



**World Health
Organization**

REGIONAL OFFICE FOR **Africa**

WHO COUNTRY COOPERATION STRATEGY

2014-2018

R W A N D A



DEM. REP.
OF THE
CONGO

UGANDA



TANZANIA

BURUNDI

North

East

City of
Kigali

South

West

Lake
Kivu

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Abbreviations

AEFI	Adverse Event Following Immunization
AIDS	Acquired Immunodeficiency Syndrome
APOC	African Programme for Onchocerciasis Control
ART	Antiretroviral Therapy
BUFMAR	Bureau de Formations Medicales Agréée du Rwanda
CCA	Common Country Assessment
CCM	Country Coordination Mechanism
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention (USA)
CFSVA	Comprehensive Food Security and Vulnerability Analysis and Nutrition Survey
CHW	Community Health Worker
CVD	Cardiovascular Disease
DFID	Department for International Development (UK)
DH	District Hospital
DHS	Demographic and Health Survey
DOTS	Directly-Observed Treatment Short-course
DP	Development Partner
DPCG	Development Partners Coordination Group
EAC	East African Community
ECD	Early Childhood Development
EDPRS	Economic Development and Poverty Reduction Strategy
EPI	Expanded Programme of Immunization
FBO	Faith-Based Organization
FP	Family Planning
GBS	General Budget Support
GDP	Gross Domestic Product
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria



GoR	Government of Rwanda
GTZ	Deutsche Gesellschaft Fur Technische Zusammenarbeit
HC	Health Centre
HF	Health Facility
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSSP	Health Sector Strategic Plan
IDSR	Integrated Disease Surveillance and Response
IHDPC	Institute of HIV/AIDS Disease Prevention and Control
IT	Information Technology
JICA	Japan International Cooperation Agency
JMP	Joint Monitoring Programme of WHO/UNICEF
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDR	Multi-Drug Resistant
MoA	Ministry of Agriculture
MoH	Ministry of Health
MOU	Memorandum Of Understanding
MPPD	Malaria and Other Parasitic Diseases Division (of RBC)
MTR	Mid-Term Review
NCD	Noncommunicable Disease
NGO	Nongovernmental Organization
NHA	National Health Accounts
NISR	National Institute of Statistics of Rwanda
P4P	Pay for Performance
PBF	Performance-Based Financing
PCT	Porphyria Cutanea Tarda

PEPFAR	President's Emergency Plan for AIDS Relief (USA)
PLHIV	Person Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
RBC	Rwanda Biomedical Centre
RDHS	Rwanda Demographic and Health Survey
REC	Reach Every Child
RTT	Resource Tracking Tool
SBS	Sector Budget Support
SDH	Social Determinant of Health
SIA	Supplementary Immunization Activity
SMS	Short Message System
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
SWAp	Sectorwide Approach
TB	Tuberculosis
UHC	Universal Health Coverage
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDAP	United Nations Development Assistance Plan
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VPD	Vaccine Preventable Disease
WCO	WHO Country Office
WHA	World Health Assembly
WHO	World Health Organization

Preface

Third Generation – WHO Country Cooperation Strategy

The WHO Third Generation Country Cooperation Strategy (CCS) crystallizes the major reform agenda adopted by the World Health Assembly with a view to strengthen WHO capacity and make its deliverables more responsive to country needs. It reflects the WHO Twelfth General Programme of Work at country level, it aims at achieving greater relevance of WHO's technical cooperation with Member States and focuses on identification of priorities and efficiency measures in the implementation of WHO Programme Budget. It takes into consideration the role of different partners including non-state actors in providing support to Governments and communities.

The Third Generation CCS draws on lessons from the implementation of the first and second generation CCS, the country focus strategy (policies, plans, strategies and priorities), and the United Nations Development Assistance Framework (UNDAF). The CCSs are also in line with the global health context and the move towards Universal Health Coverage, integrating the principles of alignment, harmonization and effectiveness, as formulated in the Rome (2003), Paris (2005), Accra (2008), and Busan (2011) declarations on Aid Effectiveness. Also taken into account are the principles underlying the "Harmonization for Health in Africa" (HHA) and the "International Health Partnership Plus" (IHP+) initiatives, reflecting the policy of decentralization and enhancing the decision-making capacity of Governments to improve the quality of public health programmes and interventions.

The document has been developed in a consultative manner with key health stakeholders in the country and highlights the expectations of the work of the WHO secretariat. In line with the renewed country focus strategy, the CCS is to be used to communicate WHO's involvement in the country; formulate the WHO country workplan; advocate, mobilise resources and coordinate with partners; and shape the health dimension of the UNDAF and other health partnership platforms in the country.

I commend the efficient and effective leadership role played by the Government in the conduct of this important exercise of developing the CCS. I also request the entire WHO staff, particularly WHO Country Representative to double their efforts to ensure effective implementation of the programmatic orientations of this document for improved health outcomes which contribute to health and development in Africa.

