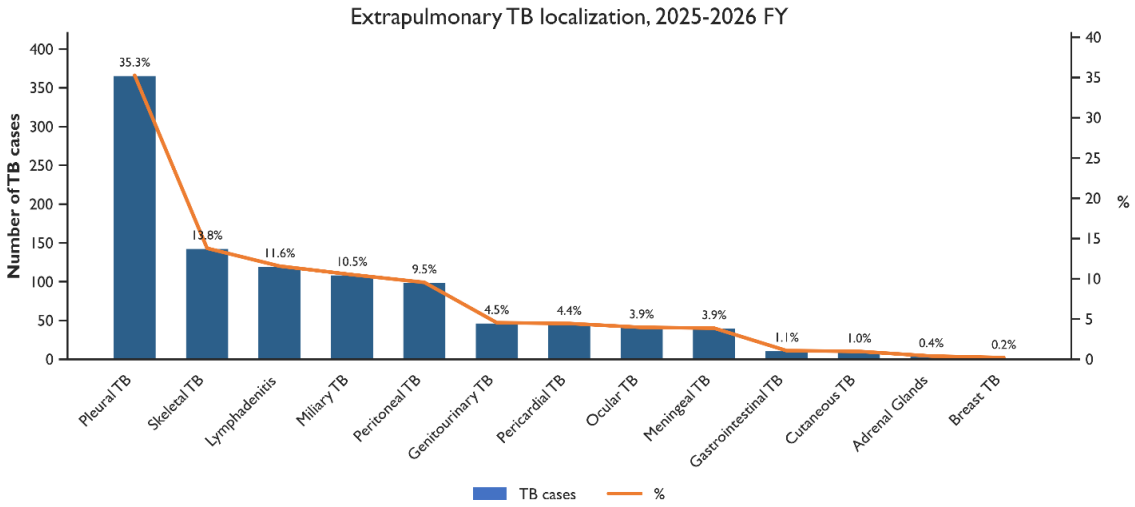


Figure 12: Extra pulmonary TB localization

The trend in TB/HIV co-infection over the past decade shows substantial overall progress, with the co-infection rate declining from 25% in FY 2015–2016 to a low of 12% in FY 2022–2023, a relative reduction of over 50%. However, the rate has since risen for two consecutive fiscal years, reaching 14% in FY 2023–2024, 13% in FY 2024–2025, and 15.6% in FY 2025–2026. Relative to the FY 2015–2016 baseline, the current rate still represents an overall decline of 37.6%; however, the renewed upward trend over the past two fiscal years warrants continued vigilance in HIV prevention, TB/HIV service integration, and case detection among people living with HIV, to safeguard the gains achieved over the past decade.

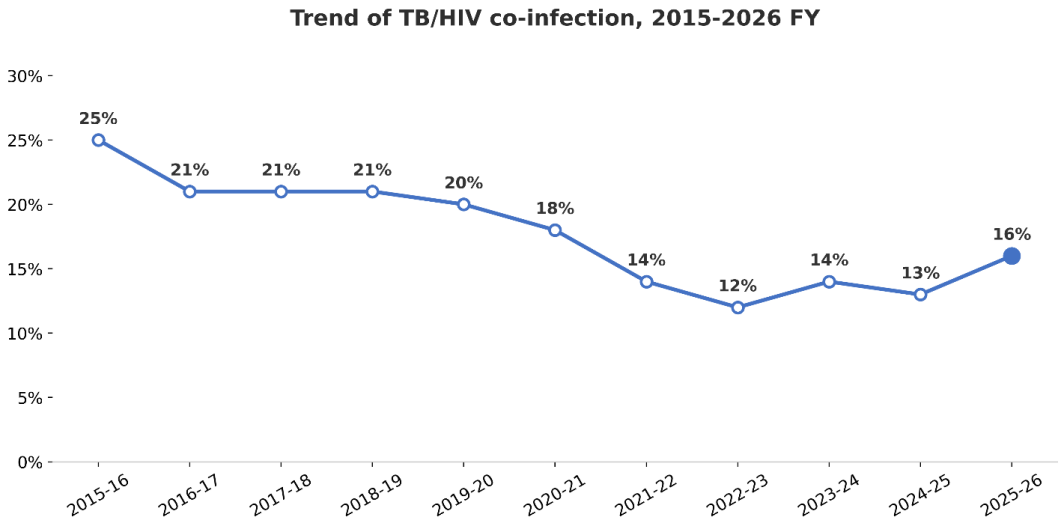
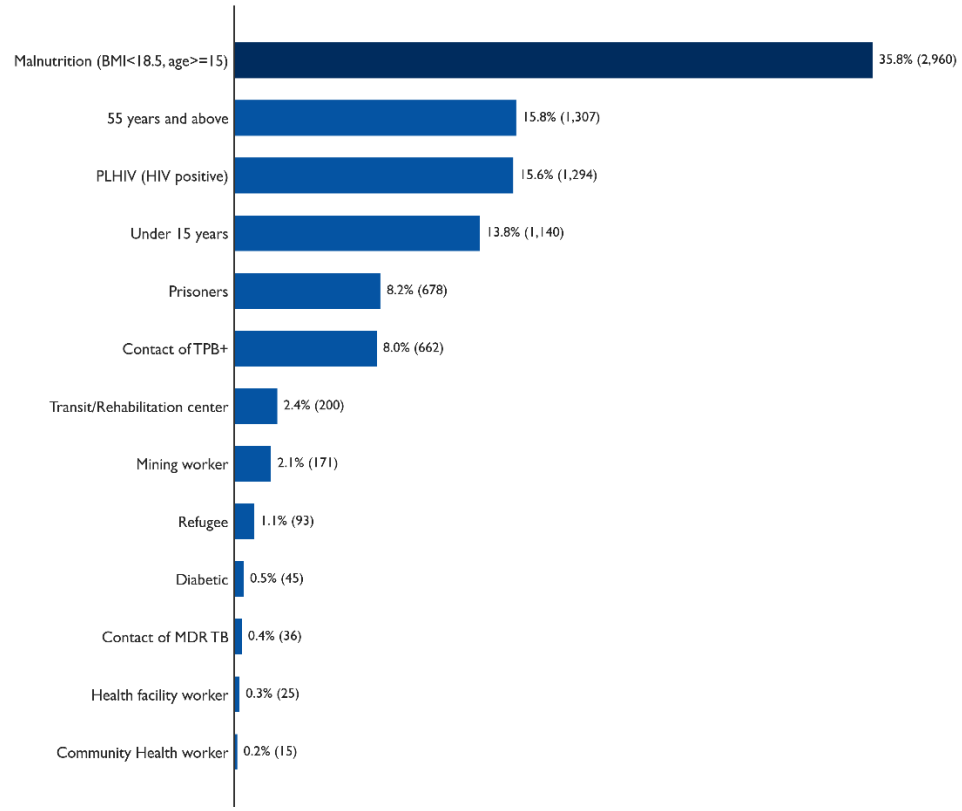


Figure 13: Trend of TB-HIV co-infection from July 2015-June 2026

2.5. TB notified among high-risk groups

The National Tuberculosis Program (NTP) has identified populations at highest risk of developing TB, including children under 15 years, adults aged 55 years and above, refugees, contacts of TB patients, people living with HIV, inmates, malnourished individuals, people with diabetes, miners, people who inject drugs, and those in transit centers. Active screening is being conducted among these groups to improve early detection. The national surveillance system captures most data on TB notifications among high-risk groups. However, information on people who inject drugs is not yet systematically integrated into the current surveillance system.

Analysis of high-risk group (HRG) categories on a mutually inclusive basis, during this reported fiscal year, shows that malnourished individuals accounted for the largest proportion of TB cases this fiscal year, 2,960 (35.8%). Older adults aged 55 years and above accounted for 1,307 cases (15.8%), and children under 15 years for 1,140 cases (13.8%). People living with HIV represented 1,294 cases (15.6%), and contacts of TB patients 698 cases (8.4%). Prisoners accounted for 678 cases (8%), and trainees of transit centers for 200 cases (2%). Smaller proportions were observed among mining communities 171 cases (2%), refugees' cases (1%), and people with diabetes (45 cases, 1%), while health care providers accounted for 40 cases (0.5%).



Source: DHIS2/e_TB tracker, 2026

Figure 14: Diagnostic of TB among HRG mutually inclusive, July 2025- June 2026

When considered on a mutually exclusive basis, TB cases notified from one high-risk group (HRGs) accounted for 73.7% (6,107/8,274) of all notified TB forms. The TB program successfully achieved the 2025–2026 fiscal year target of 70% set in the Extended TB NSP 2019–2027.

Table 6: Diagnostic of TB among HRG mutually exclusive, July 2025- June 2026

High-Risk Group (HRG)	Number	% of Total TB Cases Notified (n = 8,274)
Malnourished	2,330	28.2%
HIV-positive	1,294	15.6%

High-Risk Group (HRG)	Number	% of Total TB Cases Notified (n = 8,274)
Under 15 years	1,094	13.2%
55 years and over	492	5.9%
Prison	347	4.2%
Contact of TPB+	297	3.6%
Transit center	113	1.4%
Mining	74	0.9%
Refugees	22	0.3%
Diabetes	18	0.2%
Health care personnel	18	0.2%
Community health workers	8	0.1%
Total: at least one HRG	**6,107**	**73.7%**

When considering the achievement by sub districts, 65.2% (30/46) reached the national average (see below graph).

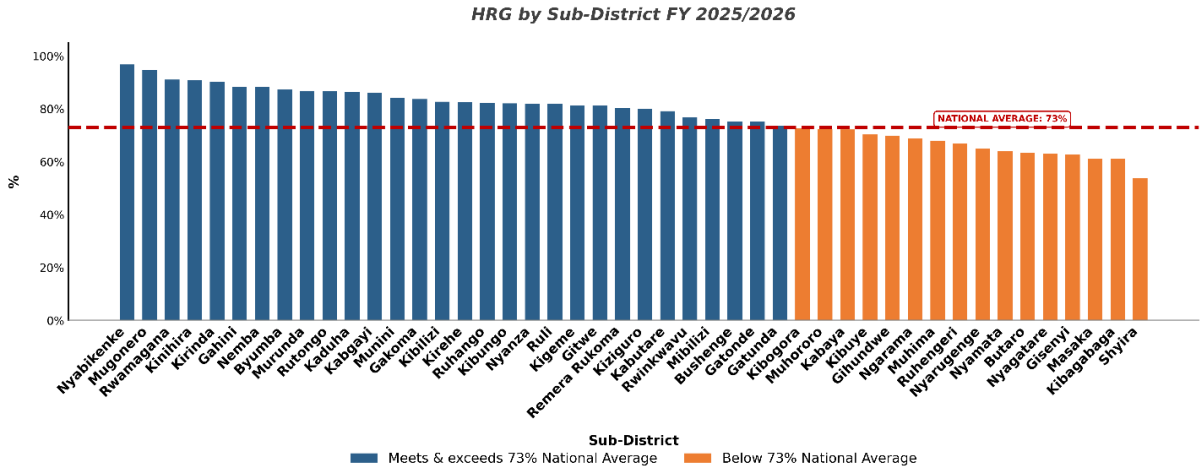


Figure 15: Diagnostic of TB among HRG by sub district, July 2025- June 2026

2.6. TB notified among children

Countrywide, 1,140 childhood TB cases (14% of all notifications) were notified among children under 15 years. 80% (24 of 30) of districts achieved the national average, and six districts (Gasabo, Gisagara, Ngoma, Ngororero, Rwamagana and Nyabihu) did not meet the national target of 7.5% for childhood TB case detection.

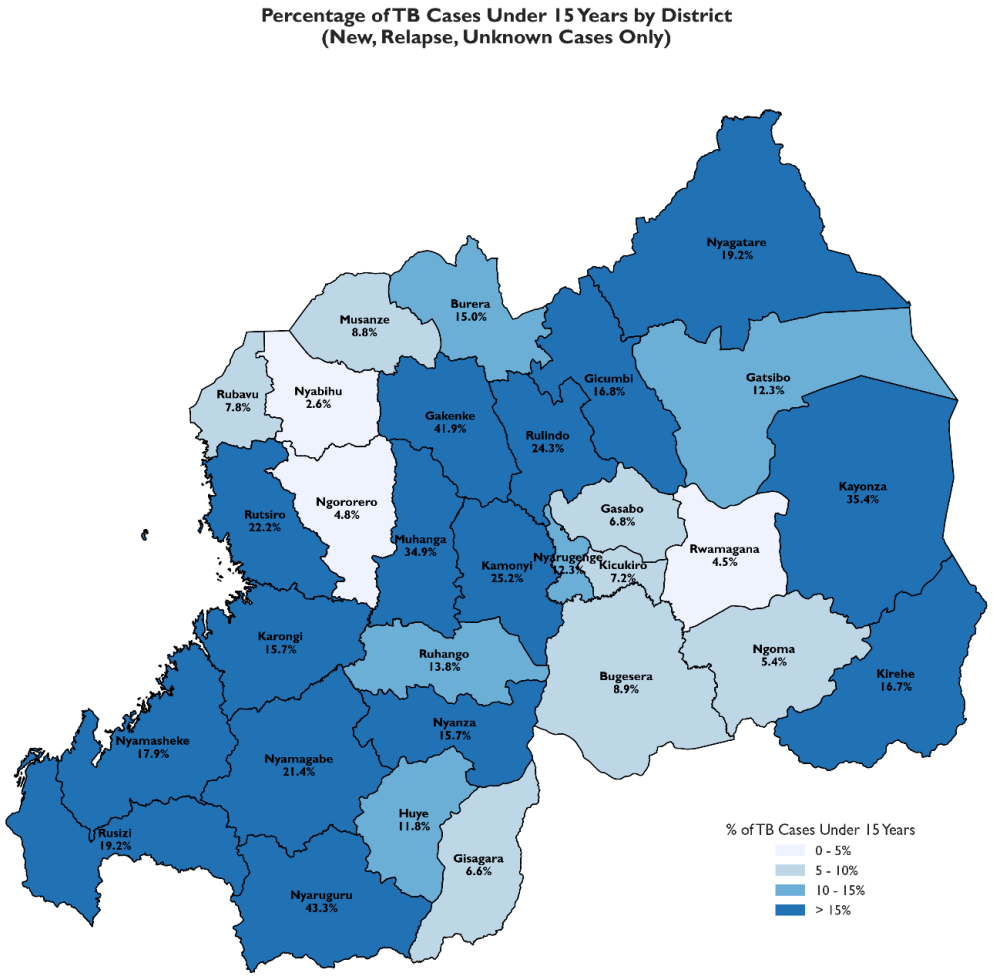


Figure 16: Map of TB cases under 15 years per district

The improvement in childhood TB case detection can be attributed to the implementation of TB active case finding among malnourished children in health facilities, together with mentorship sessions conducted in 18 district hospitals. The mentorship, led by pediatricians,

strengthened the capacity of nurses to identify and diagnose childhood TB using the national pediatric TB diagnostic algorithm. As a result of this intervention, 189 childhood TB cases were notified, representing 16.5% of all childhood TB cases reported nationally, and contributing to the overall improvement in childhood TB case detection.

2.7. Drug resistant TB notification

In FY 2025-2026, 34 DR-TB cases were notified. The 29.2% decrease in DR-TB notifications observed in FY 2025-2026 (34 cases, compared to 48 in FY 2024-2025) should be interpreted with caution, as it reflects the combined influence of two distinct factors operating in the same direction for different reasons. The revised RR-TB detection algorithm, which introduced Xpert MTB/RIF Ultra repeat testing for samples with very low bacillary load, is estimated to have reduced false-positive RR-TB results by 40–60%, indicating that part of the observed decline represents an improvement in diagnostic accuracy rather than a genuine reduction in DR-TB burden. Concurrently, the national shortage of GeneXpert MTB/RIF cartridges, resulting from the omission of the procurement budget line in the Financial Management Information System, constrained testing capacity for a substantial portion of the reporting period and reduced the pool of bacteriologically confirmed TB cases eligible for RR-TB screening. Consequently, a portion of the decline in DR-TB notifications may be attributable to reduced testing access rather than an actual epidemiological improvement. Given that these two factors enhanced diagnostic specificity and constrained testing capacity cannot be readily disaggregated within the current dataset, the FY 2025–2026 trend should not be interpreted as conclusive evidence of a declining DR-TB burden.

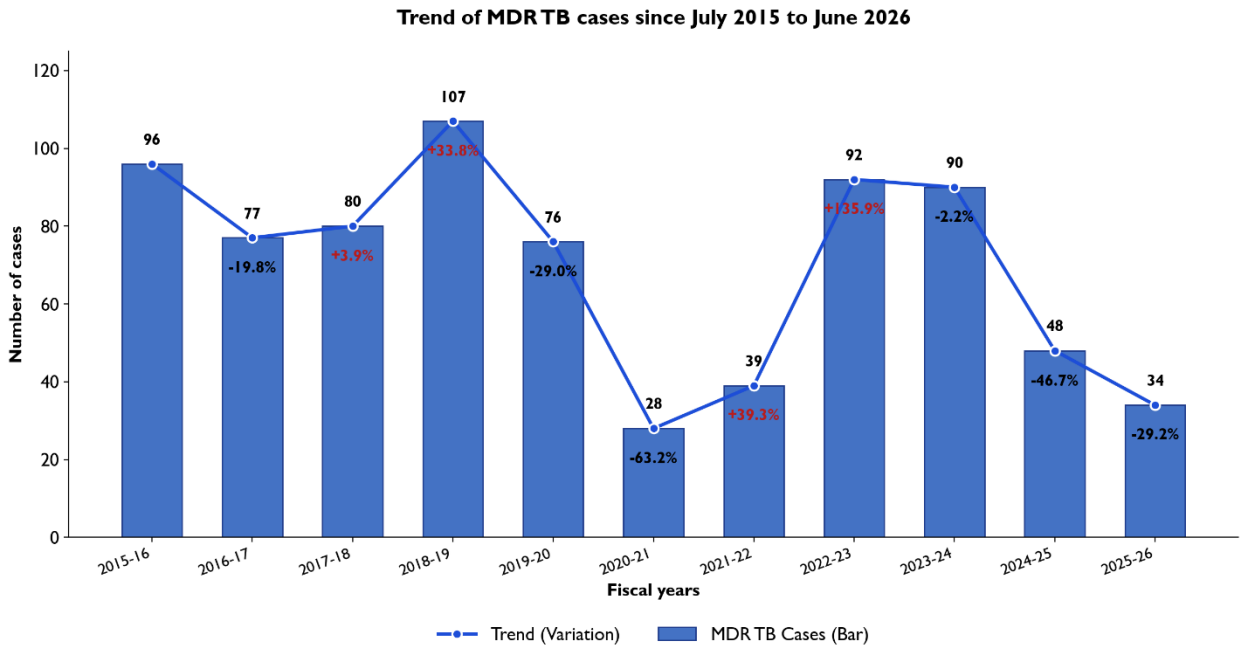


Figure 17: Trend of DR-TB notification during the last 11 years

2.7.1. DR-TB notification by province

In FY 2025-2026, a total of 34 DR-TB cases were notified nationally. By province, Kigali City accounted for the largest share, 38.2% (13/34), followed by the Southern Province, 23.5% (8/34), and the Eastern Province, 20.6% (7/34), the Western Province, 14.7% (5/34), and the Northern Province, 2.9% (1/34). This represents a marked shift in the geographic distribution of DR-TB burden compared to FY 2024-2025, when the Southern Province recorded the highest share (29%) and Kigali City's share was considerably lower (23%).

