Republic of Rwanda
Ministry of Health

Rwanda Biomedical Centre
Healthy People, Wealthy Nation

PUBLIC HEALTH SURVEILLANCE & EMERGENCY PREPAREDNESS AND RESPONSE (PHS&EPR) DIVISION

ANNUAL REPORT 2025/2026

October 2026

Foreword

Protecting communities from epidemics and other public health emergencies remains central to Rwanda's health priorities. The Public Health Surveillance and Emergency Preparedness and Response (PHS&EPR) Division Annual Report for FY 2025/26 presents the progress made toward this goal through the collective efforts of the Division's technical units: Surveillance, Outbreak Preparedness and Response, One Health, Avian and Other Highly Pathogenic Diseases, and Food and Waterborne Disease.

The past year tested Rwanda's health security on several fronts, from a cross-border Ebola (Bundibugyo) threat to outbreaks of Rift Valley Fever, measles, and foodborne illness. The Division's response, anchored in integrated disease surveillance, a functional One Health coordination mechanism, and sustained investment in the disease-detecting workforce, reflects the dedication and shared commitment of the PHS&EPR Division and its partners in safeguarding public health. These accomplishments are guided by the International Health Regulations (2005) and the Fifth Health Sector Strategic Plan (HSSP V), marking a deliberate shift from emergency-driven action toward sustained preparedness and operational readiness.

I extend my sincere gratitude to all collaborating institutions, national and local authorities, hospitals, health centers, laboratories, rapid response teams, points-of-entry staff, and Community Health Workers and to our development partners, One Health sectors, the private sector, and civil society organizations for their vital contributions. I also thank the staff of the Division's units and our partners, whose engagement made this report possible.

As we move forward, I call upon all stakeholders to take note of the recommendations outlined in this report and to support the implementation of planned interventions in FY 2026/27, including strengthening routine surveillance, laboratory capacity, cross-border coordination, and pre-outbreak preparedness. The Rwanda Biomedical Centre remains committed to providing the leadership and coordination necessary to achieve our strategic objectives. Together, let us continue to strengthen Rwanda's health system and accelerate the early detection, prevention, and control of epidemics and other public health emergencies.

For,

Prof. MUVUNYI Mambo Claude
Director General
Rwanda Biomedical Centre



Digitally signed by RBC(Deputy Director General)

Acknowledgement

The Public Health Surveillance and Emergency Preparedness and Response (PHS&EPR) Division of the Rwanda Biomedical Centre (RBC), Ministry of Health is pleased to present its Annual Report for FY 2025/26. This report reflects the collective effort of many individuals and institutions whose commitment to protecting the health of Rwandans made both the year's achievements and this document possible.

We express our sincere gratitude to the Ministry of Health and the Rwanda Biomedical Centre for their leadership, strategic direction, and sustained investment in disease surveillance, outbreak preparedness, and emergency response. We are equally indebted to the district health offices, health facility managers, laboratory personnel, and the frontline healthcare and community health workers who detect, report, and respond to public health events each day. Their vigilance is the foundation of the surveillance and response system and of the evidence presented here.

The results described in this report were achieved through a strong One Health partnership spanning the human, animal, and environmental health sectors. We gratefully acknowledge the technical and financial support of the World Health Organization (WHO), Africa CDC, and the U.S. Centers for Disease Control and Prevention (US CDC), together with UNICEF and the International Organization for Migration (IOM). We further thank our implementing and academic partners Jhpiego, the Clinton Health Access Initiative (CHAI), ICAP at Columbia University, the African Field Epidemiology Network (AFENET), WaterAid, the Health Development Initiative (HDI), CIIC-HIN, and the University of Rwanda whose collaboration strengthened surveillance, workforce capacity, laboratory systems, risk communication, and outbreak response throughout the year.

Finally, we commend the technical units of the PHS&EPR Division, whose expertise, dedication, and teamwork produced this report. To everyone who contributed, directly or indirectly, we extend our heartfelt appreciation. Together, we continue to advance a resilient, well-prepared, and responsive health system that safeguards every person in Rwanda.

PHS&EPR Division, Rwanda Biomedical Centre

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ACRONYMS

Abbreviation	Meaning
AR	Attack Rate
BDBV	Bundibugyo ebolavirus
CBS	Community-Based Surveillance
CDC	Centers for Disease Control and Prevention
CEBS	Community Event-Based Surveillance
CEHO	Community Environmental Health Officer
CFR	Case Fatality Rate
CHW	Community Health Worker
COVID-19	Coronavirus Disease 2019
cVDPV2	circulating Vaccine-Derived Poliovirus type 2
DRC	Democratic Republic of the Congo
eIDSR	electronic Integrated Disease Surveillance and Response
EVD	Ebola Virus Disease
FAO	Food and Agriculture Organization of the United Nations
FELTP	Field Epidemiology and Laboratory Training Programme
HSSP V	Fifth Health Sector Strategic Plan
IEC	Information, Education and Communication
IgM	Immunoglobulin M
IHR	International Health Regulations
IMS	Incident Management System
IPC	Infection Prevention and Control
IPV	Inactivated Poliovirus Vaccine
MoH	Ministry of Health
MR (MR1/MR2)	Measles–Rubella vaccine (first/second dose)
OPD	Outpatient Department

Abbreviation	Meaning
PHEOC	Public Health Emergency Operations Centre
PHS&EPR	Public Health Surveillance and Emergency Preparedness and Response
PoE	Point of Entry
PPE	Personal Protective Equipment
RAB	Rwanda Agriculture and Animal Resources Development Board
RBC	Rwanda Biomedical Centre
RCCE	Risk Communication and Community Engagement
RRT	Rapid Response Team
RT-PCR	Reverse-Transcription Polymerase Chain Reaction
RVF	Rift Valley Fever
SAMU	Service d'Aide Médicale Urgente (pre-hospital emergency service)
SIMEX	Simulation Exercise
TD	Tetanus–Diphtheria vaccine
TTX	Tabletop Exercise
VHF	Viral Haemorrhagic Fever
VPD	Vaccine-Preventable Disease
WHO	World Health Organization
7-1-7	Detect within 7 days, notify within 1 day, respond within 7 days

Executive Summary

During Fiscal Year 2025/26, the Public Health Surveillance and Emergency Preparedness and Response (PHS&EPR) Division sustained a robust national system for detecting, preventing and responding to epidemics and other public health emergencies, in line with the International Health Regulations (2005) and the Fifth Health Sector Strategic Plan (HSSP V). Through the electronic Integrated Disease Surveillance and Response (eIDSR) system, it monitored 44 priority diseases, events and conditions daily across all public and private facilities.

National weekly reporting completeness averaged about 99% and timeliness about 95%, both above the 80% target, and case-based timeliness for immediately reportable diseases improved to 86% by the final quarter. Community event-based surveillance through Impuruza received about 1,081 signals, though signal triage needs strengthening.

A multi-district measles outbreak recorded 3,023 confirmed cases and 14 deaths, concentrated in Kigali City, the Eastern Province and the South, and amplified by facility-based transmission. A Rift Valley Fever outbreak centred on Ngoma comprised 432 confirmed human cases (44 deaths; CFR 10.2%) and 1,251 animal cases, and was contained through a One Health response, including over 2.3 million livestock vaccine doses, vector control and risk communication. Cholera, foodborne illness (about 1,320 cases) and seasonal influenza were managed.

Rwanda's key health-security test was the cross-border threat from the 2026 Bundibugyo ebolavirus (BDBV) outbreak in the Democratic Republic of the Congo and Uganda. Preparedness enrolled over 500,000 high-risk travellers in digital follow-up and investigated 3,266 suspected cases, all negative for Ebola and Marburg, with no confirmed importation. Simulations, training of over 3,200 health workers and 88 new Field Epidemiology and Laboratory Training Programme enrolees reinforced readiness. Rwanda maintained polio-free status, achieved 90% tetanus–diphtheria coverage, and measles–rubella coverage of 95% (MR1) and 91% (MR2), with ten districts below the 95% target.

In March 2026, the Rwanda Agriculture and Animal Resources Development Board and Rwanda Biomedical Centre, with Mission Rabies and WAG Rwanda, conducted Rwanda's first systematic mass dog vaccination in Kanombe, Masaka and Rusororo sectors, vaccinating 1,868 dogs and 65 cats by door-to-door and roaming static-point methods. Only 13 vaccinated dogs were unowned, while 41% roam and 72% are unsterilised, making sterilisation and owner education priorities.

The year demonstrated the strength of Rwanda's integrated One Health approach to health security. Priorities for FY 2026/27 include sustaining reporting quality, strengthening early-response triggers, closing immunity and preparedness gaps, scaling systematic dog vaccination, and integrating emergency capacities into routine systems.

1. Introduction

1.1 Program Overview

The Public Health Surveillance and Emergency Preparedness and Response (PHS&EPR) Division plays a cross-cutting role in the surveillance of, and response to, high-priority diseases and other public health emergencies in Rwanda, working through the Integrated Disease Surveillance and Response (IDSR) strategy, a regional framework for strengthening national surveillance and response.

Its vision is a Rwandan population free from epidemic-prone diseases and other public health emergencies, and its mission is to detect early, prevent, and control such emergencies through the IDSR system. Under its mandate, the Division creates, maintains, and strengthens routine surveillance, detection, and epidemiological investigation and response systems, and expands them in preparedness for and response to incidents of public health significance.

1.2 Structure of the PHS&EPR Division

The PHS&EPR Division carries out its mandate through five technical units: Surveillance, Outbreak Preparedness and Response, Avian Flu and Other Highly Pathogenic Diseases, Food and Waterborne Disease, and One Health. Surveillance operates at community, health facility, and point-of-entry levels, while the Public Health Emergency Operations Centre (PHEOC) coordinates emergency operations and the Field Epidemiology Training Programme (FETP) strengthens the disease detective workforce. The chart below illustrates how these units and functions are interconnected.

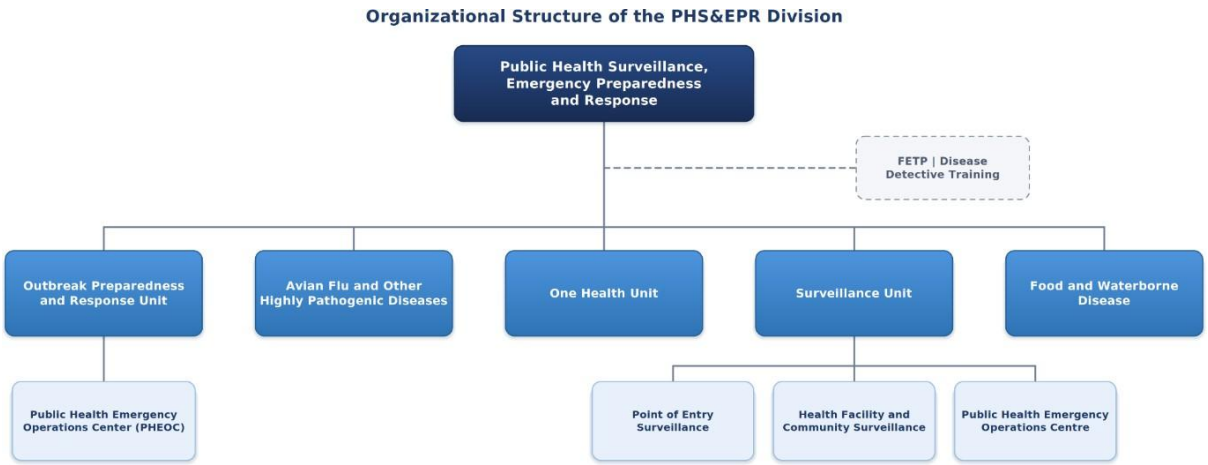


Figure 1: PHS&EPR Structure Framework

1.3 Annual Report Development Process

Based on the annual action plan, each unit documented its implemented activities describing the objectives, key achievements, outcomes, challenges, and recommendations which were then compiled into this annual report of the PHS&EPR Division.

2. Surveillance of Diseases

2.1 The eIDSR Reports Completeness and Timeliness

Both indicators show strong, consistent performance well above the 80% target threshold throughout the full 53-week period (2025W27 through 2026W27). The data reflects a well-functioning reporting system: completeness is essentially flawless, and timeliness, while slightly more variable, remains consistently strong with only one minor dip worth a closer look if you want to understand what happened around week 14 of 2026.

2.1.1 Average weekly completeness

Completeness is exceptionally stable, holding steady at roughly 99–100% every single week with no dips or volatility. This indicates that reporting sites are reliably submitting their reports week after week, making completeness essentially a non-issue for this reporting cycle (Figure 2).