Dr Matshidiso Moeti



WHO Regional Director for Africa

Executive summary

The WHO Country Cooperation Strategy 2014-2018 Rwanda outlines the medium term framework for cooperation with the Government of Rwanda (GoR) through five strategic priorities that will guide the work of WHO in the country. The CCS 2014-2018 was developed through a consultative process involving systematic assessment of country needs drawn from the key strategic documents including the Economic Development and Poverty Reduction Strategy II (EDPRS II 2013-2018), the Health Sector Strategic Plan III (2012-2018), the report on Rwanda's national consultations on the post 2015 development agenda 2013 and United Nations Development Assistance Plan 2013-2018. Consultations with key stakeholders in the health sector provided valuable contributions to the document. In general, the process was guided by the WHO Country Cooperation Strategies Guide 2010.

It is noteworthy that Rwanda has made outstanding socioeconomic progress. Significant improvements in health outcomes and other key development indicators including improvements in livelihood at the community level have been observed. The real gross domestic product (GDP) growth averaged 8.2% annually during the past 10 years, which translated into GDP per capita growth of 5.1% per year. Life expectancy at birth has increased from 51 years in 2002 to 64.5 years (NISR, 2013).

Infant mortality has declined from 86/1000 live births (NISR, 2006) to 50/1000 live births (NISR, 2010), while child mortality decreased from 153/1000 live births in 2005 (NISR) to 76/1000 live births (NISR, 2010). Maternal mortality ratio also decreased from 750 per 100 000 live births in 2005 to 476 per 100 000 live births in 2010. HIV prevalence in Rwanda has remained stable over the last five years with the national prevalence at 3% among people aged 15-49 years. Malaria as the major cause of childhood mortality has dropped significantly from the first position in 2005 to the fourth position in 2012.

Government budget allocation to health as percentage of GoR budget allocated to health increased from 7% in 2006 to 13% in 2010/11, but the total expenditure related to health as percentage of government total budget was 16.05%. Rwanda has made tremendous progress in terms of financial access and risk protection by strengthening pre-payment mechanisms such as community-based health insurance and other health insurance schemes (MoH, 2012).

The United Nations is very active as a collaborative partner of the Government of Rwanda and recently signed the UN Development Assistance Plan 2013-2018 to support

the implementation and realization of EDPRS priorities. WHO plays a leading role in implementing the health response of the UNDP in partnership with other UN agencies.

Despite the significant gains and improvements recorded, concerns still exist that coverage of some essential services is limited for some vulnerable population groups. Malnutrition is still an important problem among children aged under five years with the prevalence of stunting remaining as high at 44.2% (NISR, 2010). The burden of malaria in Rwanda has transitioned from a nationwide to a local problem mostly in five high burden districts along the eastern border which account for over 70% of the malaria burden. The success achieved in the reduction of communicable diseases is being challenged by the increasing burden of noncommunicable diseases. Several communities remain vulnerable to climate change, epidemics and disasters due to floods, food insecurity and potential displacement.

The country has implemented commendable actions to address issues related to social determinants of health with reference to the Rio+20 political recommendations including the development of the social protection action plan 2011. The Ministry of Health Social Cluster has been actively implementing identified social protection interventions; however, intersectoral cooperation needs to be improved to generate expected results.

During implementation of HSSP II, the country recorded health system improvements due to achievement of the following strategic objectives: (i) improvement of accessibility and quality of MCH services; (ii) consolidation, expansion and improvement of services for the prevention of disease and promotion of health; (iii) consolidation, expansion and improvement of services for the treatment and control of disease and by strengthening the following programme areas: institutional capacity, human resources, financial accessibility (health insurance schemes), geographical accessibility (construction, renovation and extension of health facilities), medicines supply (procurement and distribution), quality assurance of health services, specialized services (MoH, 2011).

Given the review of CCS 2009-2013 and the national health and development challenges identified, the following five strategic priorities have been identified to guide the Country Cooperation Strategy 2014-2018:

- a. Support health system strengthening towards health service integration and universal health coverage;
- b. Contribute to the reduction of morbidity and mortality from major diseases and thus contribute to the achievement of health-related Millennium Development Goals;

- c. Contribute to the reduction of maternal, newborn and child morbidity and mortality;
- d. Promote health through addressing social determinants of health, health and environment, nutrition and food safety;
- e. Strengthen disaster risk management, epidemic and emergency preparedness and response, and implementation of the International Health Regulations.

When outlining the strategic priorities, consideration was given to WHO existing comparative advantages and core functions as highlighted in the 12th General Programme of Work (GPW) including:

- a. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- b. Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- c. Setting norms and standards as well as promoting and monitoring their implementation;
- d. Articulating ethical and evidence-based policy options;
- e. Providing technical support, catalysing change, and building sustainable institutional capacity;
- f. Monitoring the health situation and assessing health trends.