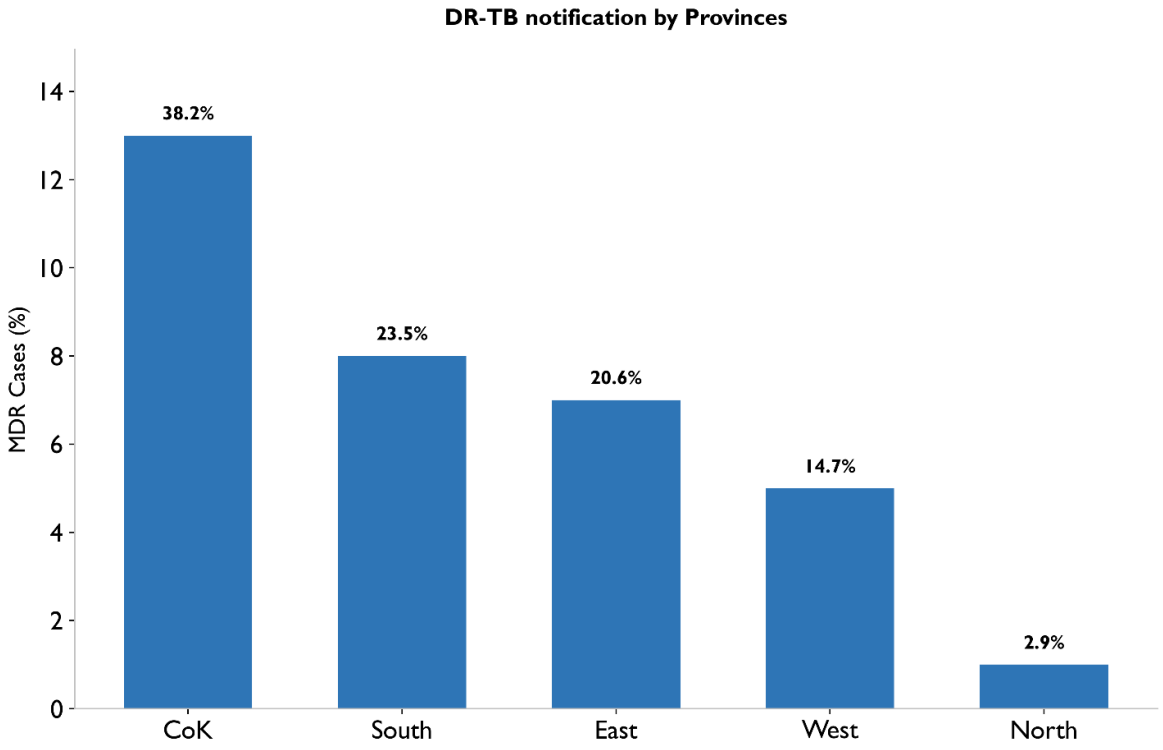


Figure 18: DR-TB notification by province from July 2025 to June 2026

2.7.2. DR-TB notification by gender and HIV status

Regarding HIV status among DR-TB cases, 23.5% (8/34) were TB-HIV coinfected in FY 2025-2026, down from 29.2% (14/48) in FY 2024-2025, and closer to the 11.1% and 14.6% co-infection rates observed during FY 2022-2023 and FY 2023-2024 respectively. The male-to-female sex ratio widened to 3.86 (27 males: 7 female), up from 2.7 in FY 2024-2025, reversing the narrowing trend observed over the two preceding fiscal years (from 7.2 in FY 2022-2023, to 2.3 in FY 2023-2024, to 2.7 in FY 2024-2025).

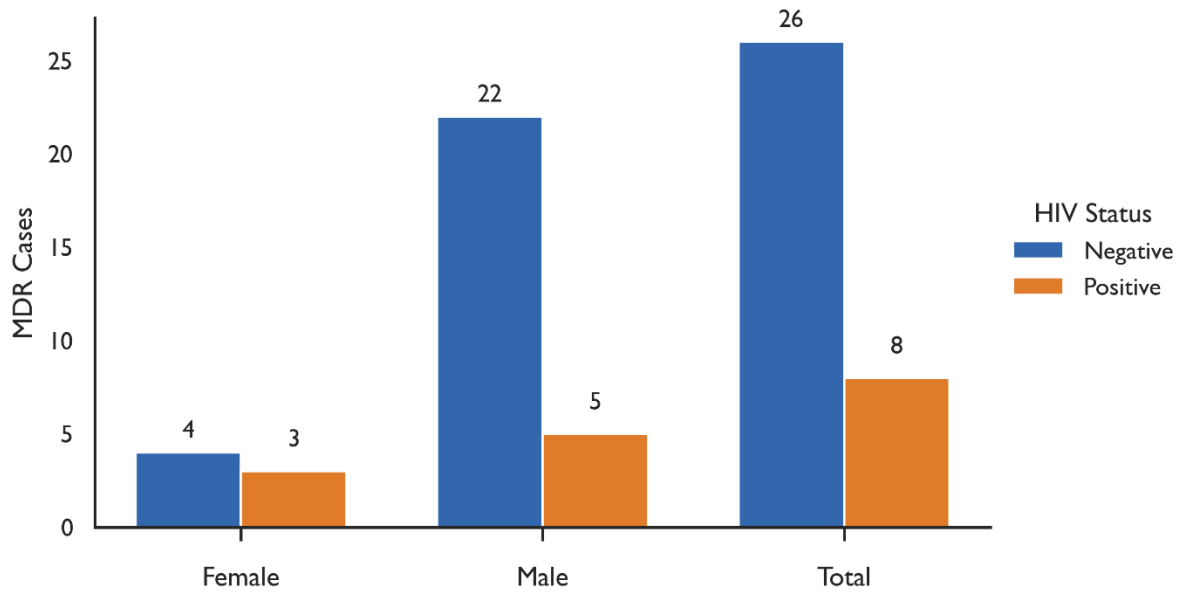


Figure 19: Drug resistance TB notification by gender and HIV status in 2025/2026 FY

CHAPTER 3: TUBERCULOSIS PREVENTION

Tuberculosis (TB) remains one of the most significant public health challenges worldwide, causing millions of illnesses and deaths annually. Despite being both preventable and curable, TB persists, particularly in low- and middle-income countries.

This chapter explores and highlights key findings from various strategies in place to combat TB:

- Application of TB infection basic measures at health facility level,
- TB surveillance among health care providers and community health workers,
- TB contacts tracing and Tuberculosis Preventive Treatment among contacts and PLHIV

3.1. Tuberculosis infection prevention and control

TB infection control plan was designed to ensure prompt detection of infectious TB patients, implementation of airborne precautions, and provision of treatment for those confirmed with TB disease. This helps reduce the risk of Mycobacterium tuberculosis spreading from TB patients to others.

The Rwanda TB&ORD surveillance system monitors compliance with TB prevention measures at the health facility level. Health centers are evaluated by hospitals, and hospitals are appraised by the central level. The minimum TB infection control (IC) package includes six basic measures: (i) the existence of an IC plan, (ii) appointment of a TB focal person, (iii) training for health workers on TB, (iv) a cough triage system, (v) Information, Education, and Communication (IEC) on cough hygiene, and (vi) ensuring doors and windows are open in high-risk areas.

According to TB&ORD surveillance, 90% (525 out of 580) of health facilities implemented all six basic TB infection control measures in the Q4 of the 2024-2025 fiscal year (April-June 2026). A good achievement once compared to TB IC application basic measures in Q4 of FY 2024-2025 which was 89.4%.

Additionally, health facilities in Rwanda conduct annual systematic TB screening for their respective healthcare providers and community health workers (CHWs) within their

catchment areas. During the 2025-2026 fiscal year, 87% (23,684/27,268) of health facility staff were screened, with 1.7% (403/23,684) identified as presumptive TB and 25 confirmed TB cases. For CHWs, 99% (58,611/59,312) were screened, with 1.9% (1,008/58,611) identified as presumptive TB and 15 confirmed TB cases. TB screening rates for healthcare providers decreased from 91% to 87% between the 2024-2025 and 2025-2026 fiscal years, while the rate for CHWs increased compared to FY 2023-2024(92%).

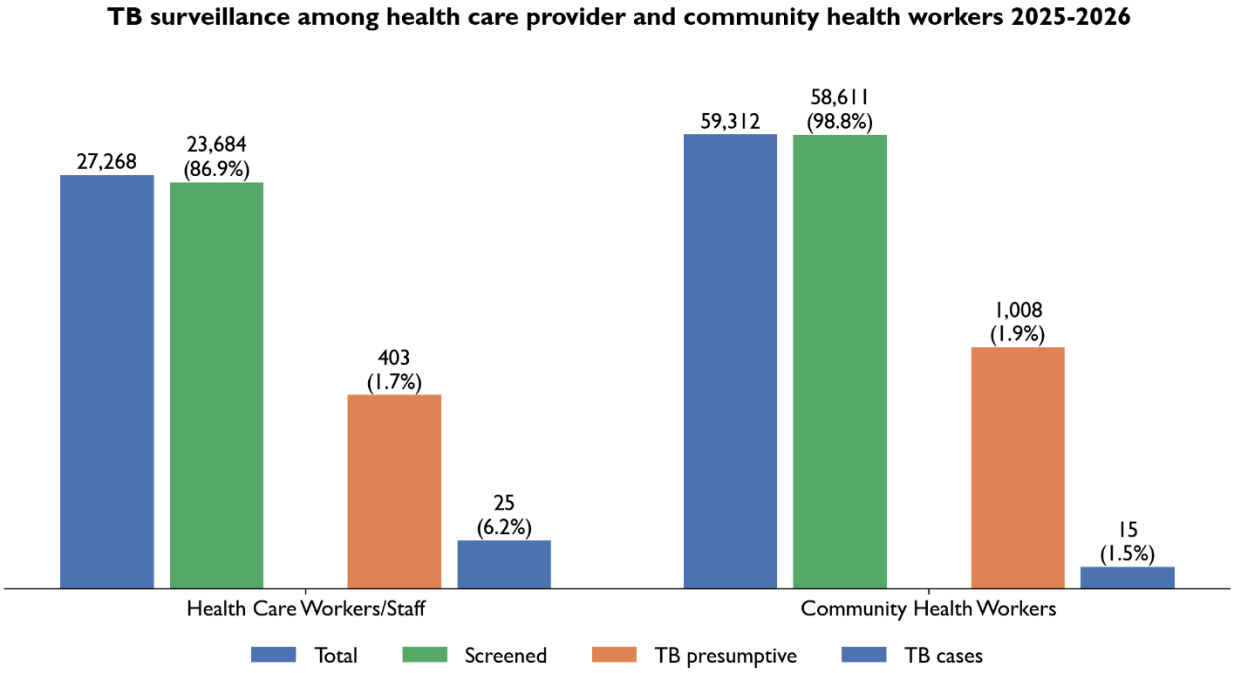


Figure 20: Screening of health care providers and CHWs, July 2025-June 26.

3.2. Tuberculosis preventive treatment among TB contacts

3.2.1. Cascade of TB contacts investigation

TB household contacts are individuals who have been in close contact with infectious TB patients. Given their high risk for TB infection, these contacts must be systematically investigated through TB screening and diagnosis. A systematic contact investigation was conducted that focused on all household members using a symptoms-based approach. TB screening for these contacts is based on symptoms such as cough, fever, night sweats, and weight loss/poor weight gain. Following this, clinical and lab investigations are carried out to rule out active TB.

During the FY 2025-2026, 15,800 contacts of bacteriologically confirmed TB cases were identified. Out of these, 15,605 contacts were screened, representing 99% of the total. Among those screened, 1.2% (187 individuals) were diagnosed and confirmed with TB disease.

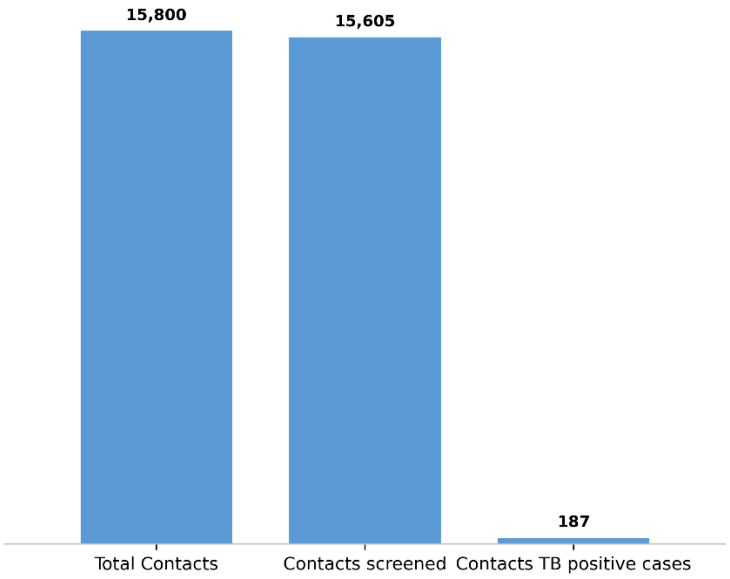


Figure 21: TB contact investigation cascade for FY 2025-2026

3.2.2. TB prevention therapy among TB contacts under 5 years

Children under five years of age who are TB contacts are at high-risk for developing active TB disease. Systematic screening is conducted to enable early diagnosis and/or TPT initiation of tuberculosis preventive therapy (TPT).

During the FY 2025-2026, there were 1,141 contacts under 5 years old. Out of these, 1,131 (99%) were screened, and 53 (5%) were confirmed with TB disease. Of the total number of under-five TB contacts, 1,088 were eligible for TPT, and 99 % (1,084/1,088) were initiated on TPT. This coverage rate is greater to 96.2% achieved in the previous fiscal year, 2024-2025.

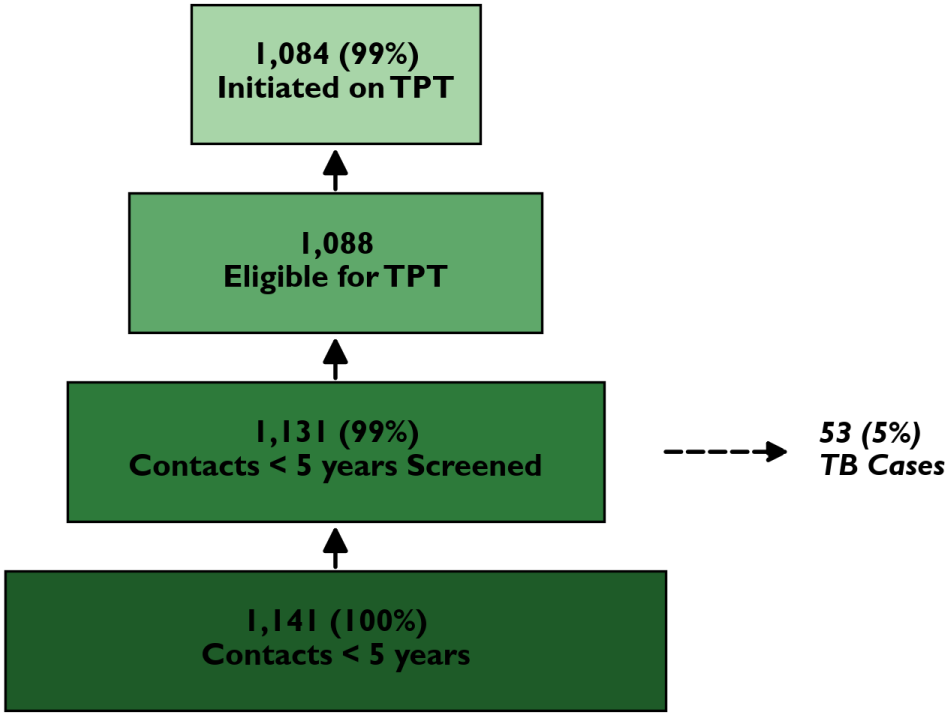


Figure 22: Under 5 years initiated on tuberculosis preventive therapy, 2025- 2026

3.2.3. TB preventive therapy among TB contacts above 5 years

Three and a half years ago, the Rwanda National Tuberculosis Program began implementing tuberculosis preventive therapy (TPT) for contacts of TB patients. According to the TPT Guidelines, contacts over 5 years old must be screened, and those who test negative based on symptoms should undergo a Tuberculin Skin Test (TST) to diagnose latent tuberculosis infection (LTBI). Inmates who are contacts of bacteriologically confirmed TB cases are not eligible for TPT.

During FY 2025-2026, 9,161 TB household contacts above 5 years old (excluding prisoners) were reported. Of these, 134 were confirmed as TB cases. Excluding these confirmed cases, 9,027 contacts were eligible for the Tuberculin Skin Test (TST). Of these, 8,610 (95 %) underwent TST, with 1,220 tested positive (a 14% positivity rate). All contacts with positive TST results, 1,220 were initiated on tuberculosis preventive therapy (TPT). With an expected 1,279 contacts eligible for TPT based on the TST positivity rate, the coverage achieved was 95% (1,220 /1,279).

The Rwanda TB Program achieved LTBI treatment coverage among household contacts above the TB NSP targets, reaching 99% among children under 5 years and 95% among contacts aged 5 years and above**.** Household contacts are defined as individuals living with a bacteriologically confirmed TB index case. Contact investigation is systematically conducted at health-facility level through the TB surveillance system, with funds allocated based on the number of bacteriologically confirmed TB (TPM+) index cases. A key challenge is that approximately 38% of TPM+ index cases are recorded as living alone**,** with no household contacts. The substantial discrepancy between the 15% LTBI treatment coverage estimated by WHO in 2025 and the much higher coverage reported by the Rwanda TB Program may partly be explained by differences in the methodology and denominators used to estimate coverage, particularly assumptions regarding household size and the number of contacts per TB index case.

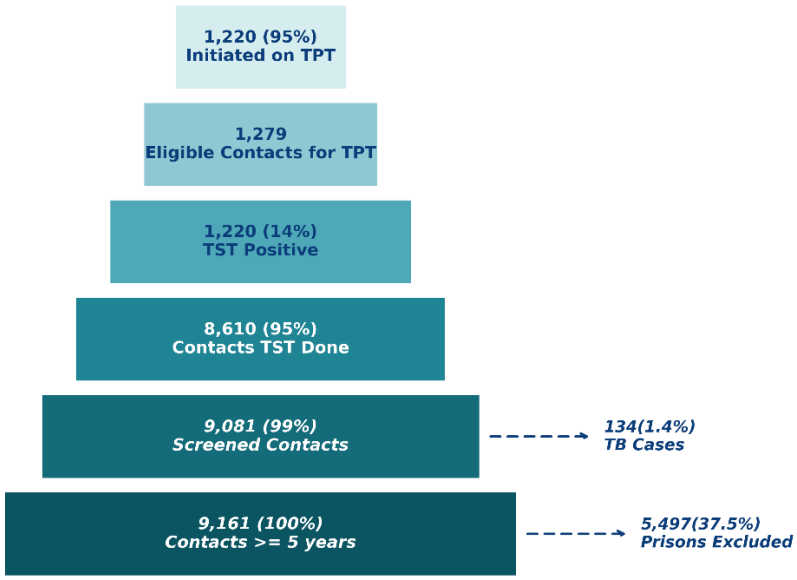


Figure 23: TPT initiation among TB contacts above 5 YO. 2025-2026

3.2.4. TB preventive therapy among PLHIV

Tuberculosis Preventive Therapy (TPT) has been integrated into HIV service delivery for people living with HIV (PLHIV) since 2019. By the end of June 2026, a cumulative total of 230,344 PLHIV were receiving antiretroviral therapy (ART) during FY 2025–2026. All districts have been equipped with the requisite skills and resources to deliver TPT through a one stop shop service delivery model. As of June 2026, 99.1% (228,364) of PLHIV currently on ART had been initiated on TPT.

During the development of the Extended TB National Strategic Plan (NSP) 2023–2027, a Results-Based Financing (RBF) indicator was introduced to track the proportion of people living with HIV newly initiated on ART who subsequently started TPT within the reporting period.

According to HMIS-reported data, TB Preventive Therapy (TPT) coverage among newly diagnosed HIV-positive clients initiated on ART during FY 2025–2026 stands at 73.6% (7,776/10,568), reached the RBF target of 70% set for this fiscal year. Sustained and further improved performance is anticipated in subsequent reporting periods, supported by targeted clinical mentorship, reinforced data quality assurance mechanisms, and strengthened collaboration between ART clinics and TB units to ensure systematic TPT initiation among eligible clients. Hospital level coverage is presented in the table below.

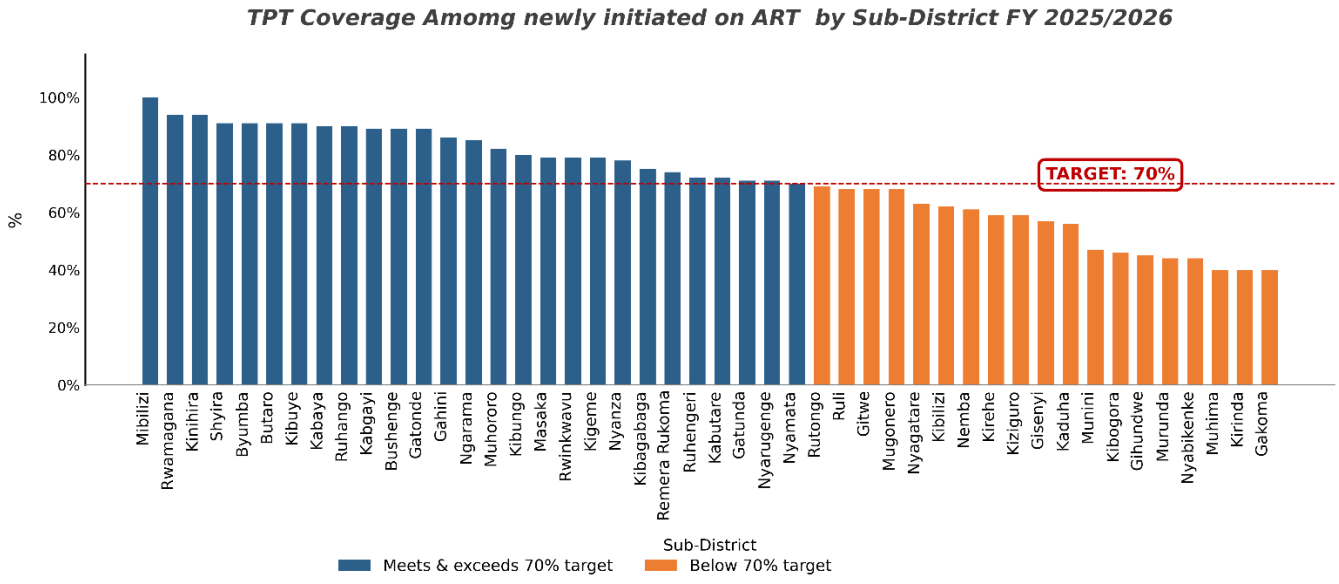


Figure 24: TPT Coverage among HIV + newly initiated on ART ,25/26 FY

3.2.5. TB preventive therapy among inmates

The Tuberculosis Preventive Therapy (TPT) pilot was implemented from 12 to 28 November 2025 in four correctional facilities in Rwanda: Rwamagana, Ngoma, Gicumbi, and Nyamagabe**.** The pilot aimed to assess the feasibility of integrating TPT into routine TB services for prison inmates by identifying individuals with latent tuberculosis infection (LTBI) and initiating preventive treatment to reduce progression to active TB disease.