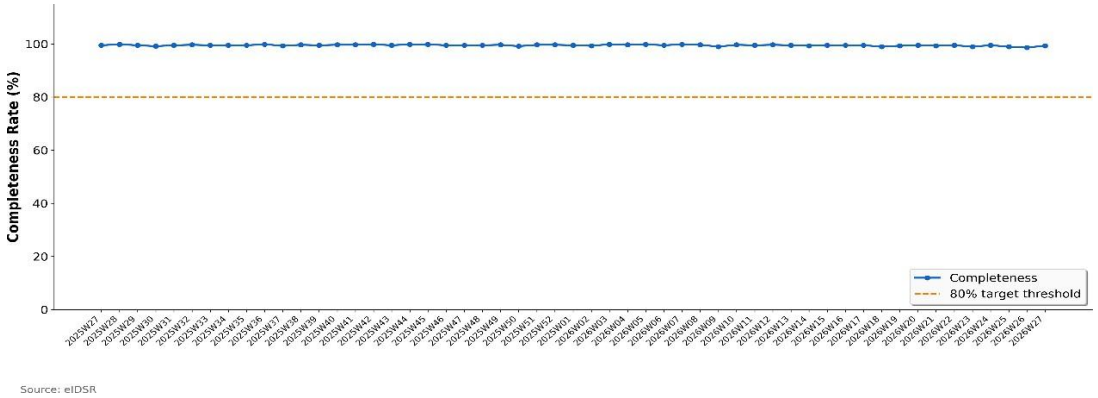


Figure 2: Weekly completeness of the national eIDSR surveillance system, FY 2025/2026

2.1.2 Average weekly timeliness

Timeliness is also solidly above target, but shows more natural week-to-week fluctuation, generally ranging between 94% and 98%. One notable dip occurs around week 2026W14, where the rate drops to approximately 91%, the lowest point across the entire year. Even so, this dip remains well above the 80% threshold, and the metric quickly recovers to its normal range in the following weeks (Figure

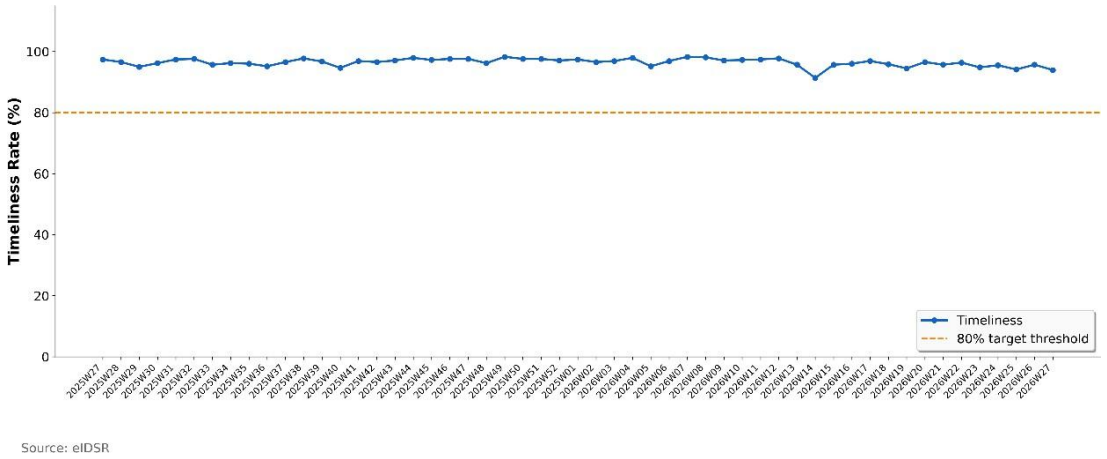


Figure 3: Weekly timeliness of the national eIDSR surveillance system, FY 2025/2026.

2.1.3 Case-Based Surveillance of Immediately Reportable Diseases

Performance of case-based surveillance for immediately reportable diseases is assessed against three core dimensions reporting timeliness, case-file completeness and laboratory investigation. The three figures below show quarterly suspected-case volumes alongside each indicator for 2025-Q3 to 2026-Q2. Suspected-case volumes rose over the year (2,417; 3,087; 2,112; and 5,619 respectively), totalling about 13,235 cases.

Completeness

Figure 4 plots quarterly suspected cases against the proportion of case files that were well completed. Completeness improved steadily across the four quarters, from 13.8% to 37.8%, but remained low throughout. While the system is capturing a growing number of cases rising to 5,619 in 2026-Q2, the quality and completeness of case documentation still require substantial strengthening. The average CBS completeness was 22.9% (2,753/12,016), indicating substantial missing data. Mandatory fields and validation rules should be introduced.

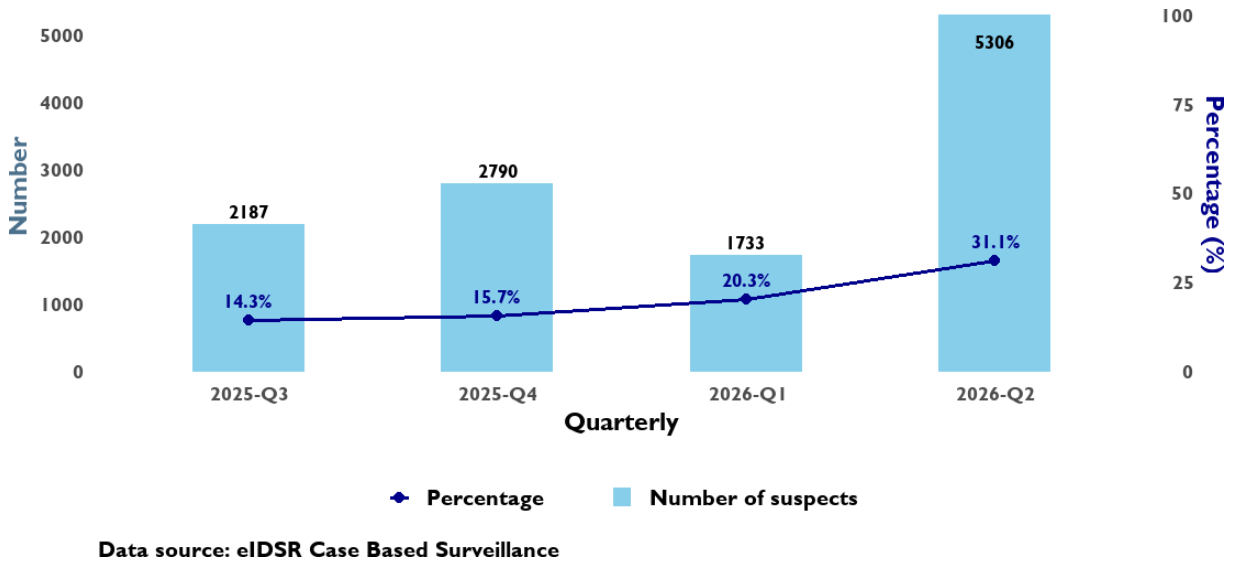


Figure 4: Immediately reportable disease cases and case-file completeness rate, by quarter, Rwanda (2025-Q3 - 2026-Q2).

Timeliness

Figure 5 plots the same quarterly case volumes against the proportion of cases reported within 24 hours. Timeliness was consistently high, holding around 77-78% through the first three quarters and rising to 86.1% in 2026-Q2. Prompt notification within 24 hours was therefore a clear strength of the system, in contrast to the lower completeness seen in Figure 4. The average timeliness was 81.2% (10,741/13,235) of cases were reported within 24 hours. Automated overdue alerts, facility-level timeliness dashboards, and regular feedback to reporting sites should be strengthened.

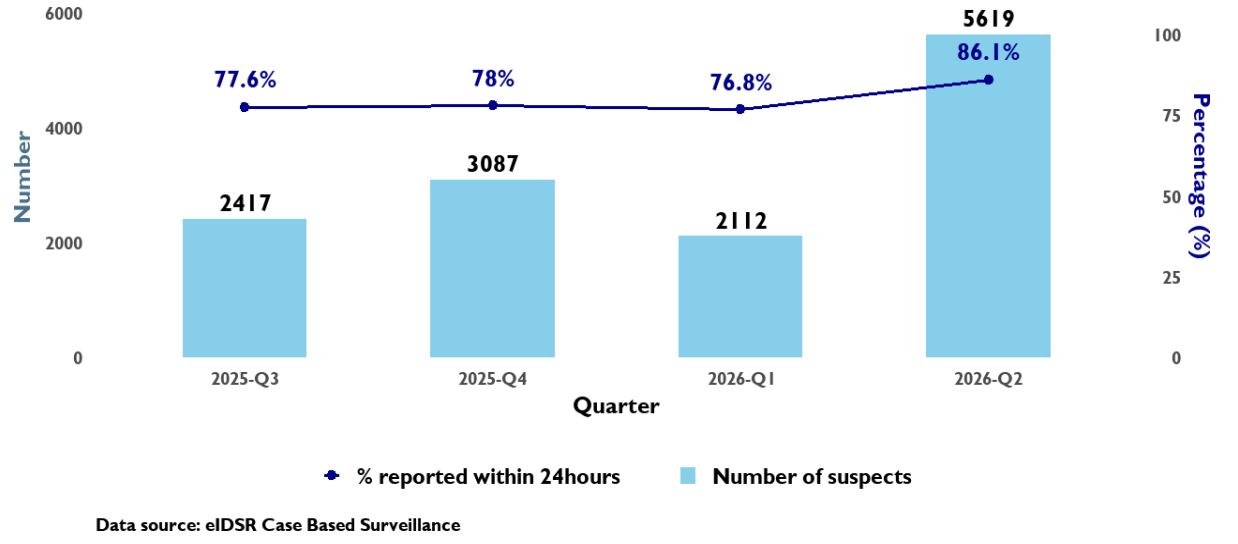


Figure 5: Immediately reportable disease cases and timely (within-24-hour) reporting rate, by quarter, Rwanda (2025-Q3 – 2026-Q2).

Lab requests completeness

Figure 6 plots the quarterly number of suspected cases requiring laboratory confirmation against the proportion for which a laboratory investigation was requested. The laboratory-request rate rose from 74.1% in 2025-Q3 to a peak of 85.9% in 2026-Q1, then fell to 66.9% in 2026-Q2 as the number of cases requiring confirmation more than doubled to 2,140. The drop in the final quarter suggests that laboratory-request coverage came under pressure during the surge in caseload, underlining the need to sustain diagnostic capacity and specimen referral during high-volume periods. The average Laboratory requesting 75.4% (4,213/5,584) of eligible cases had samples collected. Conditional mandatory fields and validation rules should ensure laboratory follow-up.

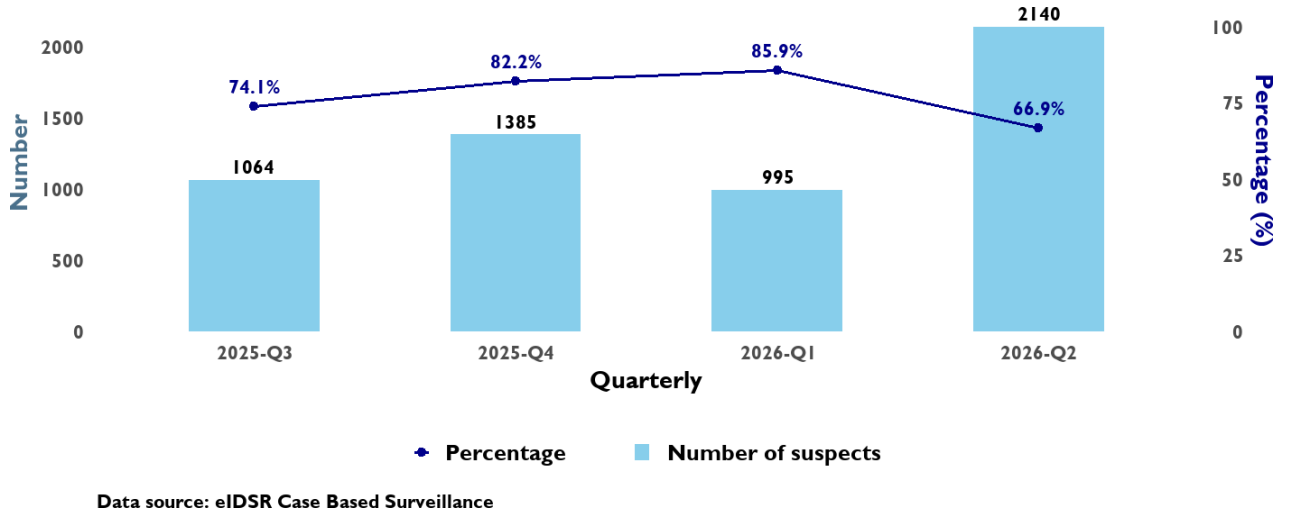


Figure 6: Immediately reportable disease cases requiring laboratory confirmation and laboratory-request rate, by quarter, Rwanda (2025-Q3 – 2026-Q2).

2.2 Surveillance of non-epidemic prone diseases

The Division monitors 8 non-epidemic prone diseases, events and conditions daily through the electronic Integrated Disease Surveillance and Response (eIDSR) system. The figures below present, for selected priority conditions, the weekly number of reported cases (solid blue line) plotted against the corresponding alert/action threshold (dashed red line), from week 27 of 2025 (early July) to week 27 of 2026 (late June). Reading observed counts against the threshold allows the Division to separate expected seasonal variation from unusual increases that warrant investigation and response.

Figure 7 presents the weekly trend of influenza-like illness (flu syndrome). Weekly counts held at a stable baseline of roughly 10,000 from July to early November 2025, then rose sharply from week 45, briefly breaching the threshold and peaking at about 24,300 cases in week 48 (late November 2025). After a short dip, a second, slightly higher peak of about 24,700 cases occurred in early January 2026 (week 4), consistent with the cool dry-season influenza period. Cases then declined steadily,

returning close to baseline (about 10,500) by June 2026. The threshold was exceeded only briefly during the November - December surge, indicating that the seasonal wave was detected early and did not sustain epidemic levels.