The WHO Country Office in Rwanda will be strengthened to support implementation of the agenda as defined in Section 5 of this document. Human resources will focus on improving the number and ensuring adequate skills and capacities existing in the Country Office to facilitate implementation of this strategic agenda.

The CCS 2014-2018 shall be used to guide workplan development over the next five years. The operational plans shall be guided by the principles of efficiency, equity and effectiveness and will focus on achieving results. A review and monitoring mechanisms shall be put in place. A mid-term review of the CCS 2014-2018 shall be carried out in partnership with stakeholders to review progress and ensure continued alignment with national priorities.

1. Introduction

The WHO CCS 2014-2018 outlines the medium term framework for cooperation with the Government of Rwanda (GoR). Five strategic priorities have been developed to guide the work of WHO in the country. The first CCS for Rwanda covered the period of 2004 to 2007; the second CCS covered the period 2009–2013; and the new CCS will cover the period 2014 to 2018.

In general, the CCS 2014-2018 articulates a clear vision of how to improve the quality of WHO work in Rwanda with the aim of providing the maximum contribution to improve the health status of the population. The CCS 2014-2018 articulates the health priorities in the country to guide WHO support in accordance with the WHO mandate and core functions to result in a stronger impact on health.

The CCS 2014-2018 is aligned to the EDPRS II (2013-2018), the HSSP III, the United Nations Development Assistance Plan (UNDAP) (2013-2018) and other important health sector strategic documents. In addition, the CCS reflects priorities identified in the WHO 12th General Programme of Work 2014–2019 approved by the Sixty-sixth World Health Assembly in 2013. Activities, monitoring indicators and required resources for implementation of identified priorities of the CCS are detailed in the WHO biennium workplans approved jointly by WHO and the Government of Rwanda.

Figure 1: WHO CCS 2014-2018 Rwanda linkages to key national strategic documents

EDPRS 2 2013-2018	HSSP II (July 2012-June 2018) plus other government guiding documents
UNDAP 2013-2018	WHO 12th General Programme of Work 2014-2019

The development of the CCS 2014-2018 was led by a task force that was guided by a road map jointly developed by the Ministry of Health and the WHO Country Office. The process included a desk review of relevant documents and review of the implementation of the CCS 2009-2013. The review also involved data collection using a questionnaire and

conducting in-depth interviews with different categories of staff in the MoH and other stakeholders in the health sector. Consultation meetings were organized with selected key agencies within the Government of Rwanda, the United Nations Country Team, development partners and key academic institutions. The CCS consultative process was driven by the principles of country ownership to reflect expectations of the GoR and other stakeholders in the health sector and WHO. Reflectively, the process of developing the CCS was guided by the WHO Country Cooperation Strategies Guide 2010.

2. Health and development challenges and national response

2.1. Macroeconomic, political and social context

Rwanda today has a vibrant democracy with transparent governance and a parliamentary system that prides itself on the fact that 56.3% of parliamentarians are women. Transparency and strong decentralization have supported a government nearer to the people and have laid the foundation for a strong district-based system. In addition, the country experienced a steady economic growth from 2003 to 2013 of 6.5%.

Based on the country vision, the Rwanda health sector has established governance structures at central and local levels complying with the principle of country ownership. In addition, consideration is given to the voice of citizens and community participation in order to increase accountability. The National Decentralization Policy was adopted with the overall objectives of (i) ensuring equitable political, economic, and social development throughout the country; and (ii) making the district the centre of the development trajectory in order to reduce poverty. The Policy defines three phases of implementation. The first phase (2001-2005) aimed at establishing democratically elected and community development structures at the local government level. The second phase (2005-2010) aimed at consolidating progress on national priorities. The third phase aims to strengthen local governance with a focus on financial and fiscal decentralization. Joint health sector review serves as a forum for all health sector stakeholders to discuss priorities, strategize and monitor sector performance.

Rwanda is a landlocked country with an estimated population of 10.5 million; 48.2% are males and 51.8% are females; and 51.7% of all Rwandans are under the age of 20 years (NISR, 2012). With 416 inhabitants per square km, Rwanda is the most densely populated country in Africa, and 16.5% of the population live in urban areas. According to the Rwanda Population and Housing Census 2012, the life expectancy at birth is 64.5 years; the average population growth rate was 2.6% for the period 2002-2012; the crude birth rate is 30.9 per 1000 people; the crude death rate is 7.7 per 1000 people, down from 14.6 per 1000 population in 2002; the total fertility rate is four children per woman.

During the last ten years, Rwanda has experienced one of the most exciting and fastest periods of growth and socioeconomic progress in its history (MFEP, 2013a). Population growth is stabilizing and the country is making great strides towards achieving the MDGs and middle income status (MECF, 2000). The real GDP growth averaged 8.2% annually, and per capita income is US\$ 644 which means a GDP per capita growth of 5.1% per year (MFEP, 2013a, b).