The implementation approach differed slightly across the correctional facilities. At Rwamagana Correctional Facility, an ACF campaign was already underway. Therefore, only inmates who had been screened negative for TB through symptom screening and chest X-ray during the ACF were eligible for TST administration. In the remaining three correctional facilities (Ngoma, Gicumbi, and Nyamagabe), systematic TB symptom screening was conducted among all inmates. Those who screened negative underwent TST, and inmates with a positive TST result in all CFs, after excluding active TB and confirming LTBI, were initiated on TPT to prevent progression to active TB.

This pilot generated valuable lessons to inform the scale-up of TPT services in correctional facilities across Rwanda. The main challenges were experienced at Rwamagana Correctional Facility, where the large inmate population affected attendance. Despite repeated sensitization of prison officials, inmates, and their representatives, some eligible inmates did not attend for TST, even after daily lists were printed and shared with inmate representatives and bloc chiefs. In addition, some inmates returned for TST reading beyond the recommended 48-hour timeframe, although induration was still observed in some cases. These experiences highlight the need for stronger coordination, scheduling, and inmate engagement to ensure timely TST administration and reading.

The graph shows the results of the TPT pilot implemented in four correctional facilities from 12–28 November 2025. A total of 9,242 inmates received TST, including 3,828 in Rwamagana, 1,023 in Ngoma, 2,802 in Gicumbi, and 1,589 in Nyamagabe. TST positivity varied considerably across facilities, ranging from 13% in Gicumbi to 48% in Rwamagana, with an average of 24.3%. Notably, the TST positivity/latent TB infection (LTBI) burden in Rwamagana Correctional Facility was almost three times higher than that observed in the Gicumbi Correctional Facility, highlighting a particularly high level of TB transmission and latent infection among its inmate population. We thought to the overcrowding factor, but based on the data given by Rwanda Correctional Service, Rwamagana Correctional Facility does not differ with the 3 others Correctional Facilities regarding overcrowding: Rwamagana 106.8% (16,128/15,099), Gicumbi 104.3% (2,992/2,870), Ngoma 85.1% (1277/1500), Nyamagabe 60.8% (1,845/3,035). This exceptionally high positivity might be associated with TB burden in Rwamagana Correctional Facility during around three previous fiscal years. The TB cases in Rwamagana Correction Facility represented respectively 78%, 44%, 58% and 59% of TB cases that were notified respectively from the FY 2022-2023, FY 2023-2024, FY 2024-2025 and FY 2025-2026.

Among 9,242 inmates, 2,681were tested positive on TST, and all (100%) were initiated on TPT in each of the four facilities, demonstrating successful linkage from TST screening to TPT initiation.

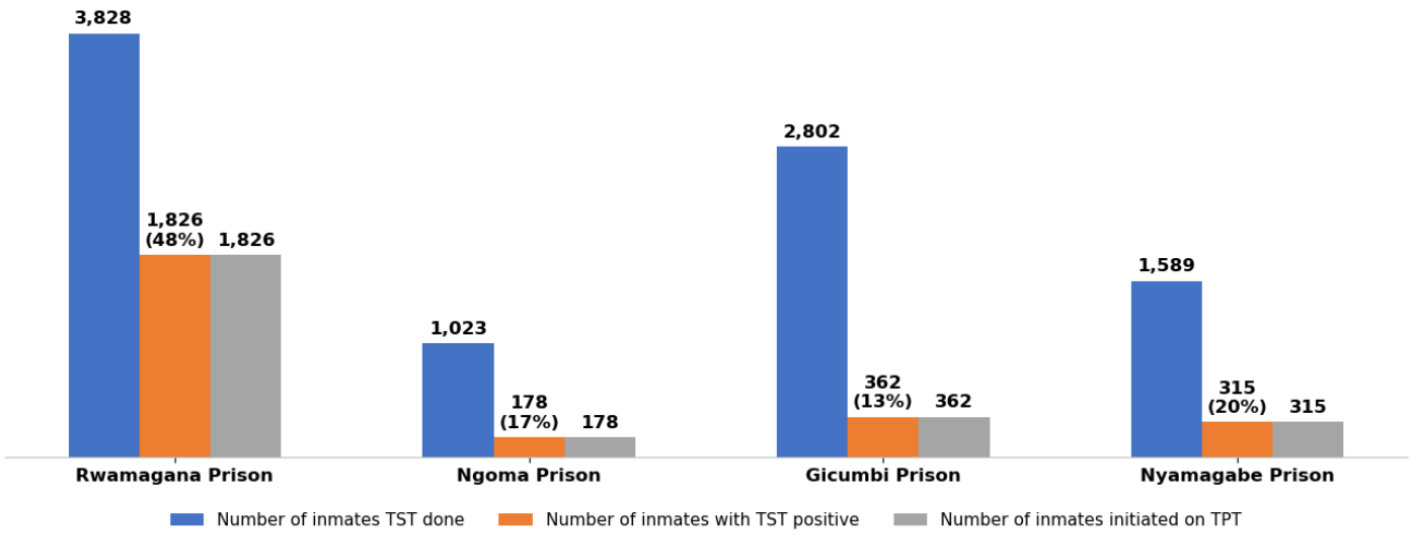


Figure 25: TPT in Correctional facility from 12-28 November 2025

The following recommendations are proposed to strengthen TST and TPT implementation

across correctional facilities, with particular attention to the exceptionally high LTBI burden at Rwamagana Correctional Facility:

- Coordination with prison authorities should be strengthened by integrating TST appointments into daily prison schedules and assigning dedicated focal persons to mobilize and follow up with eligible inmates.
- Inmate engagement should be enhanced through targeted health education involving peer educators, inmate representatives, and previously treated inmates, with brief pre-test counselling emphasizing the importance of returning within 48-72 hours for TST reading.
- Appointment-based tracking and timely follow-up of inmates who miss TST administration or reading should be implemented to minimize loss to follow-up.
- Given the particularly high LTBI burden at Rwamagana, the facility should be prioritized for intensified TB prevention and control interventions, including sustained and periodic TB screening and active case finding, comprehensive TPT coverage among eligible inmates, strengthened infection prevention and control measures, improved ventilation, and reduction of overcrowding where feasible.

Regular monitoring of TST positivity, TPT uptake, and TB incidence should be conducted to assess trends and guide targeted resource allocation and interventions

CHAPTER 4: TUBERCULOSIS TREATMENT OUTCOME

This chapter presents tuberculosis treatment and preventive treatment outcomes from the most recent cohorts recorded in the e-TB system. National treatment success reached 91%, meeting the national target of ≥90% and representing one of the highest levels achieved in recent years. The improvement was mainly driven by a sustained reduction in TB mortality, while loss to follow-up and non-evaluated cases remained stable.

Treatment success was lower among people living with HIV (81.8%), patients with extrapulmonary TB (86.8%), and adult men (90%), highlighting the need for targeted interventions. Subnational variation also persisted, with treatment success across hospital catchment areas ranging from 75% to 100%, indicating geographic disparities that require focused programmatic support.

Treatment outcomes for drug-resistant TB are presented separately for shorter and longer treatment regimens, reflecting differences in treatment duration. The chapter also presents preventive treatment outcomes among eligible TB contacts and PLHIV, as well as key findings from TB death audits reported by health facilities.

4.1. National TB Treatment Success for Drug-Susceptible TB: Five-Year Trend

Treatment success for all forms of TB (drug-susceptible and drug-resistant combined) reached 91% among the July 2024–June 2025 cohort, increasing from 90% in the previous cohort and matching the highest level achieved in recent years (Figure 4.1). Following a decline to 87% among the July 2021–June 2022 cohort, treatment success has steadily recovered and remained at 90–91% over the last three cohorts, demonstrating sustained program performance above the WHO target of 90%.

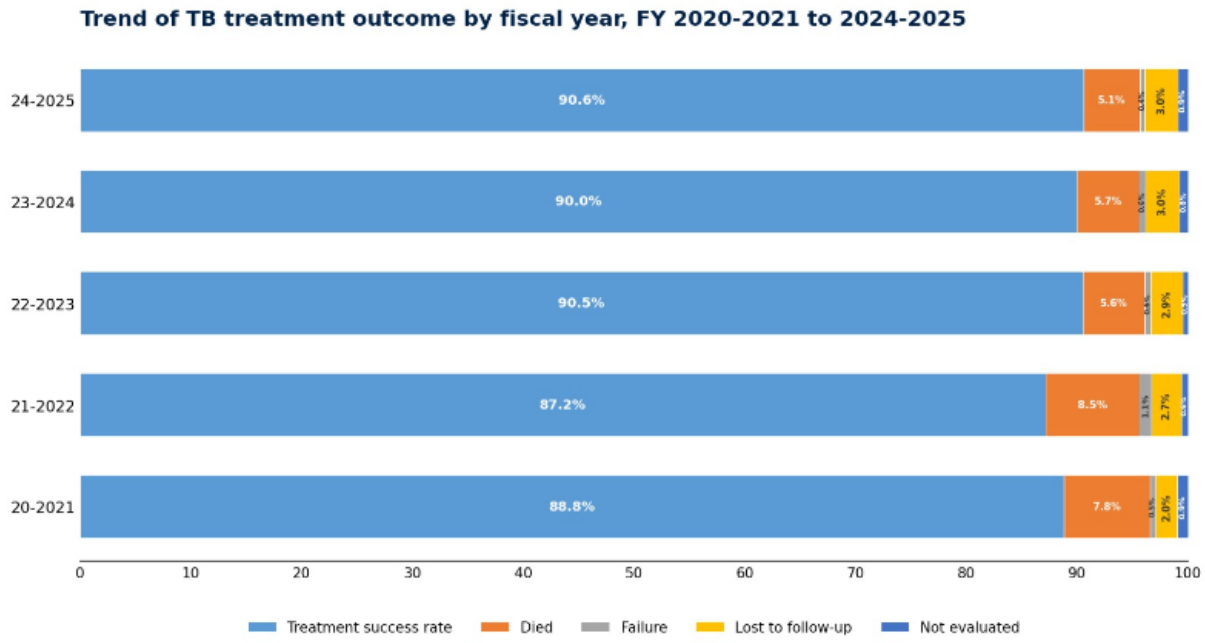


Figure 26: Trend of TB treatment outcome by fiscal year, 2020-2021 to 2024-2025.

The improvement in treatment success over the past five years has been driven primarily by a sustained reduction in TB mortality, which declined from 8% among the July 2020–June 2021 cohort to 5% among the July 2024–June 2025 cohort. In contrast, the proportions of patients lost to follow-up and those not evaluated have remained relatively stable, accounting for 3–5% of each cohort. These findings indicate that while clinical management has improved patient survival, further gains in treatment success will depend on strengthening patient retention through enhanced adherence support, systematic patient tracing, and other differentiated models of care.

Table 7. Treatment success rate per fiscal year

Fiscal year	Treatment success	Died	Note
2020-2021	89%	8%	Pre-pandemic-recovery baseline
2021-2022	87%	8%	Lowest point of the series; COVID-19 care-seeking disruption echo

2022-2023	91%	6%	First return to the 90% target
2023-2024	90%	6%	Sustained above target
2024-2025	91%	5%	Best mortality result of the five-year series

4.2. Treatment Outcomes by Clinical and Demographic Characteristics

Disaggregation of treatment outcomes for the July 2024–June 2025 cohort by clinical and demographic characteristics (Figure 4.2) shows that the overall treatment success rate of 90.6% for drug-susceptible TB masks important variations across patient subgroups. Three key patterns emerge from the analysis.

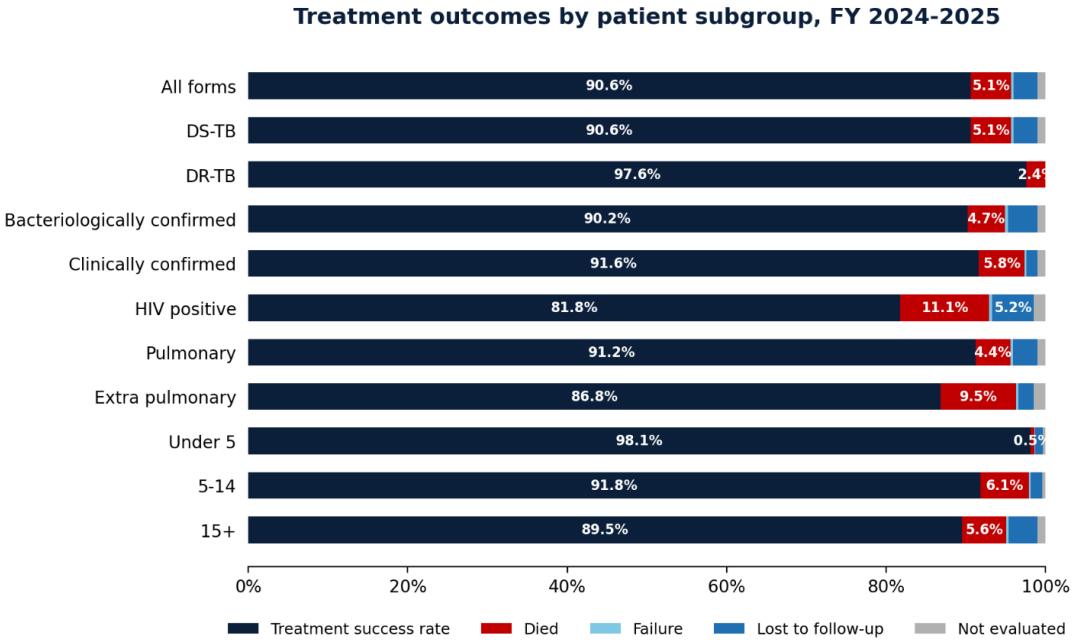


Figure 27: Treatment outcomes by patient subgroup, FY 2024-2025.

4.3. Treatment Outcomes by Age Group

Treatment success varied by age group, with the highest success observed among children under 5 years (98.1%), followed by children aged 5–14 years (91.8%), while patients aged 15 years and above had the lowest treatment success (89.5%) (Figure 4.2). These findings indicate that, although children account for a smaller proportion of notified TB cases, those

diagnosed and initiated on treatment achieve excellent treatment outcomes. This highlights the importance of strengthening childhood TB case detection through intensified contact investigation, improved access to diagnostic services, and continued mentorship of healthcare providers, while maintaining the high quality of treatment and follow-up for children diagnosed with TB.

4.4. Treatment Outcomes by HIV Status

Treatment success among TB/HIV co-infected patients was 81.8%, the lowest of all clinical and demographic subgroups and well below the national average (Figure 4.2). Despite the declining proportion of TB/HIV co-infection nationally, these findings indicate that co-infected patients remain at increased risk of poor treatment outcomes, underscoring the need to strengthen integrated TB/HIV services, ensure early ART initiation, and provide comprehensive management of advanced HIV disease and opportunistic infections.

4.5. Treatment Outcomes by Disease Site and Diagnostic Classification

Treatment success was lower among patients with extrapulmonary TB (86.8%) than among those with pulmonary TB (91.2%), reflecting the greater clinical complexity and higher frequency of HIV co-infection associated with extrapulmonary disease. Similarly, bacteriologically confirmed cases (90.2%) had slightly lower treatment success than clinically diagnosed cases (91.6%), likely reflecting differences in patient characteristics and disease severity.

4.6. Treatment Outcomes for Drug-Resistant TB

Overall, treatment success among drug-resistant TB (DR-TB) patients was 91.7%, compared with 90.6% among patients with drug-susceptible TB (DS-TB) (Figure 4.2). Compared with the previous cohort, treatment success among DR-TB patients improved from 87.5% to 91.7%, indicating continued progress in the management of DR-TB despite the relatively small number of patients.

The treatment outcome profile shows that the majority of DR-TB patients achieved successful treatment outcomes, with only a small proportion experiencing unfavorable outcomes, mainly due to death and loss to follow-up. This favorable performance reflects the continued implementation of appropriate shorter and longer treatment regimens, timely

treatment initiation, close patient follow-up, and comprehensive patient support throughout treatment.

However, owing to the relatively small cohort size and the longer, more complex treatment regimens required for DR-TB, these findings should be interpreted with caution.

Table 8. Detailed treatment outcomes by shorter and longer DR-TB regimens are presented in the subsequent section

Fiscal Year & Regimen	MDR Treatment outcome						TSR
	Cured	Treatment completed	Lost of follow up	Failed	Died	Grand Total	
2023-2024 (Longer)	2	1	2	0	1	6	50.0%
2024-2025 (Shorter)	41	0	0	1	0	42	97.6%
Grand Total	**43**	**1**	**2**	**1**	**1**	**48**	**91.7%**

More attention should be put on the RR/MDR-TB treatment follow-up to ensure all patients successfully complete their respective treatment course.

4.7. Treatment Outcomes by Sex

Treatment success was 90% among men and 92% among women in the July 2024–June 2025 cohort (Figure 4.3). Mortality was similar between the two groups, while loss to follow-up was higher among men. Given that men represent the majority of notified TB cases; this difference contributes to a larger absolute number of men experiencing unsuccessful outcomes. The findings highlight the need to strengthen retention interventions, including

adherence support and patient-centered follow-up approaches targeting men.

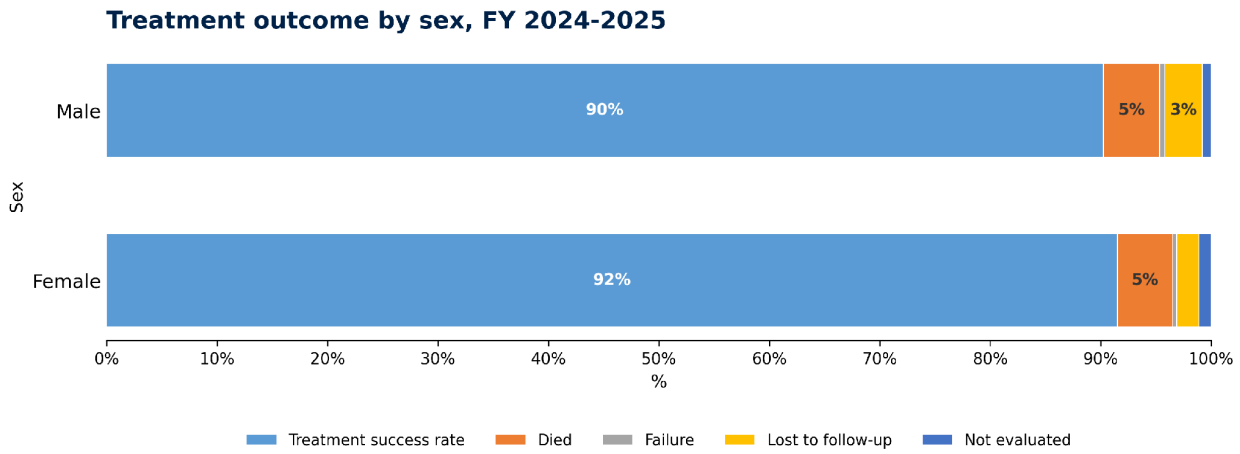


Figure 28: Treatment outcome by sex, FY 2024-2025.

4.8. Subnational Variation in TB Treatment Outcomes

A single national treatment success percentage, while important for measuring overall programme performance, may mask variations in outcomes across different geographic areas. This section presents treatment success analysis for the July 2024–June 2025 cohort at three levels: hospital catchment area, district, and sector/health facility, to identify variations in performance and areas requiring targeted improvement.

4.8.1. Variation in Treatment Outcomes Across Hospital Catchment Areas

Among the 46 hospital catchment areas included in the national cohort, treatment success ranged from 75.0% in the lowest-performing catchment area to 100% in the highest-performing catchment areas (Figure 4.4). Approximately one-third of catchment areas (16/46) recorded treatment success below the national target of 90%, despite the overall national achievement of 91%. These findings highlight the importance of subnational analysis, as national averages may conceal areas with persistent performance gaps requiring focused programmatic support.