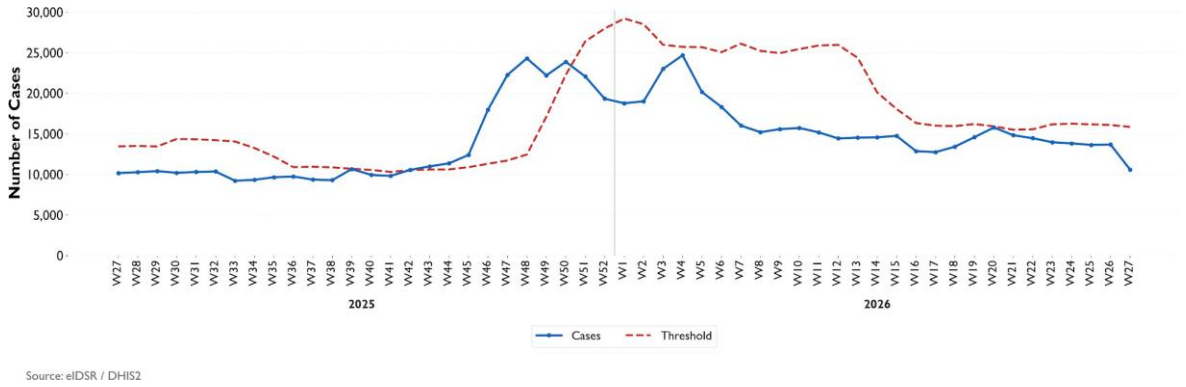


Figure 7: Weekly trend of flu syndrome (influenza-like illness), Rwanda (weeks 27/2025 – 27/2026).

Figure 8 shows the weekly trend of uncomplicated (simple) malaria. Cases followed a marked seasonal pattern: a low baseline of 6,000 - 9,000 per week through mid-September 2025, a rise from week 38 to a first peak of about 23,800 cases in week 43 and a second peak of about 23,000 in week 46 (October - November 2025), during which counts exceeded the threshold. Thereafter cases fell rapidly, dropping below the threshold from December 2025 and continuing a sustained decline to roughly 1,500 per week by June 2026. The curve reflects the post-rainy-season transmission peak followed by a strong, sustained reduction in the malaria burden over the second half of the year.

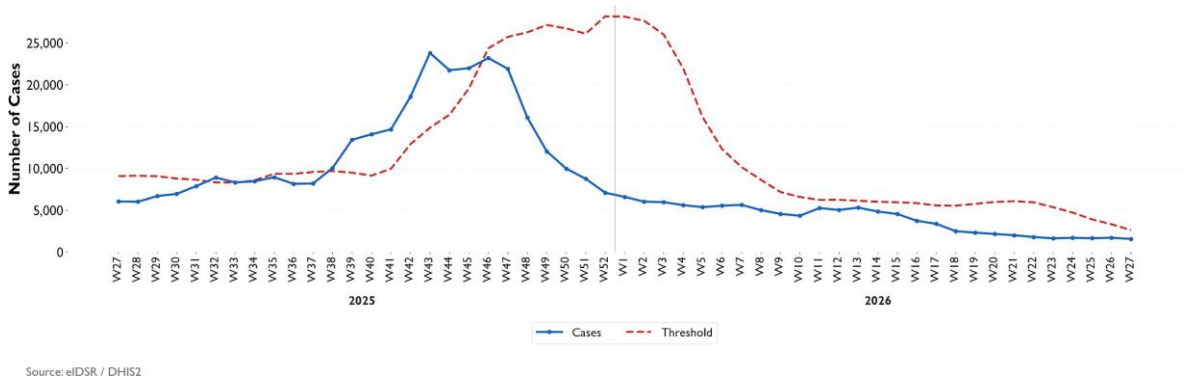


Figure 8: Weekly trend of simple malaria, Rwanda (weeks 27/2025 - 27/2026).

Figure 9 depicts the weekly trend of severe pneumonia in children under five years. From a low of about 200 - 300 cases per week between July and October 2025, cases rose gradually from week 42 and remained elevated through 2026, oscillating between roughly 430 and 630 per week. Counts tracked closely to the threshold and exceeded it on several occasions in the first half of 2026 (notably weeks 5, 14 and 20 - 22) before dropping sharply at the end of the period. The pattern is consistent with the expected seasonal rise in childhood respiratory infection during the cooler, wetter months

and underscores the continuing need for early case detection and management in this vulnerable age group.

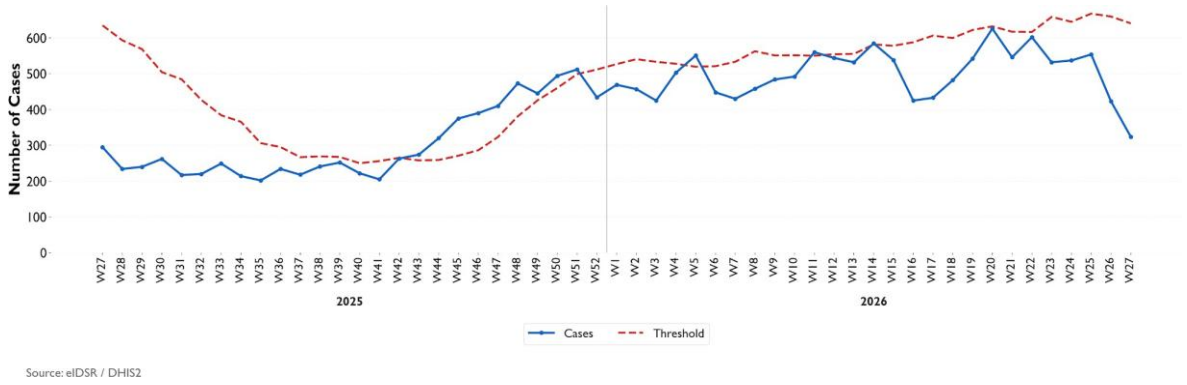


Figure 9: Weekly trend of severe pneumonia in children under five years, Rwanda (weeks 27/2025 – 27/2026).

Figure 10 shows the weekly trend of rabies exposure (dog and other mammal bites). Reported exposures were highly variable from week to week, ranging from about 48 to 115 cases, and generally remained below the threshold throughout the year, with only occasional weeks approaching it. The absence of a defined seasonal peak, combined with a persistent weekly burden of 50 - 100 exposures, points to an ongoing, year-round risk of potential rabies transmission and a continuous demand for post-exposure prophylaxis and One Health–coordinated animal-bite management.

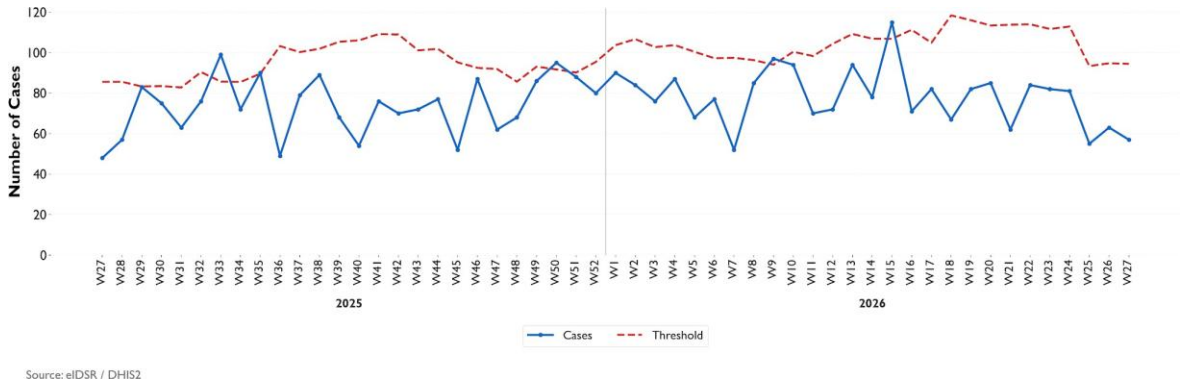


Figure 10: Weekly trend of rabies exposure (dog and other mammal bites), Rwanda (weeks 27/2025 - 27/2026).

Figure 11 presents the weekly trend of non-bloody diarrhea in children under five years. Weekly counts ranged from about 2,200 to 3,900 cases, peaking between September and December 2025 (roughly 3,600 - 3,900) and easing gradually through 2026 to around 2,700 - 2,900 before a drop at the end of the period. Cases stayed at or just below the threshold for essentially the whole year, indicating a stable, endemic diarrheal burden in young children without epidemic escalation, while still representing a substantial routine caseload for water, sanitation and hygiene and case-management efforts.

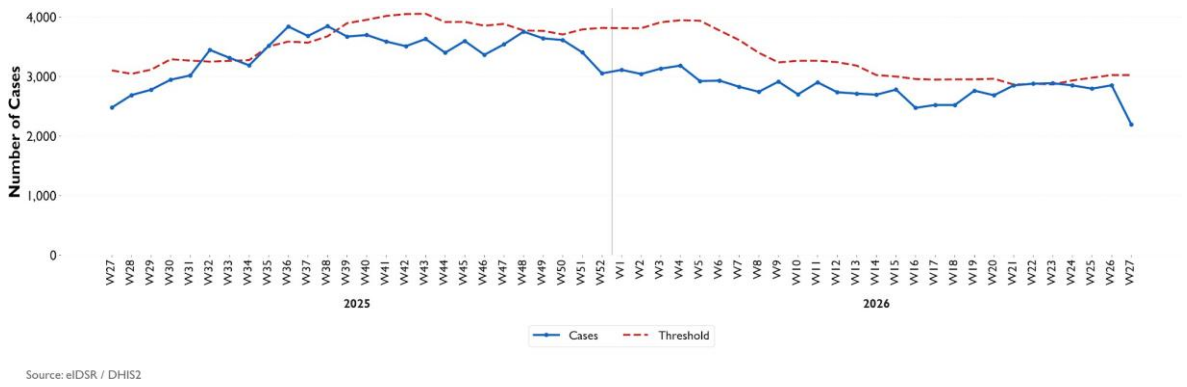


Figure 11: Weekly trend of non-bloody diarrhea in children under five years, Rwanda (weeks 27/2025 - 27/2026).

Figure 12 shows the weekly trend of COVID-19. Reported cases remained very low throughout the year (generally fewer than 20 per week), while the threshold fell sharply during the first quarter as the epidemiological baseline declined. Case counts stayed well below the threshold across all weeks, with only small isolated increases (for example around week 40 of 2025 and weeks 13, 18 and 23 of 2026). The pattern is consistent with COVID-19 having settled into a low-level, quiescent phase requiring continued but routine surveillance rather than active outbreak response.

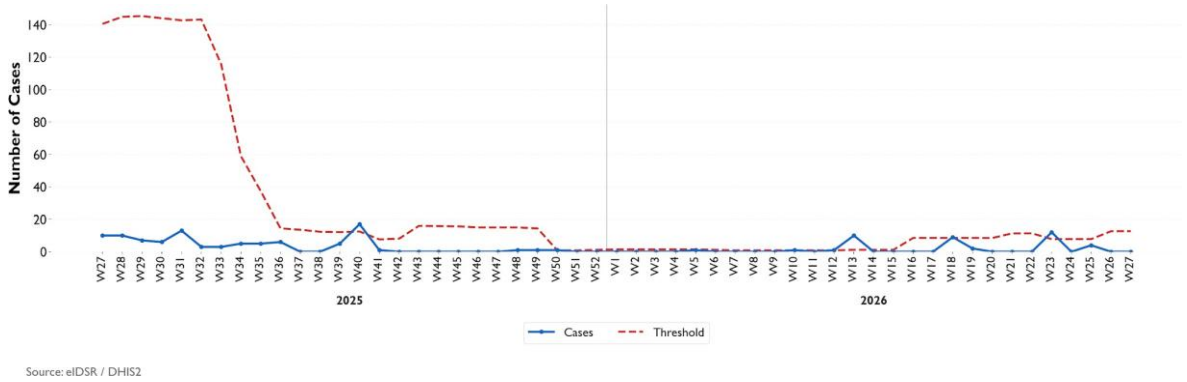


Figure 12: Weekly trend of COVID-19, Rwanda (weeks 27/2025 – 27/2026).

2.3 Sentinel Influenza Surveillance

Figure 13 shows monthly laboratory-confirmed influenza cases by type. Influenza A dominated the season, accounting for the great majority of confirmations and peaking sharply between December 2025 and February 2026 (30, 31 and 23 cases respectively). Influenza B circulated at low levels for most of the year but rose in the final months, peaking at 10 cases in May 2026. The influenza A peak coincides closely with the influenza-like-illness surge shown in Figure 7, confirming influenza A as the principal driver of the season's respiratory activity.