The agriculture sector is widely regarded as the major catalyst for growth and poverty reduction. In the most recent period between 2002 and 2012, the agricultural sector accounted for 72.7% of the national workforce while the non-agricultural sectors were 27.3%. This is about a four-fold increase from the 7.5% figure thirty years ago for workforce employment in the non-agricultural sectors (NISR, 2013).

2.2. Major determinants of health

Income distribution and poverty

Although poverty decreased more in rural areas than urban areas in 2008-2011, poverty in rural areas still stands at 48.7% compared to 22.1% in urban areas (NISR, 2012). Rwanda's poverty profile indicates that women are more affected by poverty than men; 47% of female-headed households are poor. Improved income levels resulted in reduced income inequality. The Gini coefficient, a conventional measure of income inequality, declined from 0.52 in 2005/06 to 0.49 in 2010/11, below the 2000/01 level (0.51). Nevertheless, persistent inequality between men and women in accessing economic resources remains one of the main challenges in addressing rural poverty (MFEP, 2013a).

High growth rates combined with stabilizing population growth has contributed to poverty reduction. The poverty headcount ratio declined from 56.7% in 2005/06 to 44.9% in 2010/11 with significant poverty reduction experienced particularly in rural areas where the rate fell from 61.9% to 48.7% (NISR, 2011).

The reduction in poverty was supported by a combination of factors including improved agricultural incomes where the share of marketed agricultural outputs increased from 21.5% to 26.9% (2006-2011); a 50-60% increase in off-farm job creation; reduction in household sizes as well as public and private transfers (NISR, 2013).

Education

During EDPRS I, the large-scale, innovative and cost-effective nine-year basic education programme was a significant achievement in facilitating access of all children to basic education. The nine-year programme was internationally recognized, winning the

Commonwealth Education Good Practice Awards for 2012. The national primary level enrolment rate continues to improve for both girls and boys and, at 96.5%, has surpassed the 2012 target of 95%. If progress continues, Rwanda will be on track to meet the MDG target of 100% net enrolment by 2015. The national enrolment rate for girls (98%) remains higher than for boys (95%). The primary school completion rate indicator has reached 72.7% which is a significant improvement on the baseline figure of 52.5% in 2008 but still falls short of the 2012 target of 78% (NISR, 2013).

Health promotion

Health promotion is an important component of the national HSSP III. Efforts to address social determinants of health and social protection issues are also top national priorities. The country has developed relevant policies and strategic documents including the Social Protection Strategy Action Plan 2011, Health Promotion Policy and Strategy, School Health Policy, National Food and Nutrition Policy and Strategic Plan. The national structure for health promotion from village to national level is well established, and a core team is now functional at district level. The Ministry of Health and other ministries are implementing identified social protection interventions. However, the national authorities recognize the need to enhance intersectoral cooperation to improve and generate expected results, especially the translation of national decisions to the local levels.

Nutrition

Acute malnutrition in children aged under five years has improved in Rwanda with almost a 50% reduction from 5% in 2005 to 2.8% in 2010 (NISR, ORC Macro, 2006, 2011). However, stunting in the same age group remains high with a national average of 44.2% of which 17% are severe cases. A similar picture is seen with anaemia in children under five and women of reproductive age where 38.1% of children 6-59 months and 17% women of reproductive age are anaemic (NISR, ORC Macro, 2011). During the same reporting period, the prevalence of women who are overweight or obese increased from 11.5% to 16.3% (NISR, ORC Macro, 2006, 2011). National studies show that 78% of children between 12 and 24 months receive low nutrient diets (NISR, MoA, WFP, 2012).

The multiple causes of the high rates of chronic malnutrition in children and other nutrition problems also include inadequate household food security that affects more than 20% of families in Rwanda. These problems are often complicated by the synergy of nutrition with childhood infections. A significant feature in Rwanda from 2008 to 2012 was the consistent and sustained decrease in the childhood killer diseases of malaria, pneumonia and diarrhoea especially among children aged under five years. The GoR

is currently implementing nationally-scaled, community-based, district-driven nutrition interventions including the national campaign on the first thousand days of a child's life as part of high impact interventions to eliminate malnutrition among children.

Environmental determinants

In Rwanda, the main areas of environmental health services are hygiene and sanitation; waste management; hazardous and toxic chemicals management; food quality and safety; water quality management; water supply; air quality management; community-based environmental health promotion programme; occupational health and safety; public health adaptation to climate change; environmental health intervention in emergencies and disasters.

The latest estimates from the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation put Rwanda on track for sanitation and not on track for drinking water to meet the MDG target. According to the Joint Monitoring Programme report, 64% of the national population have access to an improved sanitation facility not shared by two or more households, while 71% have access to an improved water source (WHO, UNICEF, 2014).