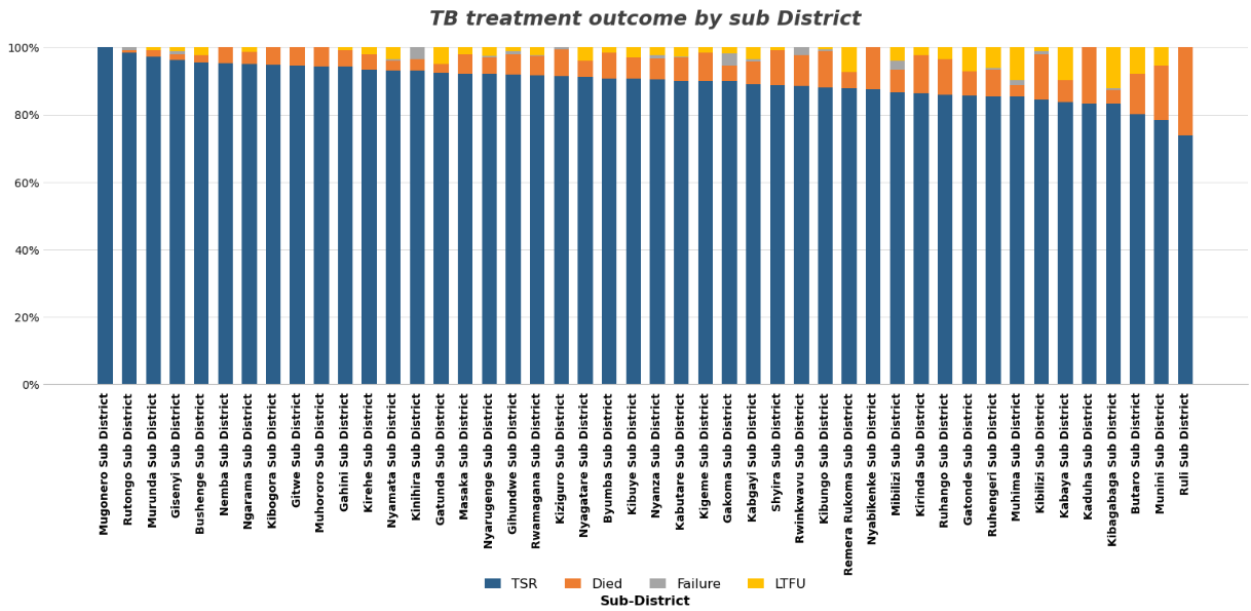


Figure 29: Treatment outcome for the TB cohort, FY 2024-2025, ranked by hospital catchment area, against the 90% national target.

4.8.2. Variation in Treatment Outcomes at District Level

At district level, the majority of Rwanda's 30 districts achieved treatment success above the 90% national target (Figure 30). However, some districts recorded lower performance, including Gakenke (81.4%), Burera (82.6%), Gasabo (82.7%), Nyaruguru (84%), and Musanze (85.6%).

The concentration of lower-performing districts in the Northern Province, which was also identified in Chapter as having a lower contribution to national TB notifications, highlights the need for further assessment of potential gaps in TB case detection, treatment follow-up, and service delivery capacity. Gasabo represents a different context, with a high population density and higher TB notification volume, suggesting that performance gaps may require targeted approaches adapted to local operational challenges.

These findings emphasize the importance of district-level monitoring to guide tailored interventions and strengthen TB treatment outcomes across different settings.

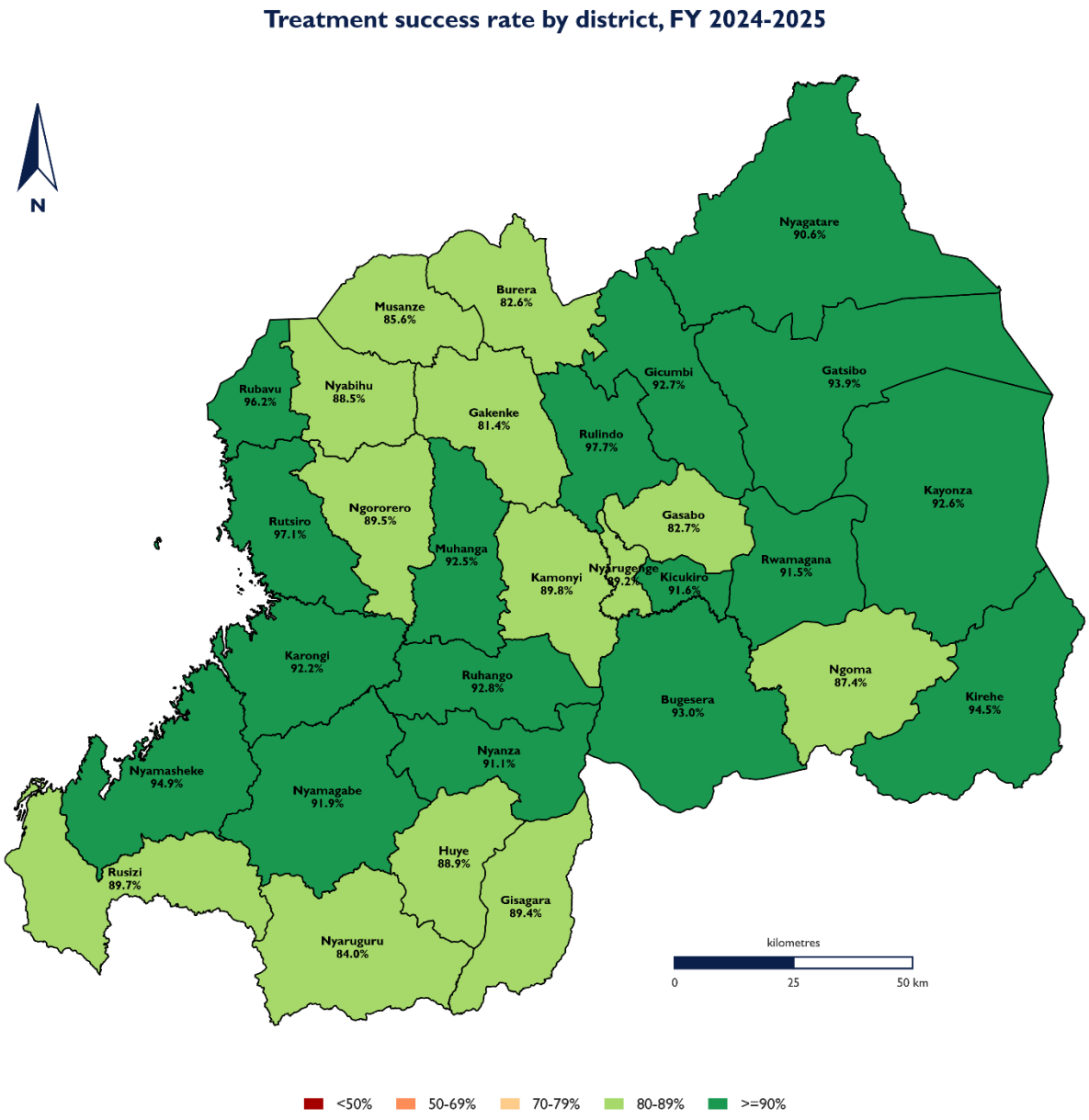


Figure 30: Treatment success rate by district, Rwanda, FY 2024-2025, with the lowest-performing district (referral) hospitals ranked alongside the map.

The district-level map and the referral hospital table provide complementary perspectives. While the map presents the average treatment outcome across all facilities within a district, the table reflects the performance of individual referral hospitals, which may differ from the overall district result. This highlights the importance of reviewing both district and facility-level data to identify specific areas requiring support.

4.8.3 Sector and Health Facility-Level Variation

Further disaggregation at sector and health facility levels (Figures 4.6a–b) confirms the geographic patterns observed at district level. Lower treatment success is concentrated in several areas of the Northern and western Province, including Burera, Gakenke, Musanze, and Nyabihu, with an additional lower-performing area identified in Nyaruguru District. The consistency of these findings across multiple levels suggests underlying programmatic and service delivery gaps requiring targeted interventions.

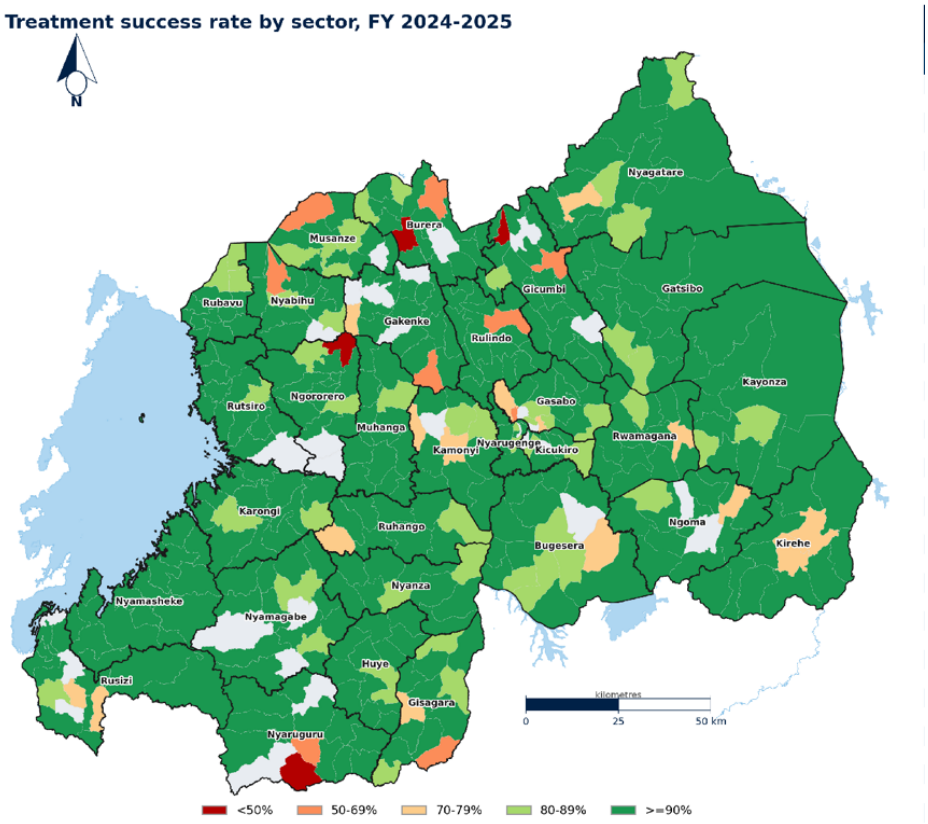


Figure 31: Health facilities below 90% treatment success rate, FY 2024-2025

Four health centres (Gashonyi, Cyumba, Ruhombo, and Runyombyi) recorded a treatment success rate of 0.0% during the reporting period. These results should be interpreted with caution; as small patient numbers can substantially influence facility-level treatment outcomes. Similarly, facilities reporting 100% treatment success may also reflect small cohorts. Performance interpretation should therefore consider the number of evaluated

cases, with low-volume facilities prioritized for supportive data review and case audit before further action.

4.9. Programmatic synthesis

Rwanda's TB programme continues to achieve strong treatment outcomes, with national treatment success maintained above the WHO target of 90% and mortality declining over the past five years. However, variations persist among key subgroups and geographic areas, particularly TB/HIV co-infected patients, patients with extrapulmonary TB, adult men, and selected districts in the Northern Province.

Priority actions include strengthening targeted mentorship and supervision in lower-performing areas, improving retention support for men, enhancing integrated TB/HIV care, harmonizing DR-TB outcome reporting, and applying minimum case-count thresholds when interpreting facility-level performance.

4.10. TB treatment outcome by nutritional status among patient ≥15years of age

We analyzed nutritional outcomes among TB patients with a baseline BMI <18.5 kg/m² who received nutritional support during TB treatment. Among 2,923 TB patients identified with baseline malnutrition, 1,791 (61%) received nutritional support. At the end of treatment, 918 patients (51% of those who received nutritional support) achieved nutritional improvement, while 873 patients (49%) did not show improvement in nutritional status.

These findings demonstrate that although nutritional support contributed to improving the nutritional status of a substantial proportion of malnourished TB patients, nearly half of the patients did not achieve nutritional recovery by the end of treatment. This highlights the need to strengthen early nutritional assessment, timely initiation of nutritional support, regular monitoring of nutritional progress, and adherence to nutritional interventions throughout TB treatment.

Expanding coverage of nutritional support to all eligible malnourished TB patients at treatment initiation, combined with strengthened follow-up and management of patients with persistent malnutrition, may further improve nutritional recovery and contribute to better TB treatment outcomes.

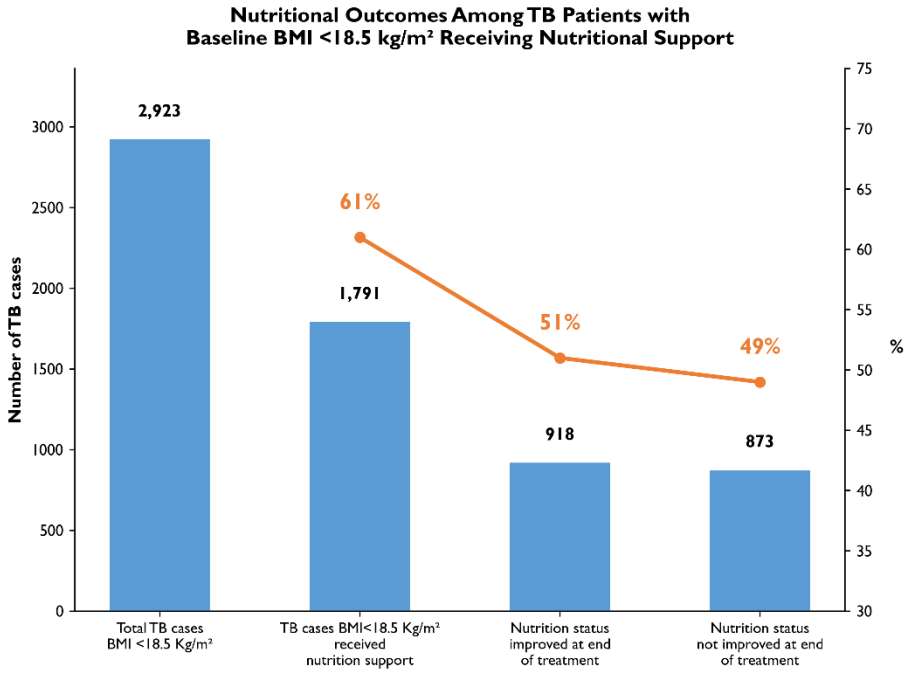


Figure 32: Nutritional outcome Among TB Patient with baseline BMI <18.5 receiving nutrition support, FY 2024-2025.

4.11. Treatment Outcomes Among Malnourished TB Patients Receiving Nutritional Support, 24-25 FY

The below graph presents TB treatment outcomes among patients with baseline malnutrition (BMI <18.5 kg/m²) who received nutritional support, compared with patients who achieved nutritional improvement (BMI ≥18.5 kg/m²) after treatment.

Among patients who remained malnourished (BMI <18.5 kg/m²) after nutritional support, the treatment success rate was 78%, with unfavorable outcomes mainly driven by deaths (17%), followed by lost to follow-up (4%) and treatment failure (1%). In contrast, patients who achieved a normal nutritional status (BMI ≥18.5 kg/m²) after treatment had a much higher treatment success rate of 97%, with only a small proportion experiencing unfavorable outcomes.

These findings demonstrate a strong association between nutritional recovery and TB treatment outcomes. Patients who remained underweight at the end of treatment experienced lower treatment success and higher mortality compared with those who achieved nutritional improvement. This highlights the importance of early identification of

malnutrition, timely initiation of nutritional support, and close nutritional monitoring throughout TB treatment.

Strengthening nutritional interventions and ensuring adequate follow-up of patients who do not achieve nutritional recovery are essential to reduce TB-related mortality and improve overall treatment success among malnourished TB patients.

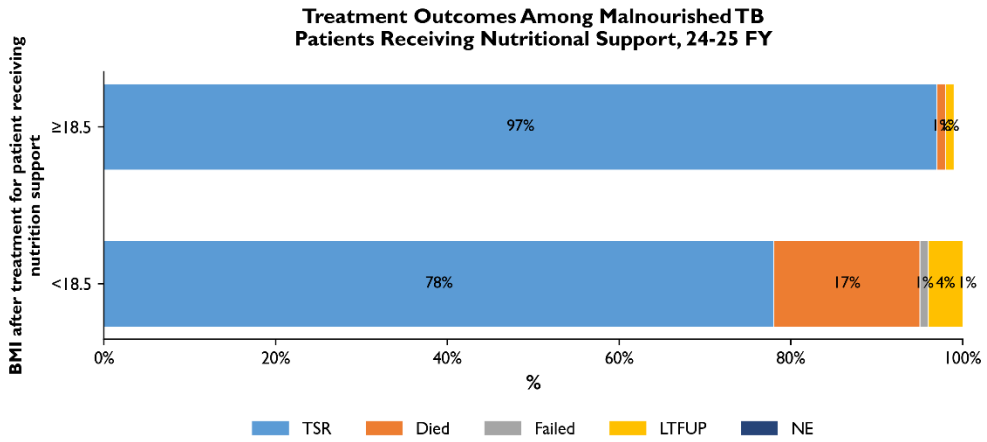


Figure 33: Treatment Outcomes Among Malnourished TB patient receiving nutritional support, FY 2024–2025

Community health worker (CHW) follow-up was strongly associated with improved treatment outcomes among drug-susceptible TB patients in FY 2024–2025. Patients who received CHW follow-up achieved a 95% treatment success rate, compared to 88% among those without follow-up. Mortality was markedly lower in the CHW group (2.1% vs. 7.2%), and loss to follow-up was also reduced (2.0% vs. 3.2%). These findings highlight the critical role of CHWs in supporting adherence, reducing deaths, and ensuring continuity of care. The data reinforce the importance of sustained investment in CHW programs as a cornerstone of TB control efforts.

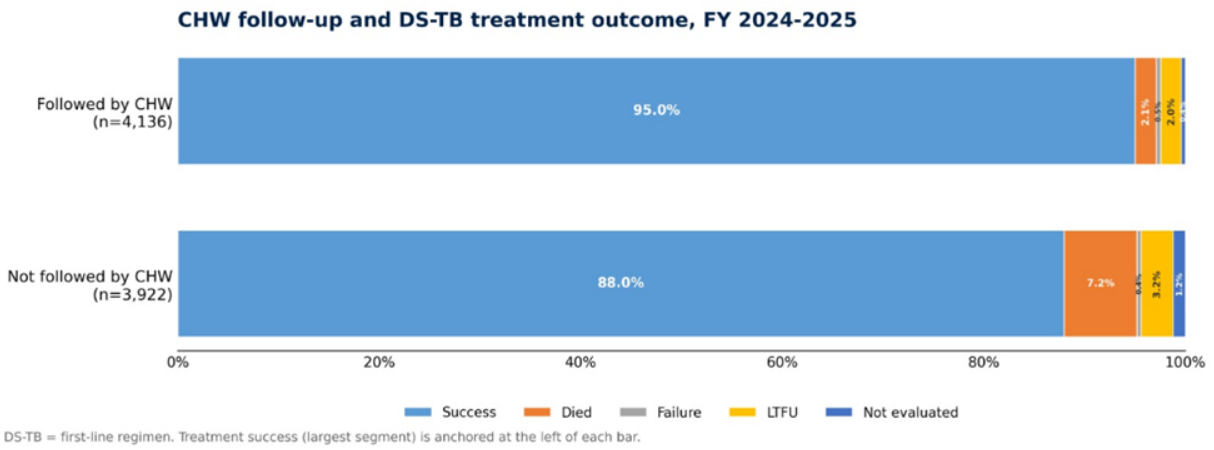


Figure 34: CHW follow up and DS-TB Treatment outcome

4.12. Treatment Outcome for TPT among Contacts of index TB cases

The treatment outcomes for TPT among contacts of TB index cases were assessed across three age groups: children under 5 years, children aged 5–14 years, and individuals aged 15 years and above.

Among contacts under 5 years of age, the TPT completion rate was 99% (1,211/1,222). One child developed TB, two were lost to follow-up, and one discontinued TPT due to side effects.

Among contacts aged 5–14 years, the TPT completion rate was 100% (415/415), with no other outcomes reported. Regarding contacts aged 15 years and above, the TPT completion rate was 99.9% (1,078/1,079), with one contact for whom the treatment outcome was not recorded in the health information system.

4.13. Treatment outcome for TPT among PLHIV

As we are reporting the FY 2025-2026, TPT outcomes findings shall consider PLHIV that were initiated one year prior, which means those who were put on TPT from July 2024 up to June 2025. We highlight that TPT outcomes among PLHIV, the reporting period is for 8 months after initiation.

The completion rate for the cohort of PLHIV initiated on TPT is 98.1% (8,181/8336). Around 1.4 % were defaulted from the TPT.

4.14. TB death audits in the context of TB control in Rwanda

The TB & Other Respiratory Diseases (TB & ORD) Division continued to strengthen TB death audits as a key component of TB mortality surveillance and quality improvement. Through supportive mentorship, supervision, and technical assistance, health facilities were supported to improve the completeness, accuracy, and timeliness of TB death audit reporting in the e-TB system.

TB death audits are conducted at the hospital level using the standardized national TB death audit tool through a multidisciplinary approach involving TB clinicians, relevant specialists, TB supervisors, and TB focal persons. Since the integration of the TB death audit module into the e-TB system in May 2023, audit findings have become more accessible for routine monitoring, gap identification, and the development of targeted interventions to reduce TB mortality.

During FY 2025–2026, the TB & ORD Division achieved 100% completeness in TB death audit reporting, with 414 out of 414 expected TB death audits reported through the e-TB system and analyzed for patients registered in the FY 2024–2025 cohort. This represents a substantial and sustained improvement in TB death audit reporting over the past seven fiscal years, increasing from 29% in FY 2019–2020, 17% in FY 2020–2021, 35% in FY 2021–2022, 46% in FY 2022–2023, 53% in FY 2023–2024, and 86.5% (412/476) in FY 2024–2025, to 100% (414/414) in FY 2025–2026. This achievement reflects strengthened implementation of the TB death audit system and provides a more complete evidence base for identifying preventable factors, informing corrective actions, and guiding interventions to reduce TB-related mortality.