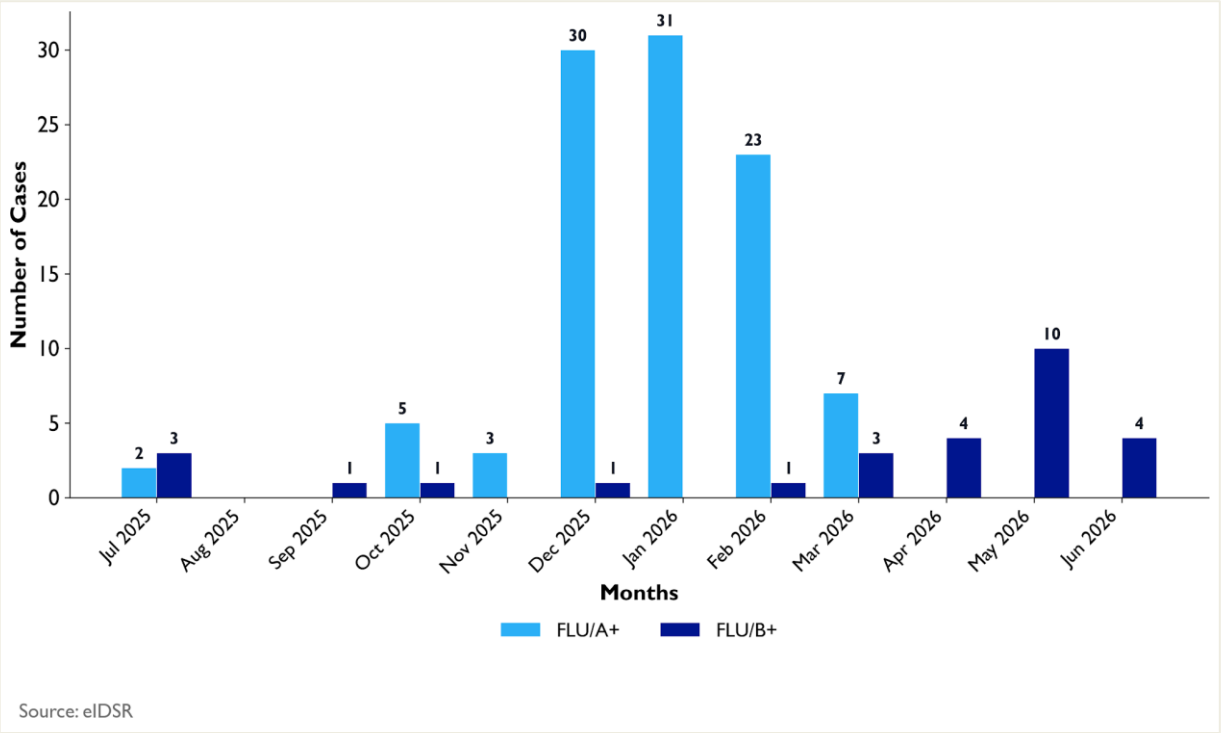
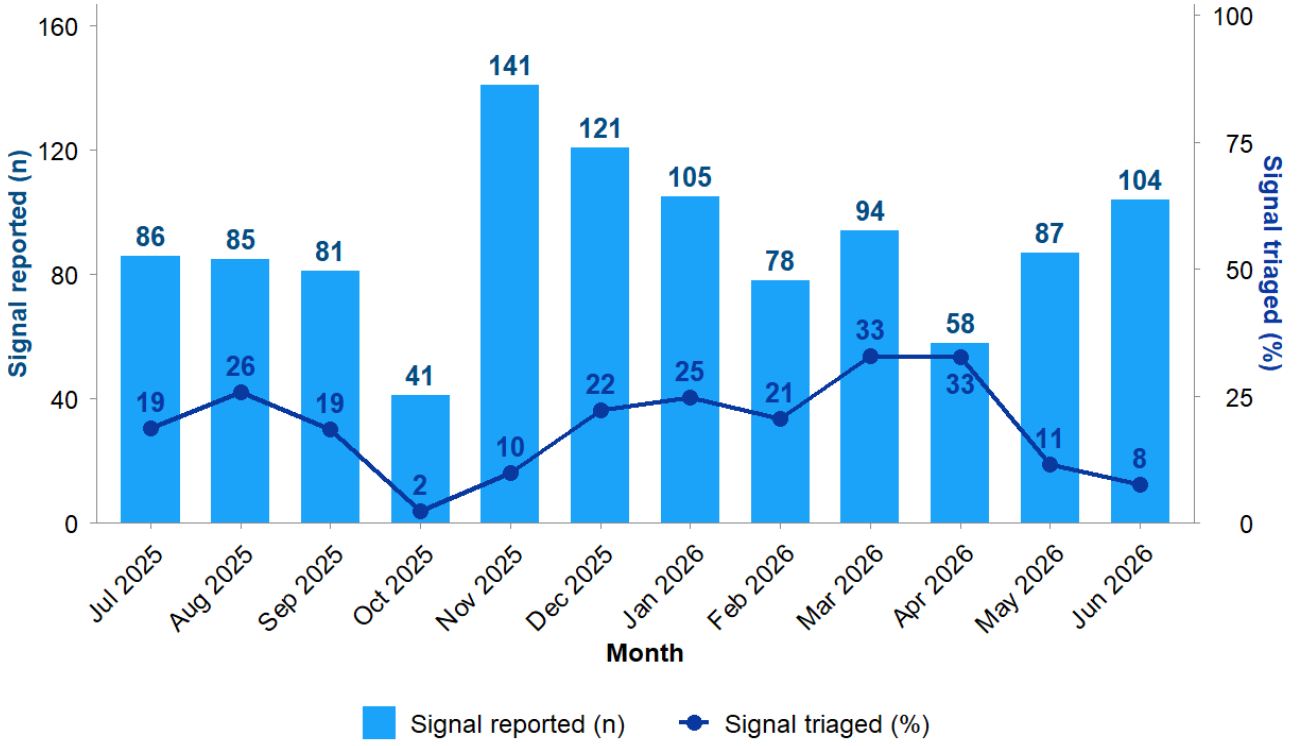


Figure 13: Monthly laboratory-confirmed influenza cases by type (Flu A and Flu B), Rwanda (FY 2025/26)

2.4 Event Based and Community Based Surveillance (Impuruza)

2.4.1 Triaging of signals reported

Event-based surveillance through the Impuruza community reporting system captures informal signals from community, health facility and environment of potential public health events and triages them for verification. Figure 14 shows the number of signals reported (bars) and the proportion of those signals triaged (line) each month from July 2025 to June 2026. About 1,081 signals were received over the year, with the highest monthly volumes in November 2025 (141) and December 2025 (121) and the lowest in October 2025 (41). The proportion of signals triaged remained modest throughout, ranging from 2% in October 2025 to 33% in March and April 2026. The high and sustained flow of community signals reflects strong community engagement, while the consistently low triage proportion identifies timely signal triage and verification as a priority for strengthening.



Source: Impuruza (Jul 2025-Jun 2026)

Figure 14: Signals reported (n) and proportion of signals triaged (%) by month, Impuruza community-based surveillance, Rwanda (July 2025 - June 2026).

2.4.2 Spatial distribution of Impuruza signals

Figure 15 maps the geographic distribution of Impuruza signals across Rwanda's districts. Each circle is sized by the number of signals reported and divided into triaged (light blue) and not-yet-triaged (dark blue) portions. Signal volumes varied widely between districts, largest in districts such as Rutsiro, Rulindo, Musanze, Gicumbi, Gatsibo and Ngororero, and smallest in Nyabihu, Gasabo and Nyamasheke. In almost every district the not-triaged portion predominates, mirroring the national pattern in Figure 14 and confirming that low triage completion is a system-wide challenge rather than one confined to particular districts.

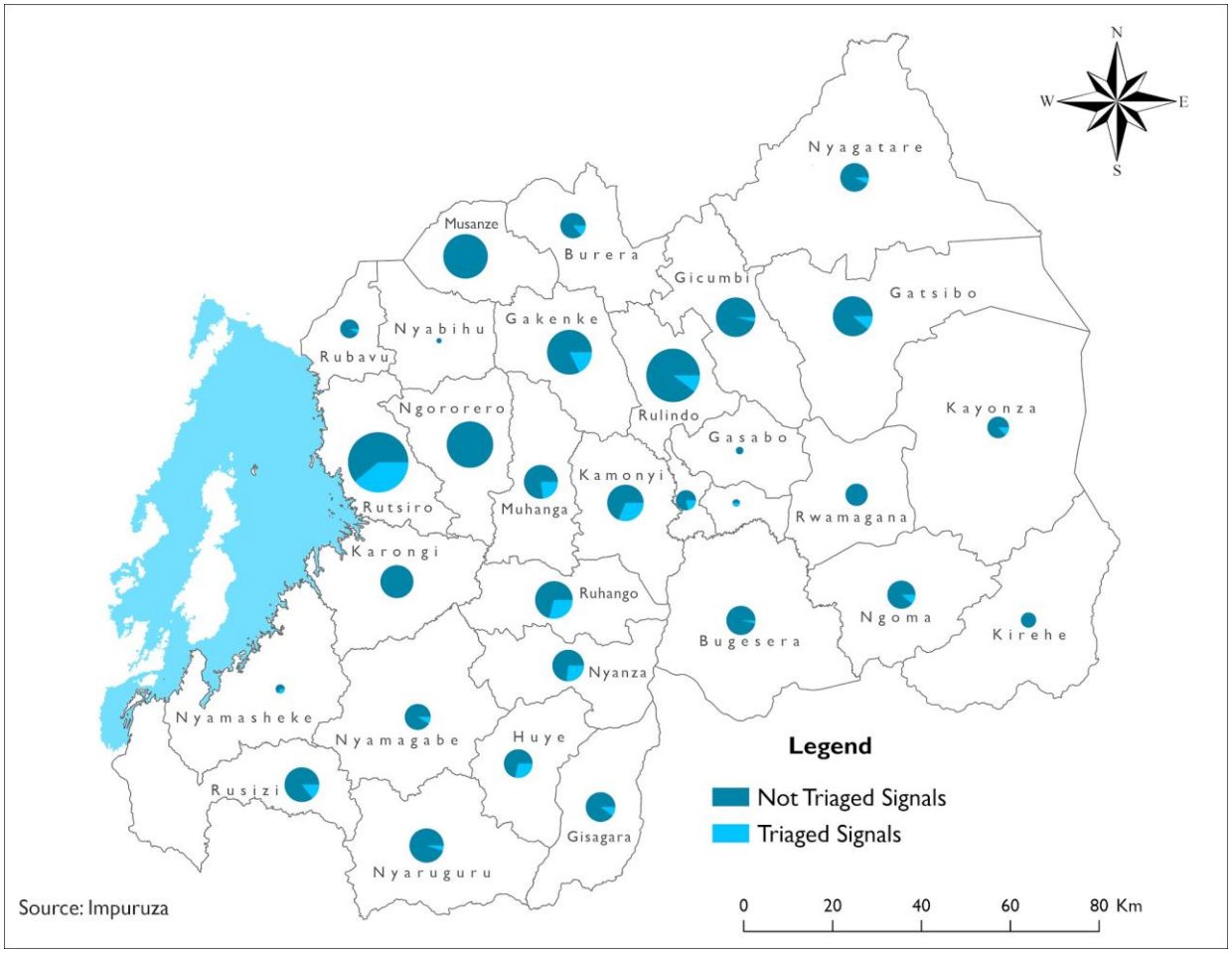


Figure 15: Reported signals by district, Impuruza community-based surveillance, Rwanda (FY 2025/26)

3. Outbreaks in FY 2025-2026

3.1 Food and Waterborne Disease

The Food and Waterborne Disease unit monitors and responds to foodborne illness nationwide. Figure 16 maps the district-level distribution of foodborne illness cases. The burden was highly uneven: Gicumbi recorded the highest number (more than 200 cases), followed by Rwamagana (151-200) and by Bugesera and Nyanza (101-150), while most other districts reported fewer than 50 cases. The clustering of cases in a small number of districts identifies clear geographic priorities for food-safety intervention and targeted investigation.