According to the demographic and household survey of 2010, 74% of households have access to an improved source of drinking water. The most common source of drinking water used by the households is protected spring water, which accounts for 38% of usage, followed by public tap/standpipe (26%). Only 5% of households have running water in their dwelling or courtyard; 25% of households use unimproved sources of water (NISR, ORC Macro, 2011).

Concerning sanitation facilities, 55% of households have access to an improved pit latrine with slab that is not shared with other households. However 16% of households use an improved pit latrine with slab but share the latrine with other households; 26% of households use an unimproved facility; and 1% of households have no latrine facility at all. Only 1% of households have a place for hand washing. Among those households, 21% have water and soap for hand washing (NISR, ORC Macro, 2011).

Gender

In terms of gender equality, Rwanda has continued to register progress. Women's representation in decision-making positions makes Rwanda the world leader in the proportion of women in parliament (56.3%). In addition, a conducive policy and legal framework for mainstreaming gender in socioeconomic sectors at all levels is in

place (existence of a national gender policy, family policy, gender-based violence law, inheritance law, land law, family law). Pro-poor and gender friendly programmes such as Girinka were initiated as well as gender mainstreaming programmes and projects such as the Gender Responsive Budgeting Initiative (MFEP, 2013a).

Risk of epidemics and vulnerability to disasters

With its geographical location in the Great Rift Valley near the Nyiragongo volcanoes and the effect of the Inter Tropical Convergence Zone on the continent, Rwanda is vulnerable to natural disasters emanating from climatic or seismic disturbances. Some of these disasters include drought, torrential rains, floods, landslides, earthquakes, volcanic eruptions and epidemics. In the past ten years, these disasters have occurred throughout the country. Such disasters are exacerbated by poor farming practices, deforestation and environmental degradation among others.

Historical analysis shows that floods and droughts have caused the most serious disasters in the country in terms of the number of people affected. Flooding and landslides are hazards that frequently affect localized areas of the country. The hilly topography and high annual precipitation rates, over exploitation of the natural environment such as deforestation and inappropriate farming on steep slopes, and climate change can increase the disaster risks. These risks result in loss of lives, malnutrition and other health consequences, disruption to health services and damage to hospitals and other property (Ministry in charge of Disaster Management and Refugees).

The disaster profile includes droughts, fire, floods, earthquakes, landslides, heavy rain, traffic accidents, diseases and epidemics. These disrupt people's lives and livelihoods, destroy infrastructure and interrupt economic activities; such disasters can retard planned development in health and other sectors.

The country has often faced outbreaks of epidemics including emerging and re-emerging infectious diseases such as Influenza A (H1N1), cholera, epidemic typhus and meningitis. The country has been implementing Integrated Disease Surveillance and Response (IDSR) since 2000 and the system is operational at East African Community level. Guidelines and mechanisms have been developed to address health emergencies, while epidemic preparedness and response interventions have been put in place in line with the International Health Regulations.

Major efforts have been made at national level including the creation of the Ministry in charge of Disaster Management and Refugees (MIDIMAR). The government has endorsed disaster management policy and strategies; at the same time, multisectoral preparedness

and response mechanisms have been put in place to strengthen coordination in the country. In the organizational framework for disaster risk management, the Ministry of Health is a member of the National Disaster Management Steering Committee and is the leader of the health cluster during emergency situations.

2.3. Health status of the population

Over the last decade, Rwanda has recorded significant improvements in health indicators. Crude death rate was reduced from 14.6 to 7.7/1000 people and life expectancy rose from 51.2 to 64.4 years (NISR, 2013). Maternal mortality has been reduced by 75% from 1071/100 000 live births (NISR, ORC Macro, 2006) in the year 2000 to 340/100 000 live births in 2013 (World Health Statistics Report 2013). Child mortality has been reduced by over 66% from 153/1000 live births in 2005 to 54/1000 in 2012, while the target was 51/1000.

HIV and AIDS

HIV prevalence in Rwanda has remained the same since 2005. According to the 2005 and 2010 RDHSs, at national level the HIV prevalence average is 3% for women and men aged 15-49 years. HIV prevalence is 3.7% for women and 2.2% for men. HIV prevalence is three times higher in urban areas (7.1%) than in rural areas (2.3%). HIV estimates vary by age, with HIV prevalence highest among women aged 35-39 (7.9%) and men aged 40-44 (7.3%); prevalence is 51% among commercial sex workers.

Across the country 97% of health facilities offer ART and PMTCT services, and ART coverage of expectant mothers is 91.6%. The number of patients on ART increased from 19 058 in 2005 to 133 942 in June 2014 (TracNet Report June 2014). The amount of PMTCT transmission at 18 months after birth has decreased from 9.1% (Tracnet 2007-2008) to 1.9% (TracNet Report June 2014).