Case Fatality Ratio (CFR): The CFR target for FY 2025–2026 was set at 5%; however, the reported CFR was 11% for this fiscal year. This calculation was based on data from the 2025 national mortality report, which captures deaths as events occurring during the reporting period. In contrast, the TB Program calculates TB deaths based on the patient cohort and treatment outcomes.

If the CFR were calculated using the TB Program's cohort-based data, as was done in previous years, the CFR would be approximately 4.7%, which is in line with the set target.

Therefore, the difference is mainly attributable to the different data sources and methodologies used to calculate TB deaths.

4.14.1. Characteristics of TB Deaths

TB deaths were predominantly reported among males, who accounted for 71.3% (295/414) of all audited deaths, compared with 28.7% (119/414) among females. The majority of deaths occurred among older adults, with patients aged ≥55 years representing 34.3% (142/414) of deaths, followed by those aged 35–44 years (26.1%) and 45–54 years (15.5%). Children and adolescents accounted for a smaller proportion of TB deaths.

Among audited TB deaths, 66.7% (276/414) were bacteriologically confirmed, while 33.3% (138/414) were clinically diagnosed. Pulmonary TB accounted for the majority of deaths (76.6%, 317/414), while 23.4% (97/414) were due to extrapulmonary TB.

Among patients who died from extrapulmonary TB, the most commonly affected sites were pleural TB (34.0%), followed by miliary TB (20.6%) and meningeal TB (16.5%), highlighting the contribution of severe and disseminated forms of TB to mortality.

4.14.2. TB/HIV Co-infection and Immunosuppression

Among TB death audits with available HIV information (n=121), 59.5% were people living with HIV, while 40.5% were newly diagnosed with HIV.

Among HIV-positive patients with available CD4 results, the majority had advanced immunosuppression, with 23 patients having CD4 counts below 200 cells/mm^3, indicating increased vulnerability to severe TB disease and opportunistic infections.

These findings emphasize the continued importance of early HIV diagnosis, timely ART initiation, screening for advanced HIV disease, and integrated TB/HIV management.

4.14.3. Nutritional Status

Malnutrition was highly prevalent among patients who died from TB. More than half of audited patients were underweight (59.2%, 245/414), while 38.4% had normal BMI and only 2.4% were overweight. Underweight was observed among both HIV-negative and HIV-

positive patients, suggesting that nutritional vulnerability remains an important factor associated with TB mortality.

4.14.4. Programmatic Implications

TB death audit findings indicate that mortality remains concentrated among older adults, men, patients with advanced HIV disease, and those experiencing nutritional challenges, with deaths occurring predominantly during the early period following TB diagnosis. Notably, 76.6% of deaths occurred within the first month and 87.7% within the first two months, highlighting the critical importance of early identification and management of patients at high risk of death.

The program should therefore strengthen early TB diagnosis and treatment initiation, integrated TB/HIV care, systematic assessment and management of severe TB and nutritional needs, and close follow-up during the first two months of treatment. Continued implementation of TB death audits, routine data quality improvement, and facility-level mentorship will support identification of preventable factors and guide targeted corrective actions to further reduce TB mortality.

Chapter 5. TUBERCULOSIS PROGRAM MANAGEMENT

5.1. Health Promotion, Community, and Stakeholder Engagement

Health promotion, community, and stakeholder engagement activities were implemented to increase public awareness of tuberculosis (TB), promote early health-seeking behavior, reduce stigma and misconceptions, and strengthen community participation in TB prevention and control. A comprehensive multimedia communication strategy was used to disseminate key TB messages through radio, television, and social media platforms, reaching diverse audiences across the country during the FY 2025-2026 as follow:

Radio Engagement

- 18 live radio talk shows conducted
- Stations included: Radio Rwanda, RBA Community Radios, Radio 1, Radio 10, Izuba Radio, Isango Star, Life Radio, Authentic Radio, B&B Radio, Umucyo Radio, and Huguka Radio
- Additional dissemination through radio spots and DJ mentions

Television Engagement

- 8 live TV programs conducted
- Stations included: RTV, TV O, Isango TV, BTN TV, Pacis TV, Life TV, TV10, and TV1

Social Media Engagement

- Platforms used: YouTube, Instagram, and X (Twitter)
- Shared TB awareness messages and campaign materials

Key TB Messages Disseminated

- Rwanda United to End TB
- Early TB screening and prompt health-seeking behavior
- Recognition of TB symptoms (cough >2 weeks, fever, night sweats, weight loss, chest pain, coughing blood)

- Early testing as key to prevention
- TB is not caused by witchcraft ("igituntu si uburozi")
- TB is curable when properly treated
- Free TB diagnosis and treatment services in Rwanda
- Treatment adherence (DOT)
- Collective community action to end TB

Furthermore, TB sensitization in refugee camps and congregated settings remains crucial for reducing TB transmission and improving knowledge in these high-risk populations. To strengthen prevention, the TB&ORD Division conducted biannual sensitization sessions in 13 prisons and six refugee camps supported by peer educators. Refresher training covering TB symptoms, diagnosis, treatment and prevention is provided to peer educators before each sensitization. Peer educators played a central role by raising awareness and referring symptomatic individuals to health services.

In total, 3,182 peer educators were trained or refreshed in prisons and refugee camps as a cumulative number. Post-training assessments confirmed significant improvement in TB knowledge, demonstrating the value of continuous capacity building. This approach also helps to dismiss misconceptions and stigma, and strengthens community-driven support for early diagnosis and adherence to treatment.

5.1.1. Community outreach activities

Integrated community outreach activities were conducted across 13 SPRP-supported districts (Bugesera, Gakenke, Gisagara, Huye, Karongi, Nyanza, Nyamagabe, Nyaruguru, Rutsiro, Rusizi, Rubavu, Ngororero, and Nyabihu) in collaboration with RHCC.

The campaign addressed multiple health priorities including TB, nutrition, malaria, HIV, hygiene promotion, and other communicable diseases. Implementation used a combination of mobile audio-visual trucks, educational videos, health talks, and sono mobile systems deployed in markets, bus stations, trading centers, and other high-traffic areas.

Interactive question-and-answer sessions were used to enhance community participation and knowledge retention. Key TB messages focused on symptom recognition, early testing, free TB services, treatment adherence, stigma reduction, and prevention practices.

Overall, the integrated approach successfully reached diverse populations and contributed to improved health-seeking behavior and increased TB awareness across all targeted districts.







5.2. World Tuberculosis Day (WTBD 2026)

WTBD 2026 was commemorated in Gasabo District under the theme: “Accelerate Detection, Strengthen Communities: Rwanda United to End TB” (Twese Hamwe Turandure Igituntu).

The main objective was to strengthen TB awareness, community engagement, and early TB detection through integrated interventions.

Activities were implemented through strong multi-sectoral collaboration involving Gasabo District, Kibagabaga L2TH, CHWs from Remera, Kagugu, and Kacyiru Health Centers, WHO, NGOs, media partners, and other stakeholders. A total of 11 preparatory meetings ensured effective planning and coordination.

Community mobilization used sono mobile sensitization, CHW engagement, and targeted health education in high-risk urban areas. A total of 389 CHWs and peer educators participated in TB awareness, screening, and referral activities. In recognition of their performance, 16 best CHWs received bicycles as incentives.



Pictures of CHWs and Peer educators during the WTBD 2026 celebration



Pictures of CHWs with awards during the WTBD 2026 celebration

- **TB Active Case Finding (ACF)**

TB ACF was conducted in three sites: Kimironko Market, Gakiriro/Gisozi, and Batsinda center. Using mobile and portable X-ray services, 579 individuals were screened, resulting in:

- 201 presumptive TB cases
- 14 confirmed TB cases

Some cases with abnormal chest X-rays were referred for further investigation. All confirmed cases were successfully initiated on treatment after a short delay in a few cases.

Additional highlights included a TB survivor testimony, which reinforced key messages that TB is curable, not caused by witchcraft, and that early diagnosis improves outcomes. The event also benefited from high-level guest participation, who emphasized commitment to TB elimination in Rwanda.

Overall, WTBD 2026 significantly contributed to increased TB awareness, strengthened community participation, improved case detection, and enhanced multi-sectoral collaboration. Continued coordination, timely planning, and strengthened follow-up of detected cases are recommended to sustain progress toward ending TB in Rwanda.



5.3. Civil Societies Organization in TB Control

Community Engagement in the TB Response

During the 2025–2026 reporting period, the Rwanda Network of People Living with HIV (RRP+) strengthened community engagement in the tuberculosis (TB) response through peer education, home visits, referrals, treatment adherence support, and youth-led awareness campaigns. These interventions contributed to improved TB prevention, early case detection, timely referral, and linkage to care among people living with HIV (PLHIV) and the wider community.

A total of 4,823 peer educators, operating across 547 health facilities, provided community follow-up services to 165,911 PLHIV receiving antiretroviral therapy (ART). Through support group meetings and community outreach activities, 116,138 PLHIV received education on TB prevention, early recognition of TB symptoms, and the importance of adherence to tuberculosis preventive treatment (TPT).

Home visits remained a cornerstone of community-based interventions. During the reporting period, 27,677 home visits were conducted to support treatment adherence, encourage completion of TPT, identify individuals with presumptive TB, and facilitate referrals to health facilities for further assessment. As a result, 2,971 PLHIV presenting TB symptoms or other risk factors were referred for TB screening and clinical evaluation. These efforts led to the diagnosis and successful linkage to treatment of 75 PLHIV with TB, including three cases identified during the World TB Day campaign conducted at the Kimironko site in Gasabo District.

RRP+ also extended TB prevention efforts beyond PLHIV through its Youth Ambassadors initiative. The ambassadors reached 18,452 people in five tea estates—Nyabihu, Gatare, Gisakura, Ngororero, and Rutsiro—and surrounding communities with TB awareness and prevention messages. In addition, a three-month mass media campaign disseminated TB

prevention messages through radio broadcasts aired in markets and major bus parks across 20 districts, reaching an estimated audience of more than six million people.

Key Challenges

- Data quality discrepancies between peer educator reports and health facility records.
- TB screening registers do not capture referrals made by peer educators, making it difficult to track their contribution to case detection.
- Limited availability of the revised HIV-TB peer educator training manual, affecting the standardization of community interventions.

CHAPTER 6: SUPPLY PLAN CHAIN MANAGEMENT AND COMMODITIES

6.1. Coordinated Procurement and Distribution system

To ensure uninterrupted availability of commodities for TB prevention, diagnosis, and treatment, the Rwanda Biomedical Centre (RBC), through the TB & Other Respiratory Diseases (TB&ORD) Division, coordinated the annual forecasting and quantification exercise under the Coordinated Procurement and Distribution System (CPDS). The exercise brought together representatives from the Ministry of Health (MoH), RBC, Rwanda Medical Supply (RMS), referral hospitals, and implementing partners to estimate national commodity requirements for the period 2026–2030 and develop the TB supply plan for Fiscal Year (FY) 2026–2027.

The integrated quantification approach strengthened coordination across health programs, improved resource utilization, and promoted cost-effective procurement planning.

Throughout the reporting period, TB commodity stocks and procurement orders were continuously monitored to identify and address potential supply risks. At the central level, most TB medicines and diagnostic commodities remained available. However, shortages were experienced for a limited number of laboratory commodities, including microscope slides, Linezolid powder, Löwenstein–Jensen (LJ) powder, selected BD laboratory products, and antibiotic standards for High-Performance Liquid Chromatography (HPLC).

To ensure continuous availability of commodities at service delivery points, the TB&ORD Division closely monitored requisitions submitted through RMS branches and coordinated timely distribution of TB medicines and laboratory supplies to health facilities. The transition of health facilities from the Electronic Logistics Management Information System (eLMIS) to the eBuzima platform, however, limited access to complete logistics data during the reporting period. Consequently, some supply chain performance indicators, including the proportion of health facilities reporting no stock-outs, could not be comprehensively monitored.

Despite these reporting challenges, continuous coordination between RBC, RMS, and health facilities ensured uninterrupted distribution of TB commodities. As a result, no nationwide stock-outs of TB medicines were recorded, safeguarding continuity of treatment and patient care.

6.2. Procurement status of TB products at end of June 2026

Implementation of the FY 2025–2026 TB supply plan showed substantial progress while highlighting areas requiring continued follow-up. Of the 181 planned consignments, 67 (37%) were fully received by the end of June 2026. An additional 41 consignments (22%) had been ordered and were awaiting delivery, while 32 consignments (18%) remained in the planning stage, primarily under Global Fund financing commitments. During routine supply plan review, 41 consignments (23%) were cancelled following reassessment of actual consumption patterns and available stock. Two consignments were partially received, and no consignments were placed on hold during the reporting period.

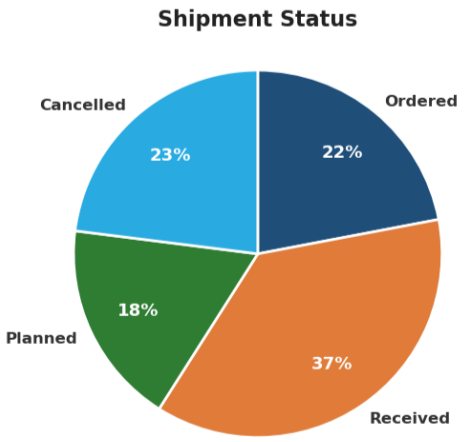


Figure 35: Procurement status of TB products, FY 2025-2026

Analysis of supply plan implementation indicates that approximately 60% of the planned consignments had been processed through procurement, and 62% of those ordered had already been delivered by the end of the reporting period. Overall, 37% of all planned consignments were successfully received.

Although this demonstrates satisfactory implementation of the procurement plan, delayed delivery of several laboratory commodities remains a concern. Most outstanding consignments consist of diagnostic and laboratory supplies, which could affect laboratory services if procurement delays persist. Strengthened follow-up with suppliers, procurement partners, and freight agents will therefore be essential to ensure timely delivery and maintain uninterrupted TB diagnostic and treatment services during the next fiscal year.

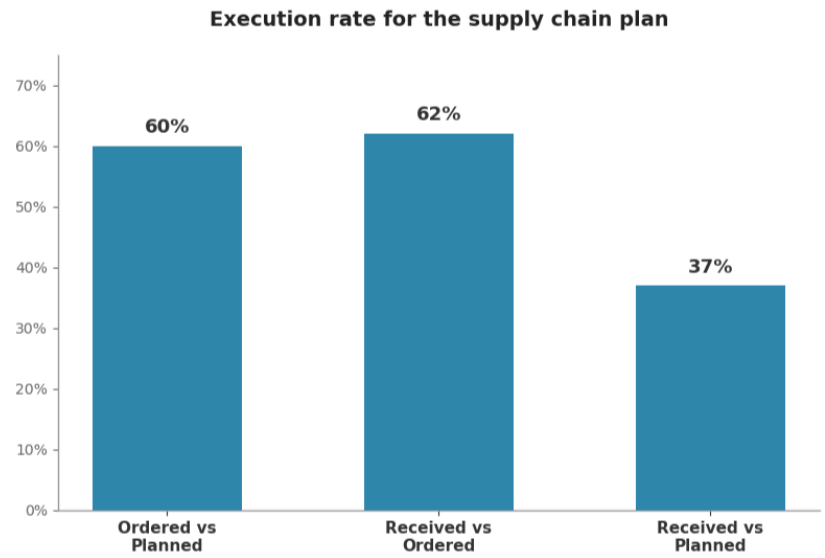


Figure 36: Execution rate for the supply chain plan

6.3 Forecasted accuracy of TB medicines

Forecast accuracy analysis for the period July 2025 to June 2026 showed that commodity forecasts were generally reliable, particularly for second-line TB medicines. However, higher-than-anticipated notifications of drug-susceptible (DS-TB) and pediatric TB cases were observed during the reporting period. This increase was largely attributed to intensified mentorship and supportive supervision activities that improved TB case detection and reporting across health facilities.

The higher patient enrollment required revision of the consumption forecasts for FY 2026–2027 and closer monitoring of stock status, particularly for pediatric formulations. To prevent stock shortages, emergency procurement was initiated to replenish pediatric TB medicines and ensure uninterrupted treatment.

The table below summarizes the forecast accuracy for different TB regimens:

Table 9: Forecast accuracy for TB medicines

Forecast accuracy			
Regimen	**Target in Quantification**	**Cases registered**	**%**
Patient on FL adult medicines	6,374	7,228	**113%**
Children under paediatrics formulations	587	1,012	**172%**
DR TB cases	58	34	**59%**
TPT contacts less 2 Years (3HR)	487	409	**84%**
TPT contacts above 2 Years (3HP)	2,504	1,749	**70%**
TPT PLHIV	11,118	8,811	**79%**

6.4 Quality Control and Quality assurance

To ensure the quality and integrity of anti-TB medicines and laboratory commodities, a receiving committee was established with designated personnel responsible for verifying product quality upon receipt. All consignments underwent visual inspection to confirm compliance with procurement specifications, packaging integrity, labeling, expiry dates, and the absence of any visible defects before acceptance into the supply chain.

However, laboratory-based quality testing was not conducted during the reporting period. Although product samples would normally be collected and submitted to a certified quality control laboratory whenever confirmation of non-visible quality attributes was required, this was not possible because Rwanda Medical Supply (RMS) was still in the process of procuring and contracting an accredited laboratory to provide quality testing services. Consequently, quality assurance activities were limited to visual inspection and documentation review at the time of receipt.

6.5.1 Active drug-safety monitoring and management(aDSM)

Tuberculosis (TB) treatment requires the use of multiple medicines, including first-line regimens for drug-susceptible TB (DS-TB), second-line medicines for drug-resistant TB (DR-TB), and tuberculosis preventive treatment (TPT). Although these medicines are highly effective, they may cause adverse drug reactions (ADRs) that can affect treatment adherence, patient safety, and treatment outcomes. Active Drug Safety Monitoring and Management

(aDSM) is therefore an integral component of the National Tuberculosis Programme to ensure the early detection, documentation, reporting, assessment, and management of adverse events associated with TB treatment.

In Rwanda, aDSM is implemented in all health facilities providing TB services. Healthcare providers routinely assess patients for adverse events during treatment follow-up visits and are supposed to report the findings in both the electronic Tuberculosis surveillance system (eTB) and the Rwanda FDA pharmacovigilance reporting system (VigiMobile).

During FY 2025–2026, a total of 8,274 TB patients were registered for treatment. Of these, 6,913 patients (83.6%) had documented adverse event monitoring information in the eTB system, demonstrating good implementation of routine safety monitoring. Overall, 34 patients (0.41%) were reported to have experienced at least one adverse event during treatment.

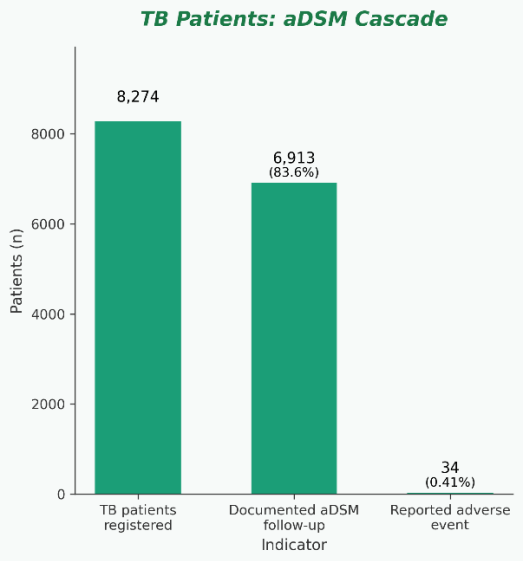


Figure 37. Coverage of active drug safety monitoring

Although relatively few patients experienced documented adverse events, maintaining high-quality monitoring remains essential to ensure timely identification and management of drug-related toxicities and to improve treatment outcomes.

6.5.2 Adverse Events Reported through the eTB System

A total of 118 adverse events were recorded in the eTB system during the reporting period. These events included both new adverse events reported among patients notified during FY 2025–2026 and follow-up of 28 adverse events from patients who had initiated treatment during FY 2024–2025. Consequently, the number of adverse events exceeds the number of patients with reported adverse events because individual patients may experience multiple events during treatment.

All reported adverse events were assigned a severity grade, resulting in 100% completeness of grading. Nearly half of the events (47%) were recorded as having an unknown severity grade, indicating the need to strengthen clinical assessment and documentation. Among events with documented severity, mild adverse events were the most common (29%), followed by moderate (14%), severe (7%), and life-threatening events (3%).

Table 10: Severity grading of adverse events reported in eTB

Grade of adverse event	DS-TB	DR-TB	Total	%
Unknown grade	53	3	56	47%
Mild	10	24	34	29%
Moderate	13	4	17	14%
Severe	5	3	8	7%
Life threatening	2	1	3	3%
TOTAL	**83**	**35**	**118**	**100%**

The most frequently reported adverse events included repeated vomiting (24%), neuropathy (19%), arthralgia (15%), depression (14%), dizziness (12%), skin rash (6%), jaundice (5%), loss of visual acuity (4%), and pale conjunctiva (2%). Severe and life-threatening events included hepatotoxicity, severe skin rash, dizziness, thrombocytopenia, persistent fever, and loss of visual acuity, all of which require prompt clinical intervention and close patient monitoring.