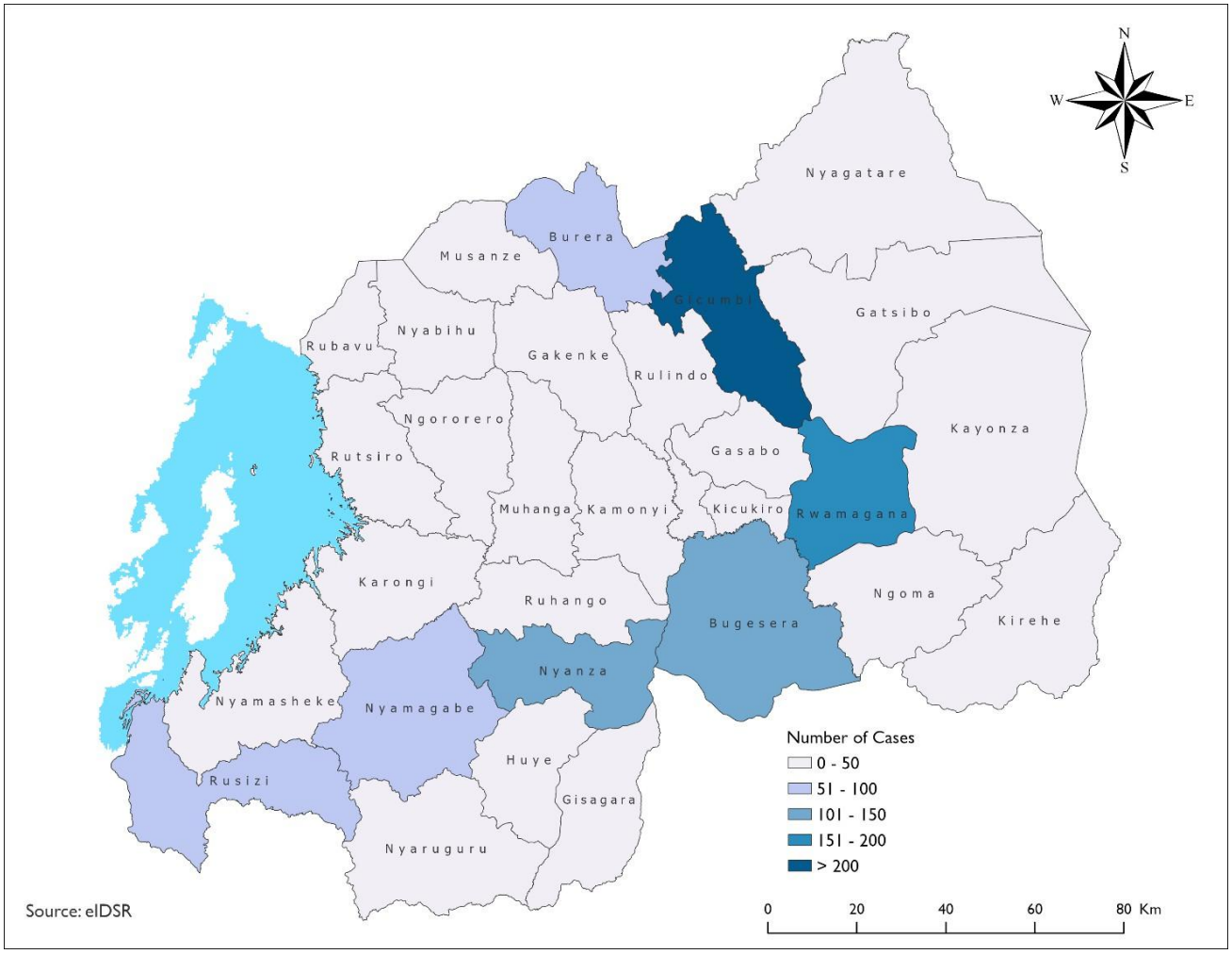
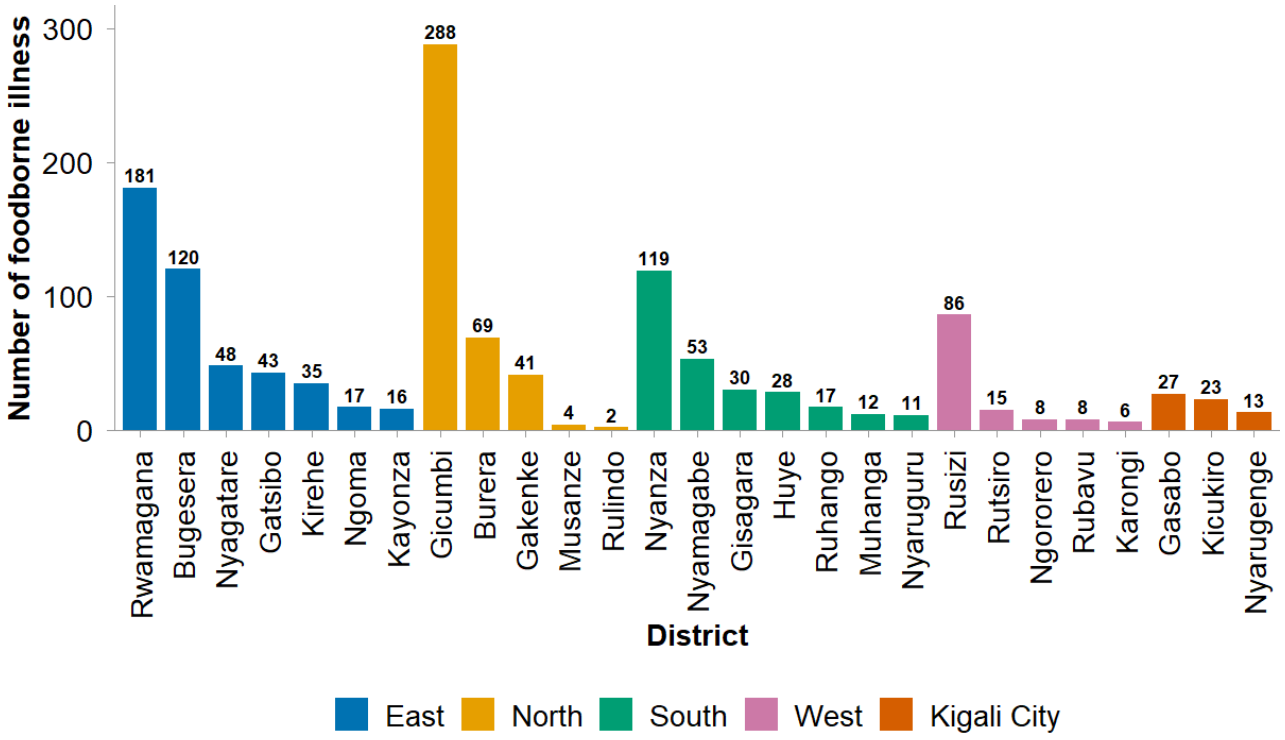


Figure 16: Spatial distribution of foodborne illness by district, Rwanda (FY 2025/26)

Figure 17 presents the same foodborne illness data by district and province. Of approximately 1,320 cases reported nationally, the highest counts were in Gicumbi (288, Northern Province), Rwamagana (181, Eastern), Bugesera (120, Eastern), Nyanza (119, Southern) and Rusizi (86, Western). The Eastern and Northern provinces together accounted for the largest share of the national burden,

while many districts reported very few cases reinforcing the value of province- and district-tailored food-safety and outbreak-response measures.



Source: eIDSR, Rwanda

Figure 17: Distribution of foodborne illness by district and province, Rwanda (FY 2025/26)

3.2 Measles outbreak

3.2.1 Epidemiological curve and spatial distribution

Figure 18 presents the epidemic curve of daily laboratory-confirmed measles cases. Cases remained low and sporadic from July 2025 to March 2026 (mostly fewer than five per day, apart from a small cluster in early August 2025), then rose sharply from April 2026 and escalated steeply through May and June 2026, peaking at about 119 confirmed cases on a single day in June 2026. Over the year the outbreak totalled 3,023 confirmed cases and 14 deaths (case-fatality rate 4.6 per 1,000). The steep late-year rise indicates an active, expanding outbreak at the close of the fiscal year, requiring intensified case management, vaccination response and surveillance.

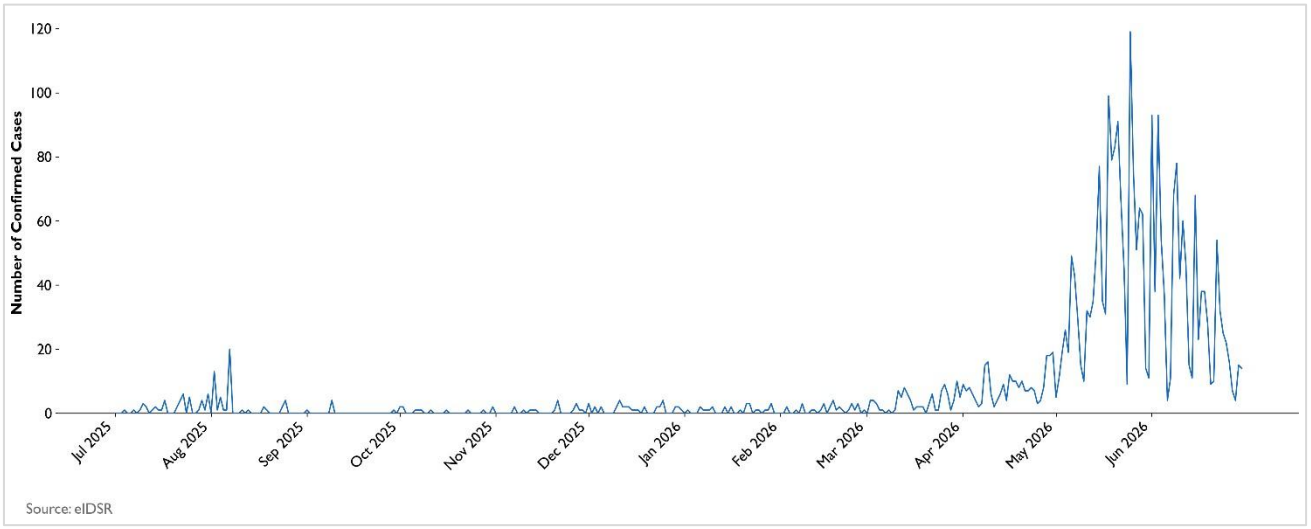


Figure 18: Epidemic curve of daily laboratory-confirmed measles cases, Rwanda (FY 2025/26).

Figure 19 maps the district-level distribution of confirmed measles cases. The burden was concentrated in Kigali City: Gasabo and Kicukiro each recorded more than 200 cases and in the Southern district of Nyanza (>200), with high counts also in the Eastern districts of Nyagatare and Kayonza (151 - 200) and in Bugesera, Ngoma and Gisagara (101 - 150). Most remaining districts reported fewer than 50 cases. This clustering in the capital, the Eastern Province and parts of the South identify the priority districts for targeted vaccination and outbreak-response measures.

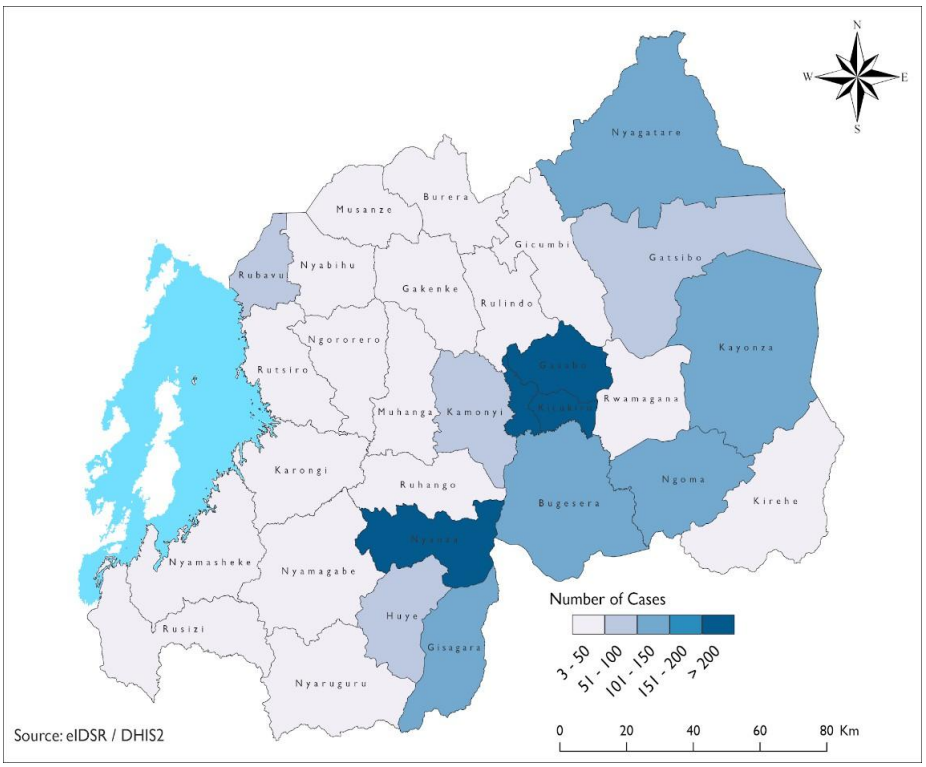


Figure 19: Spatial distribution of confirmed measles cases by district, Rwanda (FY 2025/26).

3.2.2 Response Interventions

Rwanda responded to recurrent measles outbreaks across several districts during the year through joint multidisciplinary investigations led by RBC/PHS&EPR with UR-FELTP and affected district health teams, following RBC and WHO guidelines with an emphasis on early detection, isolation and interruption of transmission. Active house-to-house case finding, led by Community Health Workers, was conducted in affected communities, supported by e-IDSR line lists, contact tracing and epidemiological network analysis to map transmission chains. Confirmed and suspected cases were isolated and given supportive clinical care antipyretics, anti-inflammatories and oral rehydration, with injectable antibiotics for secondary infections and oxygen for respiratory complications while health facilities reinforced triage and standard and airborne infection prevention and control (IPC) precautions. Mild, clinically stable patients were managed through home-based care with daily CHW follow-up and early referral on danger signs, complemented by vaccination response in affected areas.

3.2.3 Lessons Learned

The central lesson from the year's measles outbreaks was that early response must not depend on laboratory confirmation: response delays were repeatedly driven by a low index of suspicion, reliance on laboratory results and the absence of immediate isolation, by which time transmission was already established. Health facilities frequently acted as amplification points, underscoring the need to strengthen facility-level IPC triage, early isolation and airborne precautions for febrile rash illness to prevent nosocomial spread. Persistent outbreaks despite high national coverage exposed immunity gaps to close through timely infant immunization and catch-up vaccination for older cohorts and those with unknown status, alongside sustained MR1 and MR2 coverage of ≥ 95% across all districts. The large share of cases with undocumented vaccination status pointed to weak immunization record-keeping, while spread across district boundaries underscored the need for cross-district surveillance and coordination and for continuous training of clinicians on standard case definitions.

3.2.4 Strengths and Challenges

Across the year's outbreaks, detection and notification generally met the 7-1-7 targets and case fatality rate remained very low, reflecting a strong health system and good access to clinical care nationwide. Joint University of Rwanda through FELTP, RBC, district teams were rapidly deployed, and active house-to-house case finding by Community Health Workers captured cases that had not been presented to facilities. The consistent use of standardized WHO case-definition and

investigation tools, multi-source data (interviews, e-IDSR and patient files) and epidemiological network analysis enabled robust triangulation and identification of outbreak amplification points.

These strengths were offset by important challenges. Early-response intervals repeatedly exceeded the 7-day target, as low clinical suspicion, reliance on laboratory confirmation and delayed isolation allowed outbreaks to propagate before structured measures began. Health facilities amplified transmission within and across districts, exposing gaps in triage, isolation and airborne precautions. Persistent immunity gaps among infants under nine months and older, incompletely vaccinated cohorts, together with a large proportion of cases with unknown vaccination status and possible breakthrough infections, further complicated control while cross-district spread and continued case detection indicated that transmission was not always fully interrupted.

3.3 Rift Valley Fever outbreak in Rwanda

3.3.1 Spatial distribution

Figure 20 presents the One Health distribution of laboratory-confirmed Rift Valley Fever (RVF) cases, combining animal cases by district (blue shading) with human cases (red proportional circles). The outbreak was heavily concentrated in the Eastern Province: animal cases were highest (100+) in Kayonza, Ngoma and Kirehe, and the human epicentre was Ngoma, which alone accounted for the largest number of human cases. Overall the outbreak comprised 432 laboratory-confirmed human cases (44 deaths; case-fatality rate 10.2%) and 1,251 confirmed animal cases across the country. The clear spatial overlap between animal and human cases confirms zoonotic, spill-over transmission and underlines the need for coordinated One Health surveillance and response.