Malaria

In 2005, malaria was ranked the number one killer of children aged under five years. The mortality rate due to malaria has decreased nearly 85% (Farmer et al, 2013). For the past ten years, integrated and coordinated efforts have included a combination of prevention, diagnosis, treatment and vector control activities with a strong emphasis on capacity-building and strengthening the health system including community health workers (CHWs).

Tuberculosis

The current TB prevalence is 114/100 000 people (TB prevalence survey 2013). The notification rate in 2008 was 89 per 100 000 population (all forms) and 48 per 100 000 people for smear-positive cases and 72.2 and 41.4 per 100 000 for all forms and for smear-positive pulmonary TB, respectively (new cases and relapses) in 2010. TB mortality rate has been reduced by 78% over a 3-year period (1997-2010). TB treatment success rate is 89.3% while the success rate for MDR-TB is 93.9% (Rwanda Biomedical Center annual report July 2013-June 2014). For MDR-TB, the mortality rate before treatment decreased from 15% in 2008 to 4.4% in 2010 suggesting that diagnosis of MDR-TB is being done earlier, in particular through molecular rapid tests.

HIV testing among TB cases has also increased from 45% in 2004 to 98% in 2012. ART initiation among TB and HIV co-infected patients increased from 45% in 2005 to 91% in June 2014 (Rwanda Biomedical Center annual report July 2013-June 2014).

Vaccine preventable diseases

Routine immunization coverage is more than 95% for all antigens, and fully immunized children coverage is 94% (National Immunization Survey 2013). Currently 12 vaccines are being utilized in the Rwanda routine immunization programme. Due to the high percentage of coverage in the routine immunization programme as well as periodic supplementary immunization activities (SIAs), vaccine preventable diseases (VPDs) have been drastically decreased. The last case of wild poliovirus was notified in 1993, and neonatal tetanus was eliminated in 2004. Rwanda is in the process of introducing measles elimination mode of surveillance in order to meet the MDG target for 2020.

Neglected tropical diseases

Neglected tropical diseases (NTDs) are the most common infections of poor people worldwide. In Rwanda, 65.8% of school children are affected by soil-transmitted helminthes (STHs), the second most frequent problem in health clinics, following respiratory infections (MoH Annual report, 2012). In the past two years, the MoH and partners have built the foundation for an initiative to substantially reduce the disease burden of NTDs. The country was mapped for most PCT diseases (STH, schistosomiasis, lymphatic filariasis, trachoma) as well as onchocerciasis (APOC, 1999).

Noncommunicable diseases

The country is experiencing increased incidence of noncommunicable diseases (NCDs) such as cardiovascular diseases, diabetes, chronic respiratory diseases, cancer conditions, injuries and disabilities as the lifestyles and age parameters of the population change.

According to the Rwanda NCDs country profile, NCDs are estimated to account for 30% of all deaths.

Based on national Health Management Information System (HMIS) data, in 2013 NCDs accounted for 51.9% of all district hospital outpatient consultations and 22.3% of district hospital hospitalizations (HMIS, 2013). A population based survey on adults 15-64 years was conducted in 2012-2013 in order to highlight the risk factors of selected NCDs in Rwanda. The prevalence of the main risk factors are tobacco use (12.9%), unhealthy diet and physical inactivity (21.4%), harmful alcohol consumption (23.5%), injury (34.4%) and obesity (16.1%) (STEPS study 2013). Currently, prevention and management of major NCDs are hindered by challenges such as limited skilled personnel, expensive advanced NCD treatment and an ineffective multisectoral coordination mechanism.

Mental health problems as consequences of the 1994 genocide constitute a top priority in the health sector. The main mental health disorders are epilepsy (52%), psychiatric disorders (18%), psychosomatic disorders (12%), neurological disorders (8%), various psychological disorders and other conditions. (Rwanda Biomedical Center annual report, July 2013-June 2014). Although the government has integrated mental health with primary health care, there is still a need to strengthen collaboration between government and civil society in order to address the issues of psycho-active substance abuse, psycho-trauma and psychosocial problems in children and adolescents (Health Sector Policy 2014).

Maternal and child health

Rwanda has made significant progress to achieve the Millennium Development Goals. The country has achieved MDG5 related to reduction of maternal mortality by 75% in 2015. The country is also on track to achieve MDG4 related to reduction of child mortality by two thirds in 2015. Child mortality decreased from 153/1000 live births in 2005 to 54/1000 live births in 2012, while the target was 51/1000.

According to various reports, Rwanda is ranked first among countries that have shown significant progress in meeting the health-related MDGs. Although infant and child mortality rates have fallen dramatically, reducing neonatal mortality remains a challenge. The country has recorded progress in reducing the prevalence of wasting in children aged under five years. Key contributing factors for increased cognitive development as well as reduced child morbidity and mortality include efforts for prevention of chronic malnutrition and related stunting in children; capacity-building in districts to address human rights and equity issues at primary health care level; strengthening community participation; and strengthening capacities for delivering quality integrated maternal, newborn, child and adolescent services at facility level.