Table 11. Most frequently reported adverse events in eTB

Adverse drug reaction	cases	%
MDR - Vomiting repeatedly - Confirm	28	24%
Neuropathy - Confirm	22	19%
Arthralgia - Confirm	18	15%
MDR - Depression - Confirm	16	14%
Dizziness - Confirm	14	12%
Skin rash - Confirm	7	6%
Jaudnice - Confirm	6	5%
Loss of visual acuity - Confirm	5	4%
Pale conjonctiva - Confirm	2	2%
TOTAL	118	100%

6.5.3 Pharmacovigilance Reporting through VigiMobile

During FY 2025–2026, 36 Individual Case Safety Reports (ICSRs) related to anti-TB medicines were submitted through the Rwanda FDA VigiMobile system. These reports were generated through active pharmacovigilance activities involving systematic patient follow-up and proactive identification of suspected adverse drug reactions.

Most reports were associated with combination anti-TB regimens. The regimen containing Isoniazid and Rifapentine (3HP) accounted for the largest proportion of reports (38.9%), followed closely by the standard first-line regimen of Ethambutol, Isoniazid, Pyrazinamide, and Rifampicin (RHZE) at 36.1%. These findings reflect the widespread use of these regimens within both TB treatment and preventive therapy services.

Table 12. Anti-TB medicines associated with ADR reports in VigiMobile

Drug regimen	Cases	Percentage
Isoniazid; Rifapentine	14	38.9%
Ethambutol; Isoniazid; Pyrazinamide; Rifampicin	13	36.1%
Isoniazid;Rifampicin	3	8.3%
Isoniazid;Pyrazinamide;Rifampicin	2	5.6%
Isoniazid; Pyridoxine	2	5.6.%
Pyrazinamide	1	2.8%
Bedaquiline	1	2.8%

The drugs reported shows that treatment is heavily concentrated on two primary regimens, which together account for 75% of all entries. Specifically, the combination of Isoniazid and Rifapentine is the most frequently reported regimen, representing 38.9% (14 cases), closely followed by the standard 4 drug regimen of Ethambutol, Isoniazid, Pyrazinamide, and Rifampicin at 36.1% (13 cases). Other regimens appear significantly less often, including Isoniazid and Rifampicin at 8.3% (3 cases) and Isoniazid, Pyrazinamide, and Rifampicin at 5.6% (2 cases). The remaining entries consisting of single drugs like Pyrazinamide and Bedaquiline, specific add-ons like Isoniazid; Pyridoxine (with or without additional antibiotics), and broad categories each account for 2.8% (1 case each).

Across the 36 reports, a total of 55 adverse drug reactions were documented. Skin rash was the most frequently reported reaction (25%), followed by dizziness (16.7%) and vomiting (13.9%). The majority of ADRs were classified as non-serious (94.4%), while only two reports (5.6%) met the criteria for serious adverse reactions. Both serious cases were considered clinically significant, with one classified as life-threatening and another resulting in prolonged hospitalization.

Table 13. Summary of adverse drug reactions reported through VigiMobile

Indicator	Number	Percentage
ADR reports submitted	36	100%
Non-serious ADRs	34	94.4%
Serious ADRs	2	5.6%

Seriousness criteria

Criterion	Number	Percentage
Life threatening	1	2.8%
Caused/ prolonged hospital	1	2.8%

6.5.4 Summary and Programmatic Implications

The National TB Programme continues to strengthen pharmacovigilance through the complementary use of the eTB and VigiMobile systems. The high coverage of routine adverse event monitoring (83.6%) demonstrates substantial implementation of aDSM across health facilities. However, the high proportion of adverse events recorded with an unknown severity grade indicates the need to strengthen healthcare worker capacity in adverse event assessment, grading, and documentation.

Data from VigiMobile indicate that most reported adverse drug reactions were associated with commonly used first-line TB treatment and TB preventive treatment regimens, with skin rash, dizziness, and vomiting being the most frequently reported reactions. Although serious adverse reactions were uncommon, their occurrence highlights the importance of maintaining active pharmacovigilance, timely reporting to Rwanda FDA, and close clinical follow-up to ensure patient safety.

To further strengthen the national pharmacovigilance system, continued mentorship of healthcare providers, improved data quality, enhanced linkage between the eTB and VigiMobile systems, and regular review of safety data should remain priorities during the next reporting period.

CHAPTER 7: TUBERCULOSIS MONITORING, EVALUATION AND RESEARCH

7.1. Data review: Quarterly Data Quality Checking, Validation, and Performance Review

Quarterly Evaluation Meetings (QEMs) play a crucial role in ensuring health care data is accurate, complete, and sustainable. Since July 2019, the Tuberculosis Program has implemented the electronic TB (e-TB) case-based surveillance system to facilitate the collection, monitoring, and analysis of TB data. QEMs are held within one month following each quarter. The latest nationwide review for FY 2025–2026 aimed to enhance the accuracy, completeness, and reliability of TB and TB/HIV data reported by healthcare facilities. This review concentrated on rectifying discrepancies, addressing missing values, and improving the Rwanda DHIS2 dataset.

Significant challenges identified included inconsistencies in e-TB reporting, errors in data entry, missing values, and incomplete TB/HIV data. These factors compromised data reliability and hindered effective monitoring and response efforts. Additionally, there were obstacles such as limited access to rapid diagnostic tests like GeneXpert, and low TB detection rates across many health facilities.

To enhance data quality, several recommendations have been proposed: improve the accuracy and completeness of e-TB accuracy through prompt reporting from primary data sources; strengthen reporting practices and data collection by providing necessary tools while fostering accountability; and enhance monitoring of TB services via monthly coordination meetings coupled with regular reviews of data quality.

7.2. TB &ORD assessment (RSQA)

During FY 2025-2026, Rapid Service Quality Assessments (RSQA) and Data Quality Audits (DQA) were conducted throughout the West province in August 2025. The assessment involved utilizing the electronic individual case-based surveillance system as a reporting framework across all health facilities. The aim of RSQA is to assess the quality of TB services provided at these health facilities by examining various aspects such as supply chain

management, screening processes for TB, diagnostic procedures, treatment quality, and other control measures in place.

Table 14: Rapid Service Quality Assessments per selected indicators in Western Provinces, August 2025.

NA	Summary	%
1	Active drug safety monitoring and management (aDSM)	44%
2	Are algorithms for TB screening, TB diagnosis and TB treatment available and displayed in health facility	78%
3	Are rooms where TB services are provided well ventilated and Health workers personal protection existing and used?	72%
4	Are stocks of TB drugs and reagents well monitored	84%
5	Are TB diagnostics continuously functional (microscopy and GeneXpert) and their results available timely (microscopy, expert and culture)?	43%
6	Are TB monitoring tools existing, updated and well used; Supervisions and internal training conducted?	73%
7	Are TB patients early initiated on TB treatment and on ART (if indicated), and their bacteriological control performed according to guidelines	75%
8	Are there personnel trained on Practical Approach to Lung Health (PAL) strategy and PAL instruments available for use?	71%
9	Does TB infection control plan exist, implemented and its implementation monitored	63%
10	Does the BMI monitored for TB Patients and nutritional support provided to the eligible patients	73%
11	Is active case finding conducted in TB high risk groups?	33%
12	Is the general population informed on cough hygiene, coughing patients separated from others, health facilities workers screened for TB?	75%
13	Leprosy control	16%
14	TPT Implementation	70%
Average		62%

Several areas have been highlighted as needing enhancement. Key issues include frequent downtime GeneXpert machines, delays in samples transport for microscopy, and an inability to return results within the recommended turnaround time. Additionally, screening efforts among high-risk groups are limited. While some facilities have infection prevention and control (IPC) plans in place, these are often outdated or not actively monitored. The detection rates for leprosy remain low.

To address these concerns, recommendations should prioritize boosting active case finding among high-risk groups to facilitate early TB diagnosis and treatment. This can be achieved through regular screenings using recommended tools, such as GeneXpert and chest X-ray machines. Each health facility should update its infection control (IC) plans with clear performance indicators, and appoint a dedicated IC focal person to monitor implementation on a monthly basis. Furthermore, comprehensive leprosy control needs to be developed and put into action.

7.3. Digital Adherence Technology (DAT)

In FY 2025–2026, the TB&ORD Division continued to roll out Digital Adherence Technology (DAT) at selected high-burden health facilities to enhance adherence to TB treatment and minimize patients' loss to follow-up. The intervention aligns with WHO guidelines as well as Rwanda's National Strategic Plan (2024–2027). DAT employs mobile application, SMS reminders, and an online platform for real-time monitoring of patient adherence and timely follow-up by healthcare providers.

The program was implemented in 46 health facilities, where computers were distributed and healthcare personnel received training in patient registration, adherence tracking, and digital follow-up. However, the execution faced significant challenges during FY 2025–2026 due to interruptions in SMS services caused by insufficient prepaid SMS credits. Consequently, the DAT platform was not effectively utilized throughout this reporting period. Other challenges included delays in refresher training sessions, the lack of a dedicated budget for SMS services, and ongoing system upgrades.

To ensure sustainable application of DAT moving forward, it is recommended that dedicated funding for SMS services be secured alongside completing necessary system updates. Moreover, strengthening technical support while providing ongoing training and mentorship to healthcare workers is essential. Addressing these challenges will improve treatment adherence, reduce loss to follow-up, and enhance Rwanda's digital TB patient management system.

7.4. e-BUZIMA Implementation for Tuberculosis Services

The RBC support the implementation of e-BUZIMA, through its TB&ORD Division; this national electronic medical record (EMR) system aims to enhance the collection, storage, and utilization of patient specific health information ultimately supporting evidence-based clinical decision as well as programmatic choices. This digital health solution seeks to improve TB case management processes along with treatment monitoring and routine reporting activities.

A significant milestone achieved includes the successful completion of data elements within the TB module integrated into e-BUZIMA. This customized module features standardized outpatient consultation workflows complemented by improving processes for presumptive TB cases and laboratory services.

Despite these achievements, several challenges persist regarding full deployment across all health facilities. Constraints include inadequate computer infrastructure at certain sites as well as a continuous need for user training and mentorship efforts; additionally, enhancing interoperability between e-BUZIMA and other national digital health systems such as DHIS2 remains crucial. To facilitate effective implementation support moving forward, plans are underway within the TB&ORD Division to pilot the tailored TB module in five designated health facilities in Kigali during FY 2026–2027 before expanding it nationally.

7.5. Annual evaluation meeting with District Hospitals and stakeholders

An annual evaluation meeting took place aimed at sharing progress updates concerning achievements as well as challenges related to TB control effort in Rwanda throughout FY 2024-2025. It was conducted in November 2025 with 48 participants including RBC staff

along with TB provincial supervisors from various health facilities. In this evaluation meeting, the participants discussed challenges, including: poor data quality, the referral system for TB diagnosis, and community engagement.

To accelerate progress toward the NSP 2027 targets, the meeting recommended strengthening TB program implementation through improved data quality, enhanced laboratory systems, and integrated service delivery. Key priorities identified encompass enforcing comprehensive actions include enforcing complete real-time reporting capabilities within both e-TB and HMIS system, institutionalizing routine Data Quality Assessments; strengthening oversight at provincial/ district levels; expanding laboratory quality assurance practices including Drug Susceptibility Testing protocols; refining specimen referral systems methodologies; establishing consistent audits regarding TB mortality rates.

The meeting also recommended strengthening TB/HIV integration, improving nutrition support for TB patients, intensifying active case finding, enhancing contact tracing and TPT documentation, ensuring continuous availability of TB medicines and diagnostics, building the capacity of health workers and Community Health Workers, strengthening leprosy detection and surveillance, and promoting routine use of program data for planning, supervision, forecasting, and performance improvement.

7.6. Strengthening TB research, Innovation and implementation

The Rwanda National Tuberculosis (TB) Program, implemented through the Rwanda Biomedical Centre (RBC) TB & ORD Division, has made significant and accelerating progress in fostering a strong culture of operational research and evidence-based decision-making within the national TB response. A key achievement has been the promotion of routine programmatic data as a strategic resource for generating evidence to improve policy, planning, and program implementation.

To strengthen national research capacity, the TB Program has actively encouraged Master's students in Epidemiology at the University of Rwanda School of Public Health to use routine TB program data for their research projects. This collaboration has enhanced the use of high-quality programmatic data while supporting the development of the next generation of

public health researchers and ensuring that research findings directly inform TB program decision-making.

During FY2025–2026, the program also achieved important milestones in disseminating research findings internationally. Results generated from operational research were presented as posters at international scientific conferences and published in peer-reviewed international journals, increasing the visibility of Rwanda's TB program and contributing to the global evidence base on TB prevention, diagnosis, treatment, and program implementation.

This report presents the status of TB-related research projects and their implementation during the period from June 2025 to June 2026 (FY2025–2026), highlighting progress in strengthening operational research, building national research capacity, promoting data-driven decision-making, and disseminating evidence to improve TB control in Rwanda. Follow articles were published:

- Epidemiology and outcomes of multidrug-resistant tuberculosis in Rwanda:Ntwali J, Ndiaye R., Habimana Y., Sebatunzi O., Seruyange E., Migambi P., Rwabihama JP., Gallien S., Published in Infectious diseases Now 56(2026)105200. Link: https://www.sciencedirect.com/science/article/pii/S2666991925001794
- Survival and risk factors of mortality among TB/HIV co-infected patients: Didier Ndabana, Solange Nikwigize, Felix Murego, Jerome Ndayisenga, Patrick Migambi, Amanuel Kidane Andegiorgish. BMC Infect Dis 2026 Jun 5. doi: 10.1186/s12879-026-13744-2.Link: https://pubmed.ncbi.nlm.nih.gov/42249314/
- Key operational challenges at a programmatic level to achieve optimal use of the GeneXpert platform: I Cuella-Martin, F Hakizayezu, E Kamanzi, YM Habimana, P Migambi, BC de Jong, L Rigouts, JCS Ngabonziza IJTLD Open 2026 May 11;3(5):298–304. doi: 10.5588/ijtldopen.25.0630 PMCID: PMC13160268 PMID: 42125008
- Prevalence and Risk Factors of Latent Tuberculosis Infection in Rwanda, 2024: accepted oral presentation during The Union World Conference on Lung Health 2025 (UNIONCONF2025), (Abstract No. 2902)

In addition, one study related PBMC Sample Collection from TB patients for Evaluation of Targeted mRNA Vaccines conducted jointly implemented by the Rwanda Biomedical Center (RBC), Akagera Medicines, and the Center for Family Health Research (CFHR). The study aimed to collect Peripheral Blood Mononuclear Cell (PBMC) samples from adults with different latent tuberculosis infection (LTBI) profiles to support laboratory evaluation and development of targeted mRNA tuberculosis vaccines.preliminary findings highlight that;

A total of 73 participants attended the study site and completed the screening process. Following the eligibility assessment, 28 participants were enrolled in the TST+/IGRA– group, 23 in the TST–/IGRA– group, and 22 in the TST+/IGRA+ group. Overall, 70 participants successfully underwent PBMC blood sample collection, achieving the study objectives while ensuring high-quality specimen processing and storage.

Operational research funding continues to present a significant obstacle for the TB Program. It is essential to create a specific budget line within the cost NSP for 2026–2030 and to broaden co-financing opportunities with various RBC divisions, academic institutions, and development partners. A clear framework for prioritizing research, which considers disease burden, feasibility, cost-effectiveness, and alignment with End TB objectives, is necessary to direct evidence-based investments. Emphasis should be placed on research that tackles issues such as under-reporting, gaps in case detection, and gender-related mortality. Furthermore, an assessment of interoperability among digital platforms—including e-Buzima, CEMR, DataToCare, DAT, and iCLM—should guide the development of integrated and sustainable digital adherence solutions.

7.7. Capacity Building Activities Conducted During FY 2025–2026

During FY 2025–2026, the TB & Other Respiratory Diseases (TB & ORD) Division implemented a range of capacity-building initiatives, including mentorships, training, workshops, and technical meetings, to strengthen TB prevention, diagnosis, treatment, surveillance, and laboratory services. These activities targeted healthcare providers from public and private health facilities, laboratory personnel, community workers, and technical experts, contributing to improved quality of TB service delivery nationwide. The key activities conducted are summarized below:

- TB Death Audit Mentorship (7–11 July 2025): Mentorship conducted in 5 district hospitals and their catchment health facilities, reaching 36 health facilities.
- Childhood TB/HIV Mentorship (8–19 December 2025): Mentorship was conducted in 8 district hospitals to strengthen childhood TB detection and clinical management.
- Capacity-Building Training on TB Diagnosis and Clinical Management (December 2025) of healthcare providers from TB cold spots and low-coverage sectors.
- Training on TB Surveillance and Integration of TB Services in Private Clinics (22–24 December 2025): 51 healthcare providers from 21 private clinics to strengthen TB surveillance and reporting.
- TB Death Audit and Clinical Mentorship (3–13 February 2026): was conducted in 16 hospitals with high TB/HIV mortality and selected health.
- Childhood TB/HIV Mentorship (16–20 March 2026): was conducted in 10 district hospitals.
- Capacity Building on LF-LAM Diagnostics and Updated TB Diagnostic Algorithms (23 March–2 April 2026): 395 laboratory technicians and nurses from 13 districts attended the training.
- Mentorship for Integration of TB Services in Newly Accredited Private Clinics (11–22 May 2026): 19 newly accredited private clinics to support the integration of TB services into routine healthcare delivery were mentored.
- TB Sensitization, Refresher Training, and Active Case Finding in Refugee Camps (11–15 May 2026): A total of 692 peer educators were trained across six refugee camps.
- Workshop on Revision of the National TB Laboratory Testing Algorithm and Guidelines (June 2026)

7.8. National Strategic Plan (NSP)

7.8.1. NSP development, process and costing

The 2026–2030 National Tuberculosis and Other Respiratory Communicable Diseases Strategic Plan (NSP) was developed through a structured, evidence-informed, and

consultative process led by the TB&ORD Division. The process aimed to build on lessons learned from the extended 2019–2026 NSP while ensuring alignment with national health priorities, Rwanda Vision 2050, the National Strategy for Transformation, the WHO End TB Strategy, and global commitments toward TB elimination.

The process began in October 2025 with the establishment of a core team and the development of a roadmap. Between October 2025 and February 2026, the TB&ORD Division conducted a comprehensive desk review of the extended NSP. The review assessed progress against strategic objectives and targets, epidemiological trends, service delivery indicators, program performance, achievements, implementation gaps, and activities that were partially or not implemented. The findings were shared with stakeholders for validation and additional input.

In March 2026, a multisectoral workshop brought together stakeholders from TB, HIV, sexually transmitted infections, viral hepatitis, laboratory services, malaria, and other communicable disease programs. The workshop identified root causes of program gaps, formulated strategic objectives, and developed interventions in line with WHO guidance. Initial costing was conducted, and the cost estimates were revised to include additional inputs and to map potential funding sources. Care and treatment account for the largest share of the budget, followed by health system strengthening, program management, monitoring and evaluation, infection control, and drug-resistant TB management. However, final costing has not yet been concluded.

7.8.2. Challenges considerations during NSP development

Key challenges include limited access to WHO-recommended molecular diagnostics, inadequate sample transportation, suboptimal active case finding among high-risk and underserved populations, and gaps in infection prevention and control. Nutritional, psychosocial, and socioeconomic support for TB patients remains insufficient. Integration of TB services with HIV, NCD, mental health, and lung health program is also incomplete.

Other challenges include staff shortages, inconsistent community health worker incentives, limited private-sector participation, and underuse of digital data for program decision-making. Heavy reliance on external funding, estimated at 64%, remains a major sustainability risk. Domestic resource mobilization is limited, and TB services are only

partially covered by national health insurance. The absence of a formal Multisectoral Accountability Framework further limits coordinated participation across sectors.

7.8.3. NSP current status

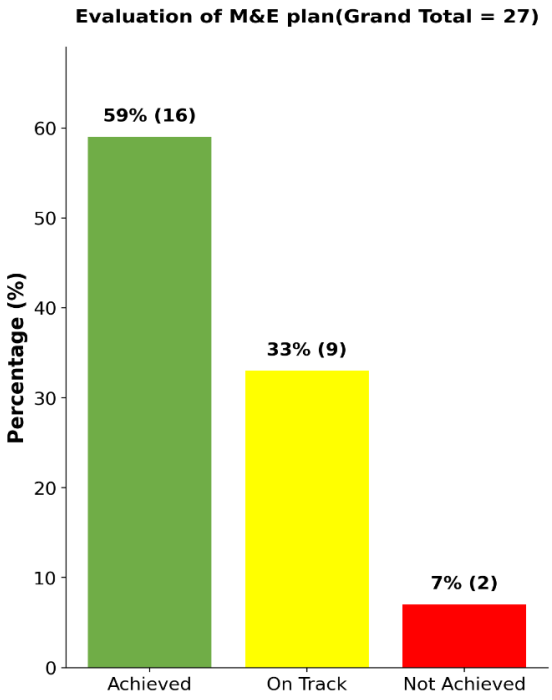
The draft NSP was circulated to key stakeholders in May 2026 for comprehensive review, and their feedback was incorporated into the document. Consensus was reached on its strategic direction, with a multisectoral workshop planned to endorse the final plan before implementation. The NSP establishes six strategic objectives focusing on TB case detection, treatment outcomes, integrated management of TB/HIV and other comorbidities, prevention, respiratory disease surveillance, and strengthened program management, accountability, research, and digital health systems.