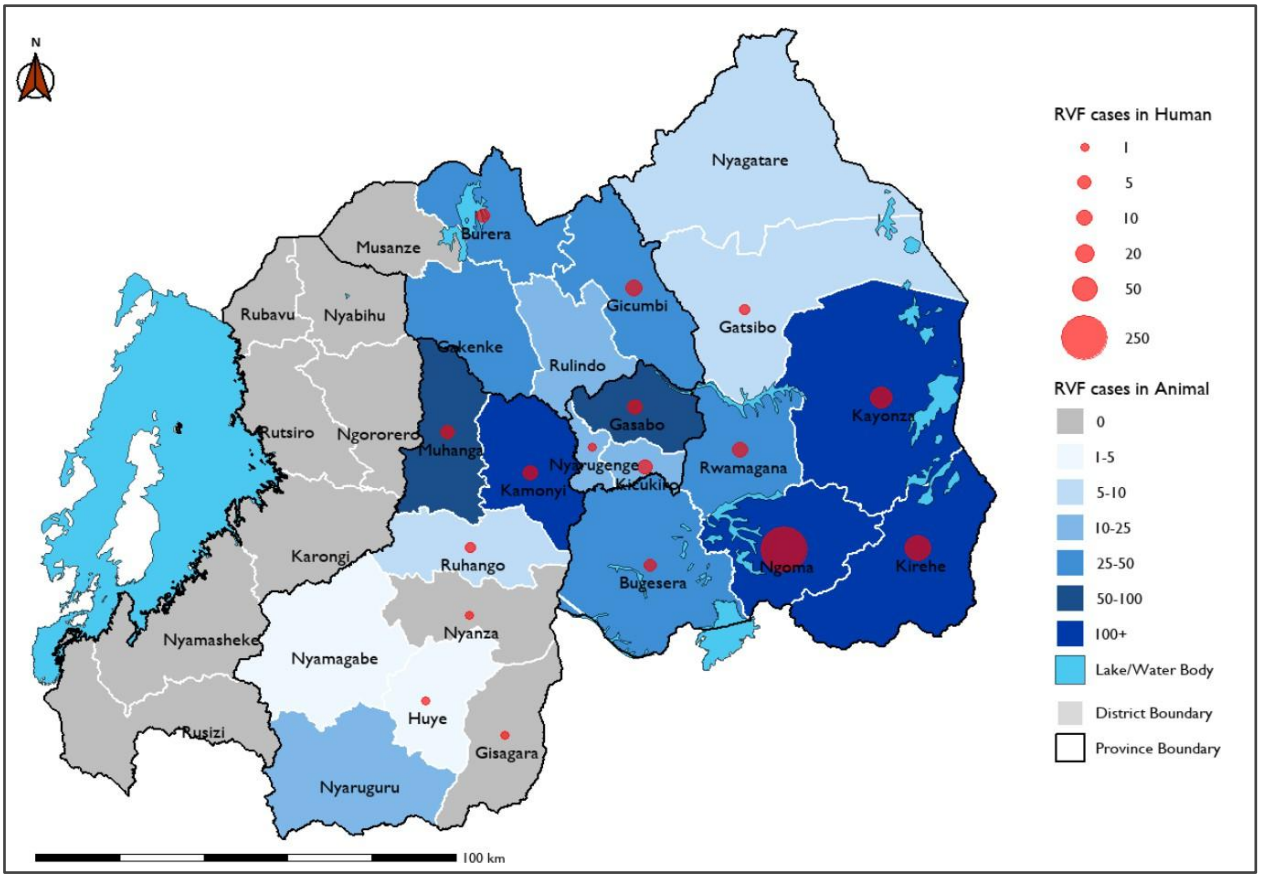


Figure 20: Geographical distribution of laboratory-confirmed RVF cases in animals and humans by district, Rwanda (2025 - 2026).

3.3.2 Case Fatality Rate in animal and human

Table 1 presents laboratory-confirmed RVF cases, deaths and case-fatality rates (CFR) in humans and animals by district, 2025 - 2026. In total, 432 human cases (44 deaths; CFR 10.2%) and 1,251 animal cases (138 deaths; CFR 11.0%) were confirmed. The outbreak was highly focal: the Eastern Province accounted for 87% of human cases (377/432) and 61% of animal cases (768/1,251), with Ngoma the epicentre (272 human cases 63% of the national total and 378 animal cases). Human cases were far fewer elsewhere (Southern 20, Northern 18, Kigali City 17). The co-location of human and animal cases across districts is consistent with zoonotic spill-over transmission. Extreme district-level CFRs (e.g., Gatsibo 50%, Kicukiro 44.4% in humans) reflect very small case numbers; the aggregate CFRs (~10 - 11%) are the reliable severity estimates.

Table 1: RVF Cases, Deaths, and Case Fatality Rate by District (Laboratory-confirmed cases, 2025 - 2026)

Province	District	Human			Animal		
		Cases	Deaths	CFR (%)	Cases	Deaths	CFR (%)
Eastern	Ngoma	272	18	6.6	378	54	14.3
	Kayonza	34	5	14.7	168	16	9.5
	Kirehe	55	6	10.9	128	17	13.3
	Bugesera	4	1	25	41	1	2.4
	Rwamagana	10	1	10	40	7	17.5
	Gatsibo	2	1	50	7	2	28.6
	Nyagatare	0	0	—	6	0	0
	Subtotal	***377***	***32***	***8.5***	***768***	***97***	***12.6***
Kigali City	Gasabo	7	2	28.6	59	7	11.9
	Kicukiro	9	4	44.4	16	3	18.8
	Nyarugenge	1	0	0	14	2	14.3
	Subtotal	***17***	***6***	***35.3***	***89***	***12***	***13.5***
Northern	Gicumbi	12	2	16.7	44	4	9.1
	Burera	6	2	33.3	36	4	11.1
	Gakenke	0	0	—	29	4	13.8
	Rulindo	0	0	—	19	5	26.3
	Subtotal	***18***	***4***	***22.2***	***128***	***17***	***13.3***
Southern	Kamonyi	9	1	11.1	191	5	2.6
	Muhanga	6	1	16.7	52	5	9.6
	Nyaruguru	0	0	—	12	1	8.3
	Ruhango	2	0	0	7	0	0
	Nyamagabe	0	0	—	3	0	0
	Huye	1	0	0	1	1	100
	Gisagara	1	0	0	0	0	—
	Nyanza	1	0	0	0	0	—
	Subtotal	***20***	***2***	***10***	***266***	***12***	***4.5***
	Total	**432**	**44**	**10.2**	**1251**	**138**	**11**

3.3.3 Possible exposure

Figure 21 shows the possible exposures reported among laboratory-confirmed human RVF cases. Direct contact with sick animals or animal abortion products was the most frequently reported exposure (119 cases), followed by consumption of meat (96) and milk (46), while occupational exposure (professional risk, 19) and animal burial or disposal (12) were less common. The dominance of animal contact and consumption of animal products as exposure routes reinforces zoonotic transmission as the principal driver, and points to risk communication on safe animal handling, meat and milk safety, and safe carcass disposal as key preventive measures.

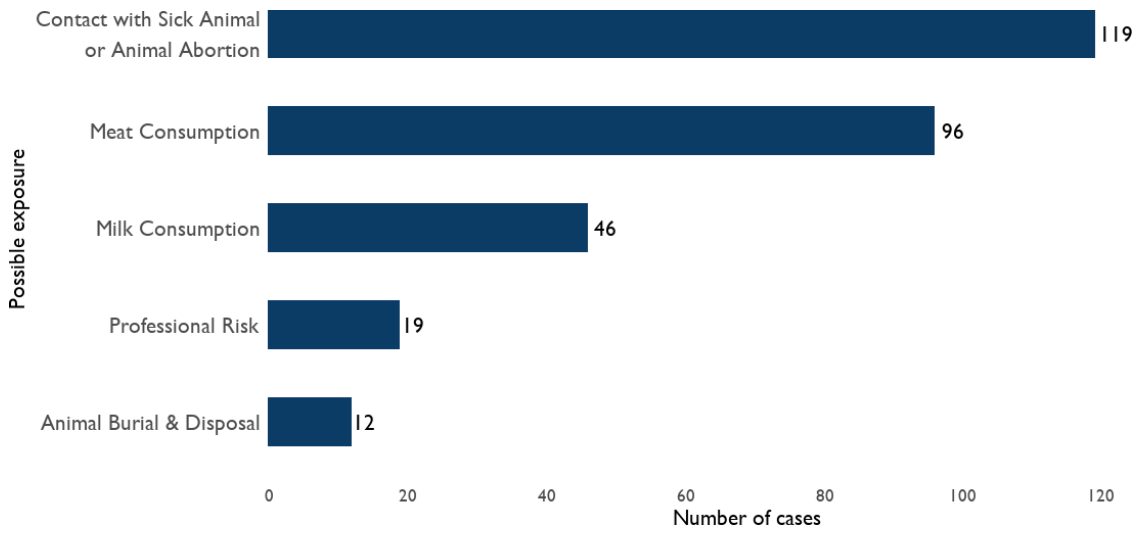


Figure 21: Distribution of laboratory-confirmed human RVF cases by possible exposure, Rwanda (2025 - 2026).

3.3.4 Response Interventions

Rwanda mounted a multisectoral One Health response coordinated through a National Command Post, combining animal- and human-health measures. On the animal side, a national emergency vaccination campaign administered 2,356,650 doses across 23 districts, reinforced by door-to-door "find-and-vaccinate" and independent counter-verification; vector control deployed spraying equipment and ~80,906 litres of insecticide; surveillance was intensified with 50,899 laboratory tests; 1,090 infected animals received supportive treatment; and safe carcass disposal, biosecurity and risk-based livestock movement and market restrictions were applied, guided by a district-level epidemiological decision matrix. On the human side, community and facility-based active case-finding through e-CEBS (Impuruza) triggered the IDSR cascade, early supportive care and Favipiravir were delivered under a "Test & Treat" strategy (366 patients recovered), and stable cases were managed through home-based care. Risk communication and community engagement trained 7,046 frontline

actors, distributed 40,500 IEC materials, and aired at least 46 radio programmes across affected districts.

3.3.5 Lessons Learned

Livestock vaccination and vector control should be integrated into routine animal-health services rather than mounted only during emergencies, and both depend on active community participation, including practical support for animal-waste management. Sustained, sensitive human and animal surveillance, together with early reporting of sick or dead animals and prompt care-seeking, was essential for timely detection and containment. RCCE was most effective when embedded from the outset and delivered through trusted, two-way channels, community radio, local leaders, mobilisers, Umuganda, Inteko z'Abaturage and farmer groups with frontline actors accelerating behaviour change when adequately trained and supervised. Above all, effective control depended on genuine One Health coordination across sectors, underpinned by stronger veterinary accountability and improved animal registration, isolation capacity and data reliability.

3.3.6 Strengths and Challenges

The response worked because a functional One Health mechanism linked human health, animal health, environmental and community systems under unified national and district command, enabling fast, coordinated decisions. Strengthened surveillance and expanded laboratory capacity supported early detection, while a large-scale vaccination campaign, vector control and farmer-led spraying rapidly cut the susceptible livestock population. Risk-based movement controls, a district-level decision matrix and strong community engagement then created a structured pathway for safe resumption and drove earlier reporting and care-seeking.

Key challenges persisted, however. Early and subclinical infections were hard to detect, transmission spread fast, and mosquito-breeding conditions endured. Surveillance and laboratories were strained by uneven district capacity, incomplete reporting and limited reagents, while vaccination was undermined by inaccurate animal numbers, weak livestock identification and traceability, and false coverage reporting ("Gutekinika"). These rested on institutional weaknesses, fragile veterinary structures, unclear roles and reliance on emergency mechanisms underscoring the need to strengthen routine veterinary systems and One Health integration before future outbreaks.

4. Outbreak Preparedness and Readiness

4.1 Field simulation exercise on responding to Ebola virus disease (EVD) outbreak

Capacity scores were computed for each site based on the key response functions tested. Each function was assessed using a set of indicators, which varied in number across sites. For every indicator, a maximum score of 2 was awarded for full demonstration of capacity, 1 for partial demonstration, and 0 for no demonstrated capacity. The scores for each indicator were summed and converted into a percentage to reflect the overall capacity score for each site. Table 3 below presents a summary of the total capacity scores per site, based on the indicators assessed.

Table 2: Capacities assessed and their scores by site

#	Site	Functions tested	Score				
			Total indicators	Full	Partial	Capacity score	%
1	La Corniche PoE	Case detection, isolation, reporting, referral and IPC	14	2	4	8/28	**29%**
2	Rugerero HC	Case identification, isolation, reporting and IPC	11	3	5	11/22	**50%**
3	Gisenyi DH (referral from PoE)	Case investigation, isolation, sample collection, case management, facility readiness and IPC	14	4	9	17/28	**61%**
4	Gisenyi DH (new suspected case at OPD)	Case detection, isolation, sample collection, case management, facility readiness and IPC	13	4	3	11/26	**42%**
5	National PHEOC, Kigali	Immediate guidance to leadership on key actions during an outbreak	10	1	3	5/20	**25%**
6	National PHEOC, Kigali	Development of an IMS structure and PHEOC coordination framework (IMS–PHEOC)	5	1	4	6/10	**60%**

#	Site	Functions tested	Score				
			Total indicators	Full	Partial	Capacity score	%
7	National PHEOC, Kigali	External communication and planning	4	1	2	4/8	**50%**
8	Community	Risk communication and community engagement (RCCE)	6	0	1	1/12	**8%**
Total							**41%**

4.2 Ebola Virus Disease (Bundibugyo) Preparedness and Readiness

The 2026 Bundibugyo ebolavirus (BDBV) disease outbreak in the Democratic Republic of the Congo and Uganda posed a substantial regional health-security threat to Rwanda, given the country's geographic proximity and the intensive cross-border movement along its western frontier. Beyond the immediate risk, the situation offered an opportunity to operationalize and test how Rwanda's existing pandemic preparedness capacities could be rapidly adapted to mitigate the importation and onward transmission of a high-consequence pathogen. The national response drew directly on lessons from the 2024 Marburg virus disease response and was aligned with the International Health Regulations (2005) and regional health-security priorities.