2.4. National responses to health challenges

The Government of Rwanda has used Vision 2020 to set long-term targets for country planning and policy development. The Economic Development and Poverty Reduction Strategy (EDPRS) is a five-year strategic plan aligned to Vision 2020 and MDGs in order to accelerate the country development agenda. The country is currently implementing the EDPRS II (2013-2018). The health sector has developed policy and a strategic plan (HSSP III) that are also aligned to EDPRS II in terms of priorities and interventions. Health challenges are addressed according to the guiding principles of the health sector policy and strategic plan which include a people-centred approach as well as integrated and sustainable services.

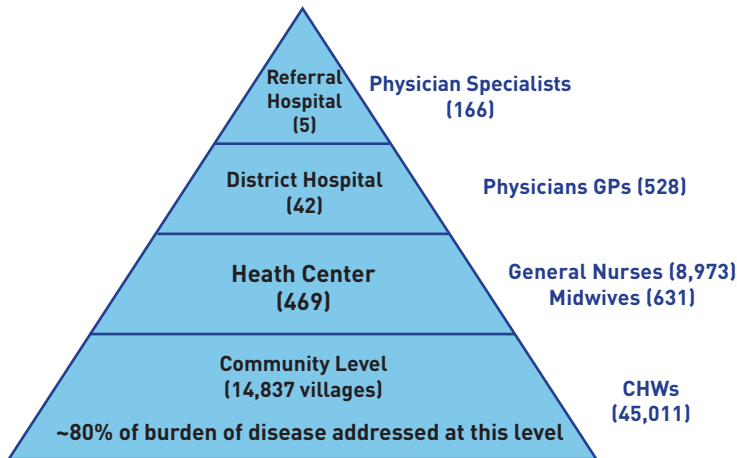
At the international level, the most important policies and commitments providing direction to the HSSP III are the MDGs, the Abuja Declaration, the African Health Strategy (2007–2015), the Paris Declaration on aid effectiveness (2005), the Accra Agenda for Action (2008) and the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (2008). More recent developments have strengthened MoH political commitment to reduce health inequities; these include the Rio Political Declaration on social determinants of health (October 2011), the Brazzaville Declaration on NCDs (2011), the Universal Health Coverage Declaration (2012), the Global Strategy for Women and Child Health Declaration (2014), NCDs countdown (WHA 2012), the Algiers Declaration on health research (2008), and Implementation of the Framework Convention on Tobacco Control (2005).

2.5. Health systems and services

The health system in Rwanda is a pyramidal structure with five levels: national, district, sector, cell and village. The health sector is led by the MoH, which, through the Rwanda Biomedical Centre (RBC), supports, coordinates and regulates all interventions aimed at improving the health status of the population. Services are provided at different levels of the health care system (community, health post, centre, district hospital and referral hospital; see Figure 2) and by different types of providers (public, FBO, private-for-profit, NGOs and traditional medicine). At the decentralized, local level, the district oversees and coordinates the local implementing institutions including health facilities and district pharmacies. Local administration entities play an important role in health promotion and prevention. The government recognizes the need to address existing disparities and has instituted several interventions to improve the situation. For example, the P4P (pay for performance) initiative has been promoted to improve sexual, maternal and reproductive health outcomes across the country.

The MoH is closely linked to the other line ministries and specifically those in the social cluster including ministries of education, local government, agriculture, gender and family promotion. This linkage means that integrated cross-cutting health-based and related programmes are implemented jointly with enhanced results. Important among these is the multisectoral approach to nutrition.

Figure 2: Organization of the Rwanda health system



Health financing system

Over the last few years, Rwanda has developed a comprehensive financing framework for health systems based on best practices in global health care financing. This framework considers both supply and demand. On the supply side, there is the implementation of fiscal decentralization with increased transfers from central government to local governments and peripheral health facilities on the basis of needs and performance as well as a health insurance system including cross-subsidies from richer to poorer categories. On the demand side, there are direct payments to the population through in-kind incentives. A lot of effort has been made to reduce the burden of out-of-pocket payments. In the last ten years, Rwanda made exceptional progress in protecting households against catastrophic health expenditures. General out-of-pocket expenditures dropped from US\$ 9.5 in 2006 to US\$ 4.09 in 2010 (NISR, 2011).

Health information management

Currently, the Rwanda MoH is conducting a series of reforms in its health management information systems. These have included achievements in the automation of systems (R-HMIS, SISCom, RapidSMS, LMIS, IHRIS, Blood transfusion, Tracnet, RTT) that are

operational at different levels and incorporate an innovative mix of paper-based and electronic solutions. The sector has improved the reporting compliance for HMIS and is addressing issues of data quality by introducing standardized data quality assessment methodology at national and district levels.