7.8.4. Way Forward to implementation of NSP

The program should finalize and endorse the NSP, mobilize domestic resources, and integrate comprehensive TB services into health insurance and social protection schemes. Priority actions should include expanding rapid molecular diagnostics, strengthening active case finding and sample transportation, improving nutritional and psychosocial support, and integrating TB screening and care into HIV, NCD, mental health, and other relevant services. Digital interoperability, workforce capacity, community engagement, private-sector participation, multisectoral accountability, and routine performance monitoring should also be strengthened to support effective and sustainable implementation.

7.9. Evaluation of performance of indicators in M&E, 2025-2026 FY

Out of 32 total indicators tracked, 27 were evaluated for FY 2025/26; the remaining 5 indicators were not expected to be evaluated in FY 2025/26. Of the 27 indicators assessed, the TB & ORD program demonstrated strong overall performance during this period, with 16 indicators (59%) achieving a performance level of ≥100%, 9 indicators (33%) falling within the on-track range of 88%–99%, and only 2 indicators (7%) classified as not achieved, with performance levels between 61% and 80%.



CHAPTER 8: STRENGTHENING LEPROSY SURVEILLANCE AND RESPONSE

Leprosy control in Rwanda remains integrated across all levels of the healthcare system. The current national strategy focuses on strengthening local facilities and communities as a cornerstone for early case detection, prompt treatment initiation, comprehensive contact investigation, and the prevention of complications, stigma, and discrimination associated with Leprosy.

During the fiscal year 2025–2026, Rwanda continued to enhance its surveillance and response systems to support the national goal of eliminating leprosy by 2030. The Division implemented a programmatic shift that aims to strengthen health centres in endemic areas. This initiative enables these centres to take ownership of case-finding and contact tracing by building the capacity of healthcare providers and community health workers (CHWs). Furthermore, funds have been decentralised to these facilities to encourage a bottom-up approach to all leprosy-related activities. Under this new approach, the TB and Other Related Diseases (TB&ORD) Division will provide leadership, technical guidance, coordination, and oversight for leprosy prevention and control efforts. Special attention will also be given to improving electronic reporting systems, enhancing the quality of routine surveillance data, and exploring innovative tools to monitor progress toward interrupting transmission and achieving elimination.

8.1. Improve the leprosy surveillance system

Rwanda continued to implement standardised electronic case-based surveillance systems for leprosy cases and contacts, for routine reporting of new cases, disability assessments, treatment initiation, contact-tracing outcomes, and post-exposure prophylaxis (PEP) provision. Through routine supportive supervision, periodic data reviews, and remote technical support to health facilities, data quality was checked to allow corrective measures for improvement.

The Division explored the use of the Leprosy Elimination Monitoring Tool (LEMT) to track leprosy epidemiological trends in Rwanda. The TB&ORD Division, the Ministry of Health, Rwanda Biomedical Centre (RBC), and the WHO Rwanda Office conducted a joint review of the tool, followed by an exercise to review Leprosy data dating back to 2003 was captured in web-based trackers and harmonise it by capturing data previously recorded only on paper-

based tools. Additionally, the trackers lack data on the actual residence of the index case, limiting the ability to identify geographical transmission hotspots for detailed epidemiological analyses. Harmonised data and LMET use will strengthen village-level surveillance and be critical for identifying residual transmission hotspots and guiding targeted interventions.

Moreover, integrated into DHIS2, the LEMT will provide real-time monitoring dashboards and automated epidemiological analyses; however, looking at the data review performed across different years, with a focus on various indicator variables regarding notified new cases, Women, grade 2, and children under 15 years, there is a need to address inconsistencies that might arise when comparing current data and previous WHO reports. Rwanda submitted data for the WHO Global Leprosy Annual Report, 2025 in May 2026.

Rwanda continued to implement a standardized electronic case-based surveillance system for leprosy, enabling routine reporting of new cases, contact investigation outcomes, disability assessments, treatment initiation, and provision of post-exposure prophylaxis (PEP). Data quality was strengthened through regular supportive supervision, periodic data review meetings, and remote technical assistance provided to health facilities, contributing to improved completeness, accuracy, and timeliness of reporting.

In alignment with the Ministry of Health's recommendation on transition to a Full Paperless (Digital) Health System Effective 1st August 2026, the Division is exploring leveraging the e-Buzima for individual surveillance data for leprosy-affected persons and contacts. In the meantime, the division is still relying on paper-based tools, especially in zones where e-Buzima is not yet fully operational. Additionally, the HMIS reporting will be amended considering a decentralized new approach in health centers relative to the leprosy program, decreasing the workload on end users and improving captured data, especially on leprosy screening and skin conditions identified in the process.

8.2. Programmatic shifts in leprosy control strategies in endemic zones

Leprosy screening and case-finding in Rwanda have primarily utilised both passive and active approaches, yet there is a strong reliance on active case-finding campaigns, especially in endemic regions. From July 2021 to June 2026, 77.1% of the 109 new leprosy cases reported were identified through these campaigns. The Rwanda Biomedical Centre (RBC) typically spearheaded active case-finding (ACF) initiatives in partnership with hospitals and health

centres. Notably, 81% of the cases (68/84) were discovered through ACF campaigns, while only 19% (16/84) were identified by health centres, indicating a significant gap in local efforts to promptly detect leprosy cases and thus prevent complications associated with the disease. This gap has influenced leprosy trends. For instance, over the last this period 60.6% of new cases were multibacillary (MB) leprosy and 14.7% (16/109) presenting with grade 2 disabilities, suggesting a trend of late diagnosis. Additionally, during the same timeframe, children accounted for 9.2% (10/109) of new leprosy cases, while women comprised 50.5% (55/109), pointing to ongoing transmission within communities in endemic sectors. Passive screening has been conducted through outpatient consultations, where individuals with skin lesions or neurological symptoms indicative of leprosy undergo clinical evaluations. Active case-finding activities have been carried out in cooperation with health facilities, Community Health Workers (CHWs), local leaders, and community structures, focusing on historically endemic areas and locations that have reported cases in the previous decade.

To bridge the existing gaps in leprosy control, it is vital to develop strategies that promote the ownership of health centres and hospitals. This ownership should extend to all facets of leprosy control, including awareness campaigns, case-finding initiatives, contact tracing, and adequate data management, to enhance the overall effectiveness of leprosy interventions. The shift allocates main responsibilities in leprosy control to health facilities in endemic areas. This enhances healthcare providers' skills and raises community awareness.

The strategy requires transferring funds to facilities in endemic areas to organise and conduct ACF campaigns independently, to build capacity for focal persons and CHWs, and to provide psychosocial support to leprosy index cases and their families.

8.3. Leprosy screening and case-finding

Before transitioning to the program shift in leprosy control, the TB&ORD Division had already conducted active case-finding campaigns in August and September 2025 in endemic areas. Community sensitization was conducted through CHWs, local administrative structures, and former patients. Information, Education and Communication (IEC) materials were distributed to increase awareness and encourage early health-seeking behaviour.

This fiscal year 697 attended IEC sessions during case-finding campaigns; this was a decline from 1051 last fiscal year. 73.6% (513/697) of them were screened, leading to 187 presumptive

cases. After screening the presumptive cases, 8 leprosy cases were confirmed, accounting for 4.3% of presumed leprosy cases.

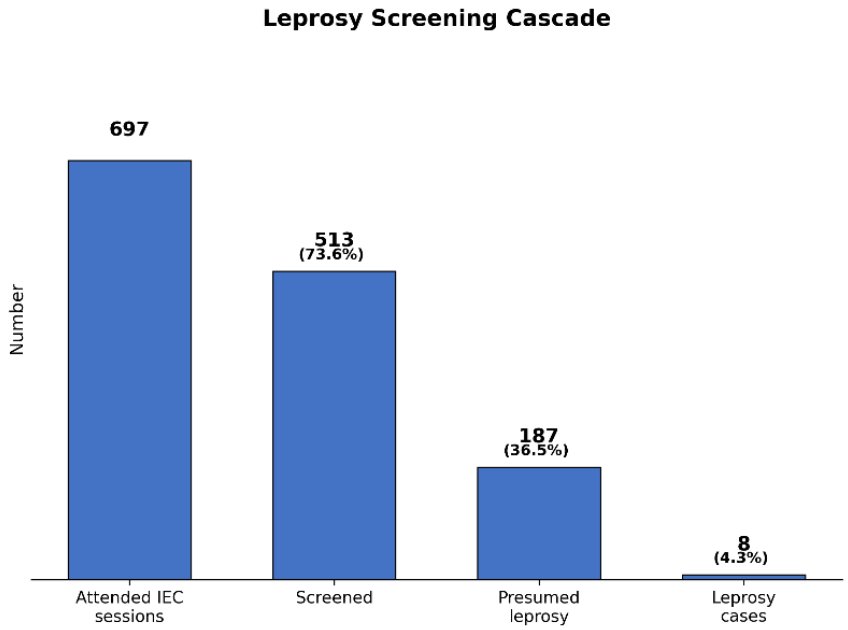


Figure 38. Leprosy screening and case-finding

8.4. Leprosy notification

During FY 2025–2026, a total of 15 leprosy cases were notified, including **10** (66.7%) new cases and 5 (33.3%) relapse cases, currently referred to as retreatment cases per WHO case definition. Among the new cases, 60% were women, 10% were children (0–14 years), and 70% were detected through active case finding (ACF), demonstrating the effectiveness of community-based screening. All new cases were assessed for disability at diagnosis (100%), with 20% presenting with Grade 1 disability and no Grade 2 disability (0%), indicating timely diagnosis before the development of complications. However, persistent notifications among children indicate ongoing community transmission, while the relatively high proportion of relapse cases warrants continued monitoring and investigation to identify underlying causes and strengthen post-treatment follow-up.

Table 15. Leprosy notification, FY 20 25-2026

LEPROSY CASES	MB	PB	Total
New cases (NC)			
# of new cases (NC)	4	6	10
# of children among new cases (0-14 years)	0	1	1
# of women among new cases	2	4	6
# of new cases detected during the active case finding campaign	5	2	7
# of new cases evaluated for their disability at Diagnosis	4	6	10
# with grade 1 disabilities	2	0	2
# of children with visible deformities (G2D)	0	0	0
# of all-new cases with visible deformities (G2D)	0	0	0
# of foreign-born new cases notified in Rwanda for less than 15 years at the time of diagnosis	0	0	0
Retreatment cases			
# of relapses	5	0	5
# of retreatment after default	0	0	0
Total cases	**9**	**6**	**15**

8.5. Leprosy treatment outcome

MB cases from the 2023-2024 cohort and PB cases of the 2024-2025 cohort treatment and disability outcomes were assessed. Overall, 97% (32/33) of MB and PB leprosy-affected persons completed treatment.

The 2023–2024 cohort had 14 new and 7 retreatments (relapse and Retreatment after default) MB cases; of them, 95.2%(20/21) completed the treatment. One new MB patient was not evaluated because he was an Eritrean refugee from Gashora transit centre who was resettled to Europe on treatment and lost communication with Gashora HC. All PB cases, regardless of their treatment history, completed their MDT courses.

The programme will continue to strengthen adherence monitoring, patient support, psychosocial counselling, and follow-up, particularly for MB patients who require longer treatment duration, to further reduce treatment interruption and achieve optimal outcomes.

Table 16: Leprosy treatment outcome cohort July 2023-June 2024 for MB and July 2024 to June 2025 for PB cases

Treatment outcomes	New cases		Relapses		Retreatment after default	
	MB	PB	MB	PB	MB	PB
Number of registered cases	14	10	3	0	4	2
Completed Treatment	13	10	3	0	4	2
Lost to follow-up	0	0	0	0	0	0
Death	0	0	0	0	0	0
Non evaluated	1	0	0	0	0	0
Treatment success rate	**93%**	**100%**	**100%**	**0%**	**100%**	**100%**
Number of patients having developed leprosy reactions during treatment	0	0	0	0	0	0
Number and proportion of patients assessed for disability at least both at the beginning and end of treatment	**13**	**10**	**3**	**0**	**4**	**2**
	93%	**100%**	**100%**	**0%**	**100%**	**100%**
Number of patients having developed new disabilities during treatment	**0**	**0**	**0**	**0**	**0**	**0**

8.6. Disability Assessment — Beginning vs. End of Treatment

For every patient with a recorded disability grade at both the beginning and end of treatment, this cross-tabulates the starting grade against the ending grade -- i.e. of everyone who started at Grade 1, how many ended at Grade 0 (improved), stayed at Grade 1, or worsened to Grade 2. Built separately for Multibacillary (cohort: 2023-2024) and Paucibacillary (cohort: 2024-2025), consistent with the cohort convention used throughout this program's reporting.

Table 17: Disability Grade Transition, Multibacillary Cohort (2023-2024)

Multibacillary: Grade at Beginning \ at End	Grade 0	Grade 1	Grade 2	Total
Grade 0	10	0	0	10
Grade 1	5	0	0	5
Grade 2	2	2	2	6
Total	17	2	2	21

Table 18. Disability Grade Transition, Paucibacillary Cohort (2024-2025)

Paucibacillary: Grade at Beginning \ at End	Grade 0	Grade 1	Grade 2	Total
Grade 0	10	0	0	10
Grade 1	1	1	0	2
Grade 2	0	0	0	0
Total	11	1	0	12

Figure 39. Disability Grade Transition, Beginning vs End of Treatment (Both Cohorts)

All patients who started at Grade 0 in both cohorts remained at Grade 0; no new nerve damage developed during treatment. All 5 Multibacillary patients who started at Grade 1 fully reversed to Grade 0. Among the 6 Multibacillary patients who started at Grade 2, 2 fully reversed to Grade 0, 2 partially improved to Grade 1, and 2 remained unchanged; none worsened. The Paucibacillary cohort had no Grade 2 patients at baseline, consistent with the typically milder presentation of Paucibacillary disease. The full Grade-2-to-Grade-0 reversals warrant clinical review of the underlying assessments, since Grade 2 (visible deformity) is generally the least reversible category; these could reflect genuine recovery or inter-assessor grading variability. The most robust finding across both cohorts is that no patient worsened during treatment, indicating that active monitoring is successfully preventing disability progression.

8.6. Contact tracing and post-exposure chemoprophylaxis

Contact investigation remains a principal strategy for interrupting leprosy transmission.

For every newly diagnosed index case, household and close-contact are investigated for leprosy. Contacts are screened for signs and symptoms of leprosy and offered Single Dose Rifampicin (SDR) as post-exposure prophylaxis in case leprosy and TB are ruled out, in accordance with national guidelines. Consenting contacts are then enrolled in the program, receive PEP, and are reviewed at least once a year for 5 years to evaluate any development of Leprosy symptoms.

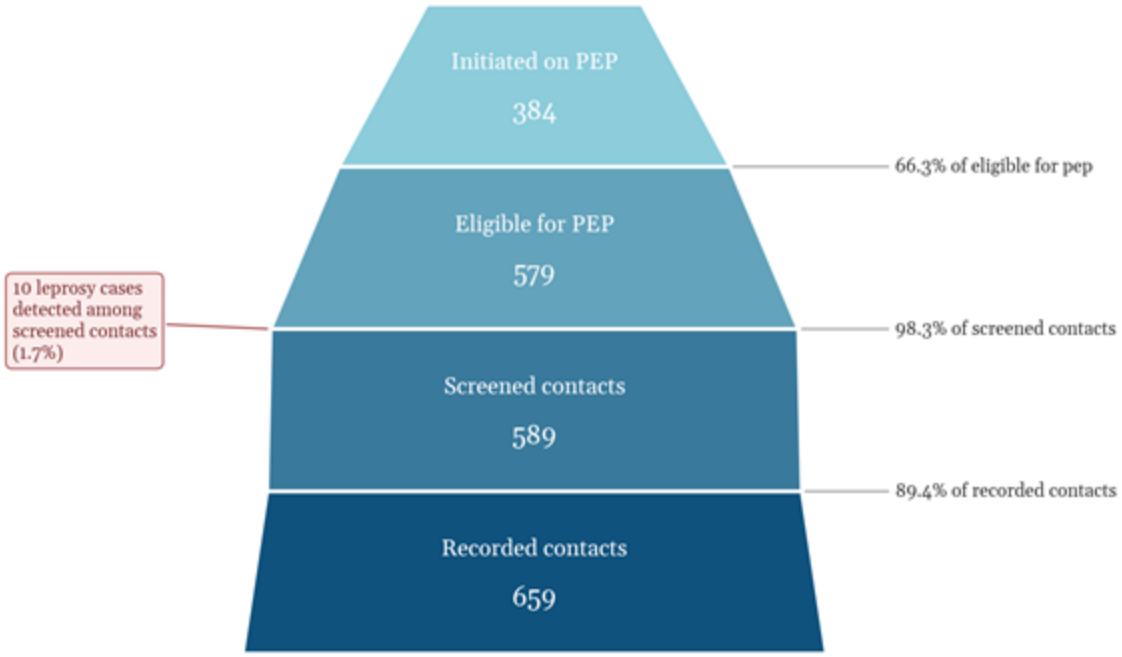


Figure 40. Household Contact Screening to PEP Cascade (Cumulative from July 2021 to June 2026)

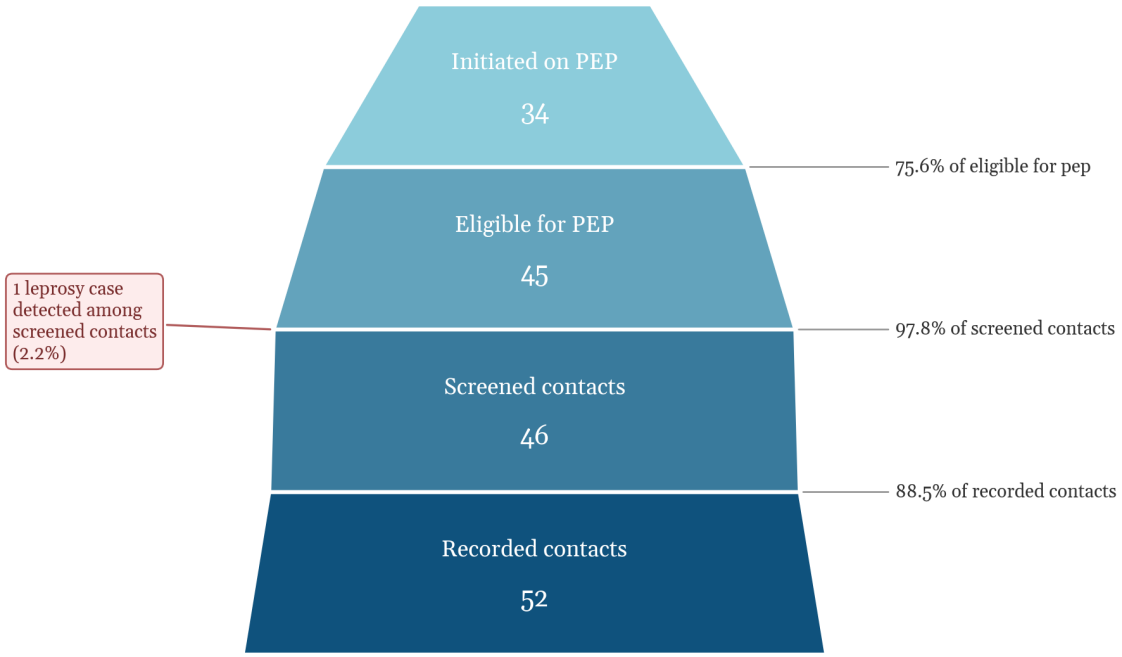


Figure 41. Household Contact Screening to PEP Cascade from July 2025 to June 2026)

From the 2021-2022 fiscal year, 659 leprosy contacts were registered, 89% of them have been screened for leprosy and yielded 10 leprosy cases, accounting for almost 1.7% of all screened contacts, which means that 579 contacts were eligible for PEP. Of them 66.3% have been initiated on PEP.

This fiscal year, 88% of 52 leprosy contacts were registered and had an initial assessment, and among them, one leprosy case was diagnosed, meaning that 45 of 46 screened contacts were eligible for PEP. So far, 75.6% of them have been initiated on PEP. Future contact tracing and case-finding campaigns should aim to optimise contact screening and PEP initiation for every eligible contact.

8.7. Healthcare Providers' Mentorship on Leprosy, Contact Tracing, and Post-Exposure Prophylaxis (PEP)

Capacity building will reach Gisagara District (Gishubi HC), Ngoma District (Jarama HC), and Bugesera District (Nzangwa HC). Thus, ensuring continuous and sustainable implementation of the bottom-up approach.