On this basis, Rwanda activated a multi-pillar preparedness strategy that integrated surveillance, points-of-entry (PoE) screening, digital traveler monitoring and follow-up, infection prevention and control, and risk communication and community engagement, underpinned by capacity building for healthcare workers and a series of simulation exercises. Crucially, rather than establishing parallel, pathogen-specific structures, implementation leveraged existing national surveillance systems, community engagement activities and emergency coordination mechanisms. Points of entry were activated, and cross-border coordination meetings were convened with neighbouring countries and partners to strengthen joint information sharing.

Between May and early August 2026, more than 500,000 high-risk travelers were enrolled in a structured digital follow-up system, and 3,266 suspected cases were identified, investigated and tested all negative for Ebola and Marburg, with no confirmed BDBV cases detected. The response demonstrated the rapid activation and integration of multiple preparedness functions without the need to build parallel systems, showing how sustained, pre-outbreak investment in interoperable surveillance, laboratory, workforce, community and cross-border capacities can translate

preparedness into operational readiness. Strengthening these capacities before outbreaks occur remains critical for rapidly detecting and containing emerging threats and for advancing regional pandemic prevention and response.

4.3 Capacity building of health care workers and frontline responders

Table 3: Training activities, target cadres and participants by sex, Rwanda (FY 2025/26)

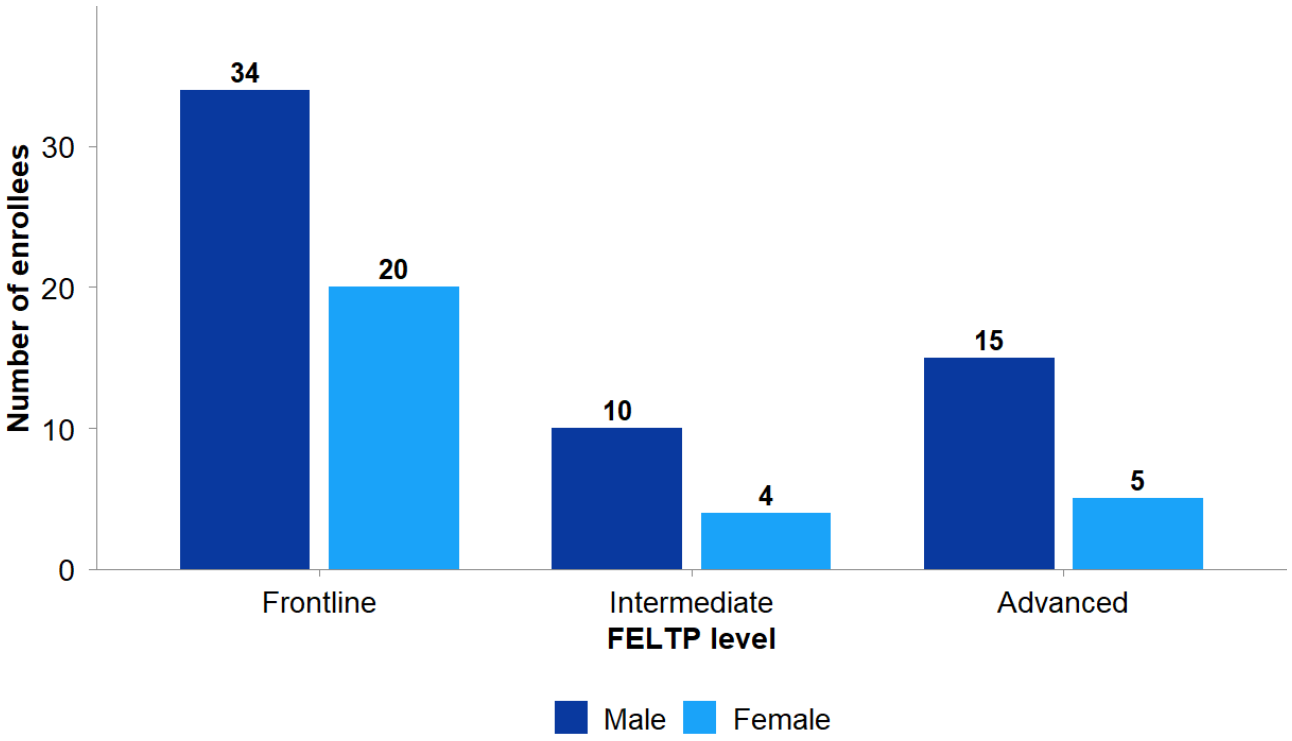
Training Name	Targeted People	Gender	
		Male	Female
Training & TTX for frontline Responders on Preparedness and Response to Floods and Landslides	Disaster management officer, IDSR FP, EHO, Director of Nursing, and Director Medical Allied Health Science Services	61	33
Training of Ambulance Staff On Epidemic Management, Emergency Trauma Care, Basic Life Support During Disaster Response	Anesthetist, EMS Nurses and Paramedics, and EMS Driver including SAMU	494	246
Cascade Training on Community Event-Based Surveillance (Impuruza) In The remaining 17 Districts	CHW supervisor, CEHO, and CHW	12400	19502
Refresher Training of Healthcare Providers on investigation, active case finding, screening, and Surveillance of Measles and Other Vaccine-Preventable Diseases (VPDs)	Hospital Surveillance Focal Person (Team lead), Matrons of pediatrics, Matron of OPD, Physiotherapist, and Laboratory Technician	310	313
Mentorship on Cholera prevention in high-risk Districts	Health Promotion and Disease prevention officer, Directors of health, and Lab scientists	34	26
Cascade Training to Community Health Workers on Cholera prevention	CHW supervisor, CEHO, and CHW	6888	3710
Training of Integrated Disease Surveillance And Response Technical Guideline 3rd Edition In Health Post	HP Nurse, IDSR FP	65	58
Onsite Mentorship on E-Idsr In Trained Health Posts	HP Nurse, IDSR FP	76	46

4.4 Field Epidemiology and Laboratory Training Programme (FELTP)

Across the three FELTP levels, 88 participants were enrolled, comprising 54 participants in Frontline FELTP (Cohorts 18 and 19), 14 in Intermediate FETP (Cohort 3), and 20 in Advanced FELTP (Cohort 8). Overall, 59 participants (67%) were male and 29 (33%) were female. Frontline FETP participants were drawn from Bugesera and Nyagatare Districts, while Intermediate FELTP Cohort 3 participants were drawn from RBC and health facilities across 14 districts, including eight district hospitals (Munini, Nyarugenge, Gatonde, Gitwe, Kirehe, Murunda, Kibirizi, and Rwamagana) and three Level II teaching hospitals (Kabgayi, Kibungo, and Byumba).

Advanced FETP Cohort 8 participants were drawn from RBC, RAB, RMH, four Level II teaching hospitals (Kibagabaga, Kibungo, Byumba, and Rwamagana), Kibuye Referral Hospital, and five district hospitals (Ruli, Remera-Rukoma, Kibilizi, Rilima, and Shyira). The participants represented diverse cadres, including medical doctors, statisticians, data managers, IDSR Nurses, district environmental officers, district health promotion officers, and veterinary officers, supporting a multidisciplinary One Health approach to disease surveillance and response.

Figure 22 summarises FELTP enrolment by programme level and sex. Of the 88 participants enrolled during the year, 54 were in the Frontline programme (34 male and 20 female), 14 in the Intermediate programme (10 male and 4 female) and 20 in the Advanced programme (15 male and 5 female). Overall, 59 participants (67%) were male and 29 (33%) were female. The distribution shows a strong Frontline base feeding a smaller Intermediate and Advanced pipeline and highlights female participation particularly at the Intermediate and Advanced levels as an area for deliberate improvement.



Source: FELTP enrolment, Rwanda

Figure 22: FELTP enrolment by programme level and sex, Rwanda (FY 2025/26)

4.5 Population Reached with Risk Communication During Emergencies

Effective risk communication during emergencies depends on reaching the population quickly through trusted, accessible channels. The Division disseminated risk messages through a multi-channel approach radio and television, SMS advisories, social media (WhatsApp, YouTube, Facebook), and community health workers for last-mile engagement. This mix supports near-universal reach: radio, the most accessible and trusted medium, covers about 99% of the country and is used by 97% of citizens, television reaches roughly 80%, and high mobile penetration (about 96 subscriptions per 100 inhabitants) enables large-scale SMS messaging (Rwanda Media Barometer 2024). Overall, risk communication during emergencies reached an estimated 91% of the target population.

5. Vaccination Preventable Diseases Under Surveillance

5.1 Schedule of National Immunization Program in Rwanda

Table 4: Schedule of the National Immunization Programme in Rwanda

Vaccines	Total doses	Age at administration
BCG	1	Birth
Hepatitis B B Dose	1	Birth
OPV	4	Birth, 6, 10, 14 weeks
IPV	2	14weeks, 9months
DTP-HepB-Hib	3	6, 10, 14 weeks
Pneumococcal vaccine (PCV13)	3	6, 10, 14 weeks
Rotavirus (Rotarix)	2	6, 10 weeks
Measles-Rubella (MR)	2	9 and 15 months
Tetanus toxoid	5	During pregnancy (first contact, 4 weeks, 6 months, 1 year, 1year)
HPV	1	12-year-old girls

5.2 Polio surveillance in Rwanda

Rwanda has made significant progress in the fight against polio. The last reported case of wild poliovirus in Rwanda was in 1993, and the country completed its documentation of interruption of polio transmission in 2004. Since then, Rwanda has continued to strengthen routine immunization and polio surveillance to maintain its polio-free status.

In 2015, Rwanda introduced the inactivated poliovirus vaccine (IPV) into the routine immunization program as part of the global polio eradication and endgame strategy. The introduction of IPV helped maintain protection against poliovirus, particularly following the planned withdrawal of the type 2 component of the oral polio vaccine.

In April 2016, following the global eradication of wild poliovirus type 2, Rwanda switched from the trivalent oral polio vaccine (tOPV) to the bivalent oral polio vaccine (bOPV) in routine immunization. The bOPV protects against poliovirus types 1 and 3, while the type 2 component was withdrawn from routine OPV use.

In 2023, the emergence and circulating vaccine-derived poliovirus type 2 (cVDPV2) in neighboring countries in the region increased the risk of poliovirus importation into Rwanda. In response, Rwanda conducted two nationwide polio vaccination campaigns targeting all children under 7 years of age, regardless of their previous vaccination status. The campaigns used novel oral polio vaccine type 2 (nOPV2) and were implemented through house-to-house vaccination and other vaccination sites.

Rwanda strengthens polio surveillance where targets are set annually, running from January to December. The country achieved its Acute Flaccid Paralysis (AFP) detection rate target for the year, ending with a rate of 4.4 per 100,000 among children under 15, well above the minimum target of ≥2 per 100,000 under 15. Notably, all districts achieved the AFP detection rate target. In 2026, the country has maintained performance above target since the start of the year; however, in June, 11 of the 30 districts fell below the required detection rate, indicating a need for targeted follow-up in those areas.

5.3 Tetanus Neonatal Surveillance

Background

Neonatal tetanus still occurs in Rwanda and remains a preventable cause of neonatal illness and death. Cases may occur due to unsafe delivery and cord-care practices, including home deliveries, as well as inadequate maternal tetanus and diphtheria (Td) vaccination and limited access to appropriate maternal and newborn health services. Rwanda has reported approximately 90% vaccination coverage; however, gaps in maternal immunization, safe delivery practices, newborn care, and access to health services may continue to contribute to the occurrence of neonatal tetanus.

Description

A fatal case of neonatal tetanus was reported in Rwamagana District. The mother had a history of seven deliveries and did not attend antenatal care during the pregnancy. She did not receive the recommended tetanus and diphtheria (Td) vaccination. The neonate was delivered at home on 2 July 2025 and first presented for medical consultation on 12 July 2025. The neonate had not received any vaccination. The condition subsequently deteriorated, and the neonate died on 8 August 2025, 37 days after the initial consultation.

Conclusion

The case highlights the continued risk of neonatal tetanus despite high reported vaccination coverage. The home delivery and absence of vaccination are important public-health concerns requiring further investigation and prevention measures.

5.4 Measles and Rubella vaccination coverage

National MR coverage in FY 2025/26 was 95% for MR1 (at 9 months) and 91% for MR2 (at 15 months), a 4% dropout; MR1 met the 95% elimination target but MR2 did not, making second-dose completion the priority gap. Ten districts remained below 95% MR1 coverage (lowest: Gatsibo and Gasabo at 86%) and several led by Rutsiro and Rubavu (9% dropout) showed high dropout (Table X), calling for targeted community engagement, supervision, monitoring and evaluation.

Table 5: Measles–rubella (MR1 and MR2) vaccination coverage and dropout rate by district, Rwanda (FY 2025/26)

District	Measles and Rubella (MR 1)	Measles and Rubella (MR 2)	Dropout rate
Gicumbi	100%	100%	0%
Ruhango	100%	101%	-1%
Nyaruguru	100%	99%	1%
Ngororero	99%	100%	-1%
Nyamasheke	99%	96%	3%
Muhanga	98%	98%	0%
Rwamagana	98%	93%	5%
Kirehe	98%	97%	1%
Rubavu	97%	89%	9%
Ngoma	97%	99%	-2%
Kayonza	97%	90%	8%
Kamonyi	97%	96%	1%
Rusizi	97%	100%	-3%
Nyagatare	96%	89%	8%
Nyabihu	96%	88%	8%
Nyanza	95%	93%	2%
Gakenke	95%	98%	-3%
Burera	95%	92%	3%
Nyamagabe	95%	92%	3%
Karongi	95%	91%	4%
National	**95%**	**91%**	**4%**
Huye	94%	89%	5%
Bugesera	94%	90%	5%
Rutsiro	93%	84%	9%

District	Measles and Rubella (MR 1)	Measles and Rubella (MR 2)	Dropout rate
Rulindo	93%	91%	2%
Nyarugenge	93%	88%	5%
Gisagara	93%	88%	4%
Kicukiro	91%	83%	8%
Musanze	91%	85%	6%
Gatsibo	86%	85%	1%
Gasabo	86%	82%	4%

5.5 Rabies Interventions, Kigali Pilot Vaccination Campaign

Figure 23A shows that most owned dogs in all three sectors are never allowed to roam (959 of 1,628, or 59%), but 669 dogs (41%) roam at least part of the time, nearly all of them only "sometimes" (571) rather than "always" (98). The highest numbers are in Masaka (318 "sometimes") and Kanombe (195). Figure 23B shows that sterilisation is low overall, with 1,017 of 1,418 dogs (72%) unsterilised, and the gap is largest in females, of whom 510 of 564 (90%) are unsterilised, against 507 of 854 males (59%). Because only 13 vaccinated dogs were truly unowned, most roaming dogs have owners. Together with the many unsterilised females, this points to a risk of rapid dog population growth and a continuing rabies risk. Sterilisation and responsible-ownership education should therefore be prioritised, focusing on females, especially as 76% of owners said they would like their dogs sterilised.

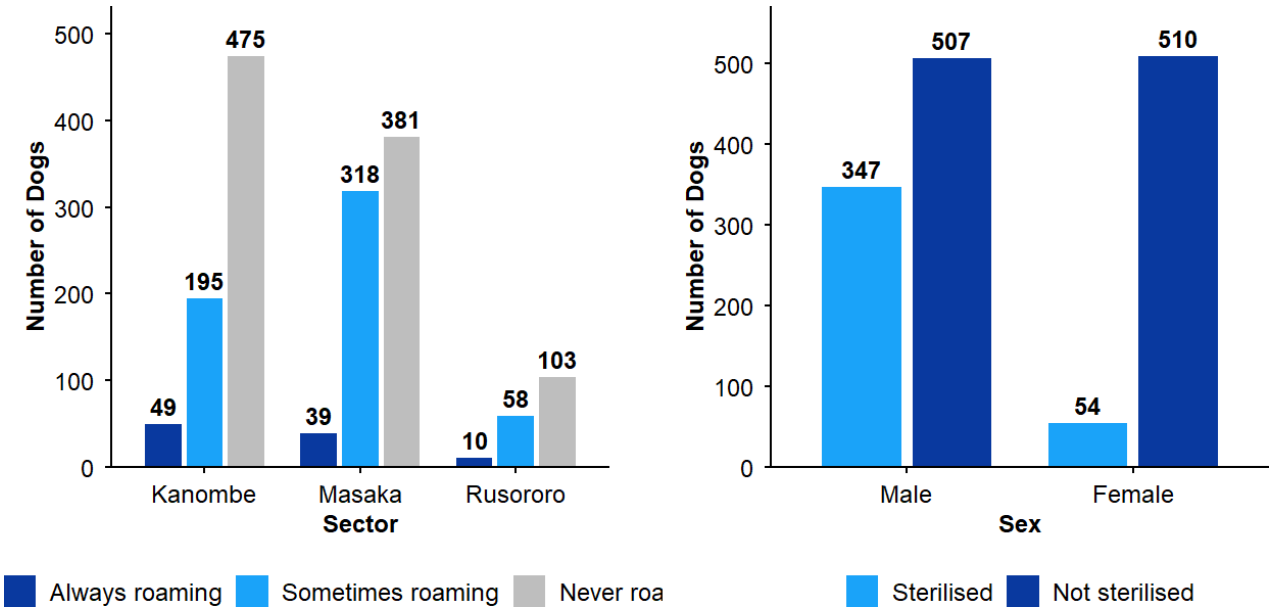


Figure 23: (A) Roaming status of owned dogs by sector; (B) Sterilisation status of dogs by sex, Kigali pilot vaccination campaign (FY 2025/26).

Source: WAG Rwanda

5.6 Key Events occurred during this fiscal year 2025/26

Special report – Scientific articles

1. Ruseesa E, Hagabimana A, Ntirenganya F, Kinani P, Hinda R, Nshimiyimana E, et al. (2025) The role of Rwanda Field Epidemiology and Laboratory Training Program graduates and residents in response to the first Marburg Virus Disease outbreak in Rwanda. PLOS Glob Public Health 5(9): e0004452. https://doi.org/10.1371/journal.pgph.0004452

2. Ntirenganya, F., Itanga, I., Uwamahoro, S., Rwagitinywa, B., Benimana, J. L., Mucunguzi, H. V., Ruseesa, E., Igihozo, E. H., & Rwagasore, E. (2026). Age-specific hospitalization dynamics during a measles outbreak in Nyanza District, Southern Province, Rwanda, 2026: A survival analysis with implications for clinical management. *International Journal of Infectious Diseases, 171*, 108999. https://doi.org/10.1016/j.ijid.2026.108999

6. Conclusion

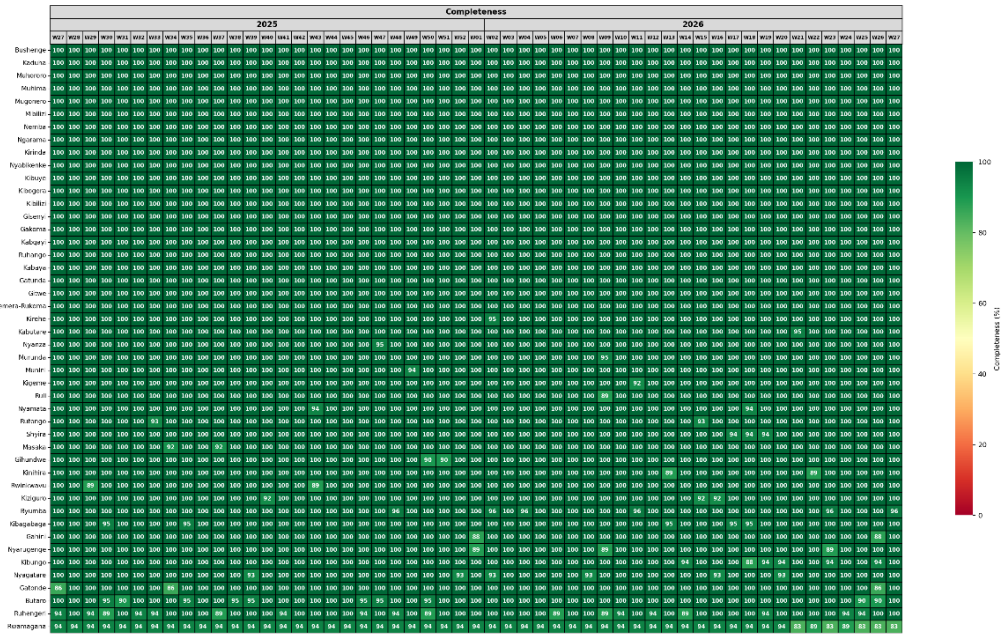
During FY 2025/26, the PHS&EPR Division sustained a robust integrated disease surveillance system monitoring 44 priority diseases through eIDSR with high national reporting completeness (around 97%) and mounted timely, multisectoral responses to a demanding series of concurrent public health events, including measles, Rift Valley Fever, and foodborne illness outbreaks, alongside a major cross-border Ebola (Bundibugyo) preparedness effort that detected no importation despite intense exposure. These achievements reflect the strength of Rwanda's One Health approach and sustained investment in surveillance, laboratory, workforce and community capacities.

The year also exposed persistent gaps. Early response repeatedly lagged behind detection and notification, facility-based transmission amplified the measles outbreak, immunity gaps persisted among specific age groups and districts, and a small number of health facilities consistently under-reported. Addressing these requires strengthening early response triggers that do not depend on laboratory confirmation, reinforcing facility-level infection prevention and control, closing immunity gaps through catch-up vaccination and improved documentation, and sustaining reporting quality in lower-performing facilities.

Looking ahead to FY 2026/27, the Division will prioritise integrating emergency capacities into routine systems, continued strengthening of the disease-detective workforce, cross-border coordination, and pre-outbreak preparedness so that Rwanda continues to detect, prevent and control public health threats rapidly and effectively, advancing regional health security and the goal of a population protected from epidemics and other emergencies.

Annexes

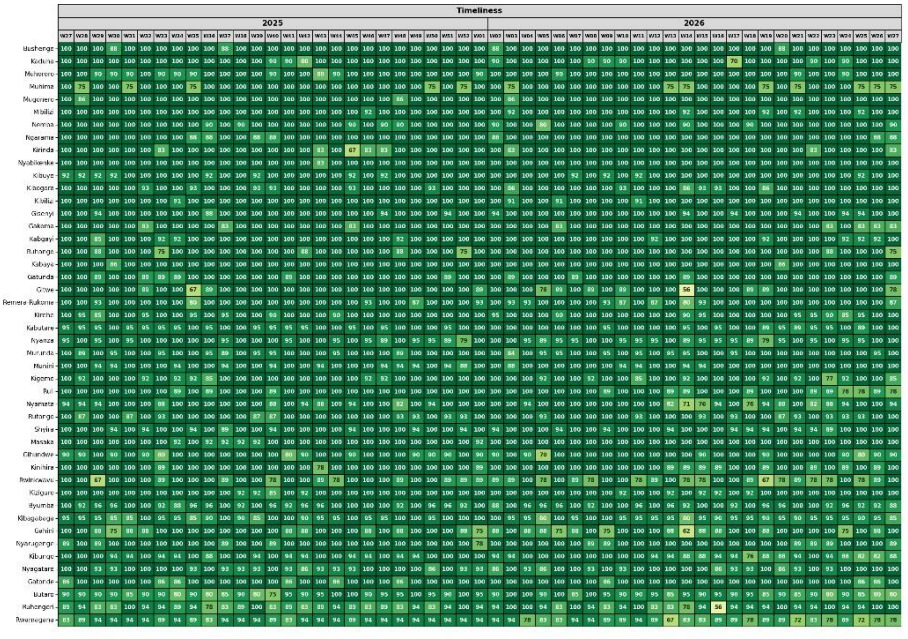
Annex 1. Weekly completeness by hospitals catchment areas



Source: eIDSR

Figure 24: Weekly eIDSR reporting completeness by hospital catchment area, Rwanda (weeks 27/2025 - 26/2026).

Annex 2. Weekly timeliness by hospitals catchment areas



Source: eIDSR

Figure 25: Weekly eIDSR reporting timeliness by hospital catchment area, Rwanda (weeks 27/2025 - 26/2026).

Annex 3. PHS&EPR Division staff list, FY2025/26

#	Name	Position
1	Dr RWAGASORE Edson	Division Manager
2	Dr MUCUNGUZI Hugues Valois	Ag. Director, Avian Flu and Highly Pathogenic Diseases Unit
3	Dr RUSEESA Edward	Director, Outbreak Preparedness and Response Unit
4	Dr KARAMAGE Pax Axel	Ag. Director, Food and Waterborne Diseases Unit
5	Dr ISHEMA Leandre	Ag. Director, One Health Unit
6	NSEKUYE Olivier	Ag. Director, Surveillance Unit
7	NTIRENGANYA Frederic	Senior Biostatistics Officer
8	HAGABIMANA Aphrodis	PHEM Programme Officer
9	Dr IRADUKUNDA Sonia	Disease Monitoring Officer
10	ITANGA Ines	Surveillance Officer
11	UFITINEMA Longin	PHEOC Data Manager
12	RWAMWIZA Theophile	PHEOC Specialist
13	Dr MUTABAZI Alain Patrick	PHEM Programme Officer
14	UWAMAHORO Sandrine	Disease Monitoring Officer
15	RURANGWA Jessica	Senior Consultant in Systems Monitoring
16	NIZEYIMANA Felicien	Senior OPR Officer
17	NZEYIMANA Louis	PHEOC Specialist
18	TWAHIRWA Marie Solange	IDSR Quality Assurance Officer
19	NIRAGIRE Esperance	PHEOC Manager
20	Dr DUSHIMUMUREMYI Patrick	PHEM Operation Officer
21	BIGIRIMANA Jean Claude	PHEM Operation Officer
22	RUYANGE Laurent	Senior IDSR Document Production Officer
23	KAPITENI Alexis	Epidemic Prone Disease Prevention Officer
RBC-PHS&EPR Division Technical Assistants: Staff from Partners		
1	KANYABASHI Fiacre	Health Emergency Consultant/UNICEF

PUBLIC HEALTH SURVEILLANCE & EMERGENCY PREPAREDNESS AND RESPONSE (PHS&EPR) DIVISION

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