The programmatic shift implementation in leprosy necessitates adequate skills for all involved professionals. Health care providers should have a good understanding of leprosy, physical examination to diagnose leprosy and other skin and communication skills allowing them to diagnose leprosy and conduct

Capacity building remained a key component of Rwanda's leprosy elimination strategy during FY 2025–2026. Healthcare providers received mentorship on leprosy diagnosis and classification, contact tracing and household investigation, disability assessment and prevention, multidrug therapy (MDT) management, post-exposure prophylaxis using single-dose rifampicin (SDR-PEP), and the use of electronic reporting and surveillance tools.

In addition to health facilities, the approach will enhance district-level authorities' understanding, ownership and involvement in leprosy-related activities. An annual budget of 6,163,201 RWF was allocated to the activity of conducting community–based leprosy active case finding (ACF) by health centres with endemic zones in their catchment areas and leprosy

contact tracing for every leprosy index case by health centres with endemic zones in their catchment areas. For the subsequent years, facilities in endemic areas will request funds every quarter subject to justification of previously received funds with financial supporting documents and narrative activity reports in a standardised reporting format.

All health facilities in leprosy-endemic areas have at least one CHW trained on leprosy and other skin NTDs per village in their respective catchment areas. During this FY, an additional CHW per village was trained to increase the pool of CHWs capable of assisting facilities with case-finding and contact tracing in Rusizi District; however, given financial constraints, this year's capacity-building was conducted in Rusizi District.

179 CHWs and 5 CEHO from Nyabitimbo HC, Gikundamvura HC, Bugarama (Rusizi) HC, Bugarama Islamic and Nyakabuye HC were trained to recognise leprosy, raise community awareness and conduct active case-finding and contact tracing. Additionally, 5 focal persons were trained on leprosy screening, management and prevention. A supplementary one-week mentorship was also organised for all trainees to apply their skills and knowledge in alignment with their responsibilities in leprosy control. Moreover, more emphasis was placed on M&E tools, including web-based trackers, especially the contact tracker, as it was underutilised. During this mentorship, CHWs reached 26,780 of 31,323 households in the selected catchment areas, bringing in 204 with skin patches; of them, 152 were presumed to have leprosy, leading to 2 new and 2 retreatment leprosy cases.

CHAPTER 9: FINANCING THE NSP TB

9.1. Introduction

The TB National Strategic Plan (NSP) is a key instrument to guide TB control work in Rwanda in accordance with the most recent World Health Organization (WHO) international guidance.

The major funding sources for the Rwanda TB programs are:

- Government Revenues
- Development Partners contributions through General and Sector Budget Support and Donor funds, partially on budget as seen in the development budget, and partially earmarked and project related. These include the Global Fund for HIV & AIDS, TB and Malaria, and US Government (USG).

9.2. Funding Sources for TB Expenditures in Rwanda FY 2025-2026

The Ministry of Health and the Rwanda Biomedical Center in collaboration with its partners worked on the design and development of the Health Resource Tracking Tool (HRTT), where all health sector actors (Government institutions and development partners) report on a periodic basis. The system is designed to collect expenditures and budgets on a quarterly and annual basis.

To facilitate the collection of financial information for this year's report, a separate data collection process was adopted using SMART IFMIS (Integrated Financial Management Information System) for Global Fund grant and Government contribution.

9.3. Public and external funding sources for TB NSF

The Global Fund for AIDS, TB and Malaria (GFATM) contributed USD 3,988,044; the GoR contributed USD 2,652,747 to give a total budget of USD 6,640,791 for fiscal year 2025-2026

The TB/NSP total spending amounted to USD 6,539,395 represents 98% as follows: Global Fund spent USD 3,842,194 representing 96% of total budget; GoR expenditures were USD2,697,201 representing 102% of planned budget for Fiscal year 2025-2026.

Table 19: Source of Fund for TB NSP for the Financial Year 2025-2026

Source of fund	Approved budget for FY 2025-2026 in USD	Revised budget for FY 2025-2026 in USD	Expenditures for FY 2025-2026 in USD	Balance for FY 2025-2026 in USD	Budget execution rate in%
Global Fund for AIDS, TB and Malaria (GFATM)	3,988,044	3,988,044	3,842,194	145,850	96%
GoR	2,518,241	2,652,747	2,697,201	-44,454	102%
Total	**6,506,285**	**6,640,791**	**6,539,395**	**101,396**	**98%**

9.3. 1. Government contribution to TB National Strategic Plan

Methodology used to estimate the GOR allocations to various health programs

The GoR funds are allocated to different health programs during the annual planning and budgeting process, which entails prioritization process by the Ministry, RBC and decentralized levels basing on HSSP III and different disease program strategic plans serve as guiding documents.

A part from program specific financing, the estimation of GoR contribution takes into consideration all other health related programs costs, categorized as health systems strengthening costs in the MTEF Chapter of Compensation of employees; Use of Goods & Services; Subsidies; Grants; Social assistance; Other expenditures; Inventory, Building and structures, and Machinery and equipment.

Table 20: GoR TB NSP budget and expenditure per MTEF chapter for the year ended 30 June 2026

MTEF chap	Approved budget for FY 2025-2026 in USD	Revised budget for FY 2025-2026 in USD	Actual expenditures for FY 2025-2026 in USD	Balance in USD	Performance in %
21 Compensation of employees	1,520,388	1,546,792	1,516,992	29,800	98%
22 Use of goods and services	376,905	439,612	564,981	-125,369	129%
25 Subsides	40,263	58,783	65,021	-6,238	111%
26 Grants	100,193	126,968	123,205	3,764	97%
27 Social assistance	121,917	121,442	112,268	9,173	92%
28 Other expenditures	25,126	20,018	17,402	2,617	87%
33 Inventory	7,003	9,524	9,524	0	100%
36 Building and Structures	68,189	94,968	31,017	63,951	33%
37 Machinery and Equipment	258,256	234,640	256,791	-22,151	109%
Total	**2,518,241**	**2,652,747**	**2,697,201**	**-44,454**	**102%**

As the table above shows for FY 2025-2026, the GoR is contributing to TB Program the total budget of USD 2,652,747 with TB Expenditures by MTEF budget category of USD 2,697,201 representing 102 % of total budget planned for financial year 2025-2026.

The type of MTEF Chapter with the highest budget ceiling is Compensation of employees with USD 1,546,792; Use of goods and services with USD 439,612 and Machinery and equipment for USD 234,640.

The expenditures were respectively USD 1,516,992 for Compensation of employees, USD 564,981 for Use of goods and services and USD 256,791 for machinery and equipment.

Table 21: GoR TB NSP budget and expenditure per Budget agencies for the year ended 30 June 2026

Budget Agency	Budget for FY 2025-2026 in USD	Revised budget for FY 2025-2026 in USD	Actual expenditures in USD	Balance in USD	Performance rate in %
CHUB	86,670	93,329	93,329	0	100%
CHUK	122,025	149,847	149,847	0	100%

Districts	1,172,325	1,120,315	1,073,910	46,404	96%
HNN	27,611	44,685	54,413	-9,728	122%
MINISANTE	417,940	463,163	510,283	-47,120	110%
RBC	539,673	619,253	651,160	-31,907	105%
RMH	93,859	108,266	108,266	0	100%
RWANDA FDA	58,138	53,889	55,991	-2,102	104%
Total	**2,518,241**	**2,652,747**	**2,697,201**	**-44,454**	**102%**

As reflected in the table below, the GoR budget per budget agencies is USD 2,652,747 whereas the expenditure is USD 2,697,201.

The type of budget agencies with the highest budget ceiling is Districts hospitals with USD 1,120,315; RBC with USD 619,253 and Ministry of Health with USD 463,163.
The expenditures were respectively USD 1,073,910 for Districts, USD 651,160 for RBC and USD 510,283 for Ministry of Health.

9.3.2 The Global Fund contribution

For the Global Fund contribution, the budget for the year 2025–2026 was USD 3,988,044 out of this budget, a total of USD 3,842,194 have been effectively spent by Global Fund per MTEF Chapter representing 96 % of total budget for RBF TB grant.

Table 22: GF TB NSP budget and expenditure per MTEF Chapter for Fiscal Year 2025-2026

MTEF Chapter	Approved Budget for FY 2025-2026 in USD	Actual expenditures FY 2025-2026 in USD	Variance end June 2025 in USD	Performance rate in %
22 Use of goods and services	2,941,637	2,924,061	17,576	99%
26 Grants	638,950	660,609	-21,660	103%
27 Social assistance	60,805	38,382	22,423	63%
28 Other expenditures	346,652	219,143	127,510	63%
Total	**3,988,044**	**3,842,194**	**145,850**	**96%**

The type of MTEF Chapter with the highest budget ceiling is Use of goods and services with USD 2,941,637 and Grants transfer with USD 638,950. The expenditures were respectively USD 2,924,061 for Use of goods and services and USD 660,609 for Grants transfer.

Table 23: GF TB NSP budget and expenditure per Budget agencies for Financial Year 2025-2026

Budget Agency	Approved budget for FY 2025-2026 in USD	Expenditures for FY 2025-2026 in USD	Variance in USD end June 2026	Performance in %
CHUB	27,920	28,467	-548	102%
CHUK	27,920	28,467	-548	102%
MOH	351,698	364,023	-12,326	104%
RBC	3,580,506	3,421,237	159,271	96%
Total	**3,988,044**	**3,842,194**	**145,850**	**96%**

As reflected in the table below, the approved budget is USD 3,988,044 whereas the expenditure is USD 3,842,194. The type of budget agencies with the highest budget ceiling is Rwanda Bio Medical Centre with USD 3,580,506 and Ministry of Health with USD 351,698. The expenditures were respectively USD 3,421,237 for RBC and USD 364,023 for Ministry of Health.

CHAPTER 10: CONCLUSION

Rwanda's TB & ORD Division demonstrated sustained progress across the TB and leprosy response during FY 2025–2026, while continuing to identify targeted areas for programmatic strengthening. TB screening and diagnostic services advanced through expanded molecular testing, sputum pooling, TB-LAM, and DST, supported by laboratory quality assurance performance.

TB notification stabilised at 8,274 cases, aligning with the plateau seen since the post-COVID surge. Notably, case-finding among high-risk groups reached 73.7% and pediatric cases accounted for 14%, both exceeding targets. However, the contribution of CHWs was 24.1%, just short of the 25% target. Additionally, there was a concerning 29.2% decline in drug-resistant TB (DR-TB) notifications, which calls for further trend analysis and optimal use of DST coverage.

Strong tuberculosis preventive treatment coverage with 99% for children under five, 95% for contacts aged five and above, and 99.1% for people living with HIV (PLHIV) on ART. A promising pilot for TPT in correctional facilities was also noted; however, coverage among newly initiated ART patients was only 73.6%, and there are ongoing gaps in infection control in certain sub-districts.

Access to treatment was uninterrupted and treatment outcomes remained robust overall, with success rates exceeding targets and a consistent decline in mortality. Nonetheless, there is a need for targeted follow-up and support for TB/HIV co-infected patients, those with extra-pulmonary TB, adult men, and malnourished individuals, inclusive of nutritional support and adherence interventions. Health promotion initiatives led by peer educators and Youth Ambassadors bolstered community-based screening, adherence, and referrals.

In the leprosy programme, progress is being made toward the 2030 elimination target with a focus on facility-owned, community-based detection methods, which have resulted in strong treatment completion rates and minimal disability progression. However, challenges such as surveillance data quality, the initiation of post-exposure prophylaxis (PEP), and the limited geographical expansion of services need ongoing attention. Financially, the programme displayed robust performance with a budget utilisation rate of 98% for the fiscal year.

These combined results highlight the resilience and effectiveness of Rwanda's TB and leprosy initiatives. Yet, there's a clear need for continuous mentorship, supportive supervision, improved data systems, and targeted resource allocation to address the existing gaps in community case-finding, enhance diagnostic capabilities, and ensure comprehensive coverage for high-risk populations as Rwanda moves toward its elimination goals.

Appendix

ANNEXES 1: TB Indicators in Monitoring and evaluation framework, from July 2025 to June 2026.

Indicator	2025/26 (Target)	2025/26 (performance)	level of performance	status
TB notification rate new and relapses (per 100,000)	44/100K	57%	130%	Achieved
TB treatment coverage (End TB Top-ten indicator N° 1)	95%	89%	94%	On Track
Contact investigation coverage (End TB Top-Ten N°6)	95%	99%	104%	Achieved
Proportion of TB cases notified among high-risk groups (HRGs(Number and Percentage)	55%	74%	134%	Achieved
The proportion of eligible malnourished DS TB patients (BMI<18.5) who have accessed appropriate nutrition support	90%	57%	64%	Not Achieved
Proportion of children 0-14 years notified among TB cases new and relapse	7.5%	14%	187%	Achieved
Proportion of newly notified patients diagnosed using WHO recommended rapid tests (End TB Top-Ten N°4)	75%	72%	96%	On Track
DST Coverage for TB patients (End TB Top-Ten indicator N° 7)	85%	95%	112%	Achieved
Proportion of notified patients with rifampicin resistant (RR) or MDR who receive second line DST	100%	100%	100%	Achieved
Proportion of health facilities diagnostic sites scoring pass in EQA for smear microscopy	95%	77%	81%	Not Achieved
Proportion of health facilities Xpert sites scoring pass in EQA for Xpert MTB/RIF	88%	79%	90%	On Track
Treatment success rate (TSR) for all forms of TB cases (DS & DR-TB cases) (End TB Top-ten 2)	90%	91%	101%	Achieved
Percentage of CDT with no stock out of FL tracers (RHZE and RH ad) drugs of experienced in the last 12 months	100%	100%	100%	Achieved
Percentage of MDR TB centers with no stock out of SLD in the last 12 months	99.5%	100%	101%	Achieved
Proportion of eligible PLHIV initiated on TPT	94%	99%	105%	Achieved
Treatment success rate, confirmed RR/MDR-TB	93%	92%	98%	On Track
Treatment coverage new drugs (End TB Top-ten indicator N°8)	100%	100%	100%	Achieved
Proportion of TB treatment cards where ADSM section is completed	95%	84%	88%	On Track
Proportion of diagnosed TB cases tested for HIV infection (End TB Top-ten indicator N°9)	98%	100%	102%	Achieved
Proportion of HIV positive TB cases given antiretroviral therapy during TB treatment	96%	95%	99%	On Track
Treatment success rate for TB patients (all forms) receiving DOT through community health workers (CHW)	96%	95%	99%	On Track
Percentage of Health providers screened for TB at least once during the year. (health facility workers)	85%	86%	101%	Achieved
LTBI treatment coverage among contacts < 5 years (End TB Top-ten indicator N°5)	90%	99%	110%	Achieved
LTBI treatment coverage among contacts > 5 years	83%	95%	114%	Achieved
Proportion of TB cases (all forms) referred by community health volunteers during the evaluated year.	25%	24%	96%	On Track
eTB coverage in CDT and CT proxy of Timeliness of routine reporting	80%	78%	98%	On Track
Case fatality ratio (CFR) (End TB Top-ten indicator N° 10)	<5%	4.7%	106%	Achieved
Proportion of first level health facilities that have at least one staff trained to provide PAL services	90%		N/A	N/A
Number of standard criteria met using WHO TB standard and benchmarks checklist			N/A	N/A
Proportion of public health facilities where at least one staff has participated in training on TB			N/A	N/A
Percentage of people diagnosed with TB who report stigma in health care settings that inhibited them from seeking and accessing TB services			N/A	N/A
Percentage of population with adequate knowledge* on TB symptoms, transmission and prevention			N/A	N/A

ANNEXES 2: RBF Achievement, from July 2025 to June 2026

Coverage/Output Indicator	RBF Target 2025-2026 %	Program Results 2025-2026 N# / D#	Program Results 2025-2026 %	Level of Achievement
TBDT-1 Number of patients with all forms of TB notified (bacteriologically confirmed + clinically diagnosed); "includes only those with new and relapse TB	5,961	8108		100%*
TBDT-2 Treatment success rate (all forms): Percentage of patients with all forms of TB, bacteriologically confirmed plus clinically diagnosed, successfully treated (cured + treatment completed) among all TB patients notified during a specified period; includes only those with new and relapse TB	90.0%	7282 / 8026	90.7%	100.8%
TBDT-1 Other 4: Proportion of TB cases notified in high-risk groups among all TB cases	55.0%	6105 / 8274	73.8%	134%
TBP-1 other 5: TPT coverage among contacts >5 years	84.0%	1220 / 1279	95.4%	114%
TBT/HIV-6 Percentage of HIV-positive new and relapse TB patients on ART during TB treatment	96.0%	1019 / 1072	95.1%	99%
DRTB-9 Treatment success rate of RR-TB and/or MDR-TB: Percentage of patients with RR and/or MDR-TB successfully treated	93.0%	44 / 48	91.7%	99%
TBDT-4 Percentage of new and relapse TB patients tested using WHO recommended rapid diagnostic tests at the time of diagnosis	75.0%	5840 / 8108	72.0%	96%

ANNEXES 3: Leprosy Monitoring and evaluation indicators, from July 2025 to June 2026

No	Indicator	2022-2023		2023-2024		2024-2025		2025-2026	
		Target	Achievement	Target	Achievement	Target	Achievement	Target	Achievement
	Population		**13,372,596**		**13,797,269**		**13,951,765**		**14,714,043**
1	Number of children diagnosed with leprosy and visible deformities (G2D)	0	0	0	0	0	0	0	0
2	Rate of newly diagnosed leprosy patients with visible deformities (G2D)	0,3 per milli	0,9 per million	0,3 per millio	0.29 per million	0,3 per millio	0.28 per million	0,3 per million	0 per million
3	Availability of webbased, casebased reporting system allowing disaggregation by age, sex, place of residence and other relevant criteria	juil-21	Yes	juil-21	Yes	juil-21	Yes	juil-21	Yes
4	Percentage of endemic health facilities that have had at least 2 supervisory visits from district hospital in the reporting year	100%	100%	100%	100%	100%	100%	100%	50%
5	WHO certification of leprosy elimination in Rwanda (prevalence < 1 case per 10.000 habitants)	juil-21	No	juil-21	No	juil-21	No	juil-21	No
6	New case detection (number and rate per 100000)	27	12	27	29	27	28	27	10
		(0,20)	0,09/100,000	(0,20)	0,21/100,000	(0,20)	0.2/100,000	(0,20)	0.07/100,000
7	Leprosy prevalence rate per 10000.		12		29		28		30
		0,014	0,01 per 1000(	0,014	0,02 per 10000	0,014	0,02 per 10000	0,014	0,02 per 10000
8	Proportion of G2D cases among total new cases detected.	≤ 12%	8.3% (1/12)	≤ 12%	14% (4/29)	≤ 12%	14% (4/28)	≤ 12%	0% (0/10)
9	Proportion of child cases among total new cases detected.	5%	0.0% (0/12)	5%	0.0% (0/29)	5%	17.9% (5/28)	5%	10% (1/10)
10	Proportion of MB cases among total new cases detected.	38%	66.7% (8/12)	38%	44.8% (13/29)	38%	64.30%	38%	40%
11	Proportion of female cases among total new cases detected.	> 45%	50% (6/12)	> 45%	55.20%	> 45%	46.4% (13/28)	> 45%	60% (6/10)
12	Proportion of contacts screened.	85%	85.7% (72/84)	85%	75% (382/509)	85%	92.3% (72/78)	85%	88.5% (46/52)
13	Proportion of foreignborn among total new cases detected	0	0	0	7% (2/29)	0	4% (1/28)	0	0% (0/10)
14	MDT completion for new PB	> 95%	71% (5/7)	> 95%	80% (4/5)	> 95%	93.3% (14/15)	> 95%	100% (12/12)
15	MDT completion for new MB	> 95%	100% (9/9)	> 95%	96% (22/23)	> 95%	62.5% (5/8)	> 95%	95.2% (20/21)
16	Proportion of new PB patients assessed for disability status at least both at beginning and at end of treatment	> 90%	71% (5/7)	> 90%	80% (4/5)	> 90%	93.3% (14/15)	> 90%	100% (12/12)
17	Proportion of new MB patients assessed for disability status at least both at beginning and at end of treatment	> 90%	100%(11/11)	> 90%	96% (22/23)	> 90%	62.5% (5/8)	> 90%	95.2% (20/21)
18	Number and proportion of new PB patients who have developed new disabilities during the course of treatment	0	0(0%)	0	0(0%)	0	0(0%)	0	0(0%)
19	Number and proportion of new MB patients who have developed new disabilities during the course of treatment	≤ 1 case	0 case (0%)	≤ 1 case	0 case (0%)	≤ 1 case	0 case (0%)	≤ 1 case	0 case (0%)
20	Number of cases treated (new and retreatment) having developed leprosy reactions during treatment	≤ 3 cases	0 case	≤ 3 cases	0 case	≤ 3 cases	0 case	≤ 3 cases	1 case
21	Number and proportion of retreatment cases over the total leprosy cases notified	≤ 10%	7.7 % (1/13)	≤ 10%	22 % (8/37)	≤ 10%	28 % (11/39)	≤ 10%	33.3 % (5/15)
22	Existence of an association of patients affected by leprosy in the endemic sectors	(2/8)	(2/8)	(2/8)	(2/8)	(2/8)	(2/8)	(2/8)	(2/8)