The GESIS platform which was formerly used for health facility reporting has been replaced by the district health information system (DHIS-2). There are efforts underway to establish a national health observatory at the request of the Minister of Health. The observatory is expected to complement existing health information platforms to strengthen national health information systems. Technical support is being provided by the African Health Observatory. A five-year road map for accountability and information on maternal and child health has been developed. Rwanda completed a national population census in 2012, and the UN is supporting a set of surveys including a new RDHS 2015. There are ongoing efforts to improve quality of information including data on health disparities.

Human resources for health

Although the community health centre is the first level of health care service at community level, the community health worker (CHW) is a non-professional cadre approved to provide basic services as determined by the MoH. From 2008 to 2013, the number of public health professionals increased from 11 604 to 12 012 with health managers and other health supporting staff amounting to 23.3% of all total HRH. Rwanda had 0.02 physicians per 10 000 population in 2005 with a health facility utilization rate of 47%. At present, the utilization rate of health services and facilities is 95%. The ratio of physicians per 10 000 population increased markedly to 0.6 in 2013 (National HRH policy 2014), but there is still a pressing need for increased quantity and quality of health professionals to ensure delivery of quality health services.

According to the December 2011 MoH HRIS report, specialized physicians represent a small portion (28.3%) of the total physicians in clinical practice in the country. Additionally, they are mainly located in and around the capital city Kigali, whereas 80% of general practitioners are distributed in district hospitals in the rural areas. This concentration of specialists creates limitations in expertise available to the community in rural hospitals during time of need.

The problems of shortage and performance of HRH still exist and this has direct and indirect impacts on the quality of service delivery. The MoH has been implementing innovative interventions including P4P to enhance health workers' motivation and performance.

In addition to the strategic plan developed in 2012, the MoH has developed the National Human Resources for Health Policy. Related HRH sustainability strengthening and motivational strategies are under development; they are designed to address comprehensive challenges. The MoH has also initiated interventions to improve health workforce information, forecasting and performance tracking using the HRIS information platform and WSIN methodology.

Medical products

The Ministry of Health has established a pharmacy desk in charge of policy formulation and responsible for health product regulations. The Rwanda Food and Medicines Authority will be established as an autonomous agency to separate implementation and regulation functions.

Procurement, storage and distribution of health commodities are key pillars of an effective health-care system. In Rwanda, procurement functions are mainly fulfilled by the Central Medical Store (currently MPPD), referral hospitals, BUFMAR, private pharmacy wholesalers, district and private pharmacies. District and hospital pharmacies have been created and strengthened providing a system of active distribution of medicines and commodities.

2.6. Contributions to the global health agenda

Rwanda has made major contributions to the global health development agenda. Most of these contributions have been in knowledge management and research, innovative approaches, and financial and technical support.

Knowledge management and research

Health research in Rwanda is benefiting from strong political commitment within the MoH and in the country at large. There are several high-level research institutions with wide international networks including the Institute of HIV/AIDS Disease Prevention and Control (IHDPDC) and the Division of Medical Research both part of the Rwanda Biomedical Centre; the School of Public Health (University of Rwanda); and two academic (university teaching) hospitals.

Important health research has focused on disease control and prevention, social determinants of health in Rwanda and health systems. Specific studies have included monitoring and evaluation of system strengthening for HIV, tuberculosis and malaria; TB prevalence; implementation of indoor residual spraying for malaria; yellow fever risks; rotavirus vaccine (in collaboration with CDC, Atlanta); NCDs (also with CDC); measles/

rubella and congenital rubella syndrome campaigns; immunization; and the economic burden of diarrhoea among children aged under five years (in collaboration with PATH). The health sector was examined through the EDPRS I self-assessment using the sectorwide approach (SWAp) and integrated into HSSP III. Functionality of CHWs was assessed (in collaboration with New Vision) in nine districts.

Innovative approaches

Rwanda has introduced a variety of innovative programmes and initiatives in the health sector (Table 1).

Table 1: Health sector programmes and initiatives, Rwanda

Programme or initiative	Description (purpose, expected outcome, beneficiaries)	Impact
Community health	Provision of health services at community level in order to improve child and maternal health and health promotion; 3 CHWs at village level (includes 1 male and 1 female CHW for child case management, 1 female CHW for maternal and child health support)	Improvement of the health status of the population
Community-based health insurance	Ensure that the entire population accesses health services without financial barriers in a more equitable, progressive and sustainable manner with strong subsidization for the poor and vulnerable groups	Serve the population that is not in other health insurance schemes (90%)
Performance-based financing	Financing of health services based on performance; incentive to health care providers; regular assessment using quantitative and qualitative indicators	Public health facilities
Rapid SMS	Mobile phones distributed to CHWs for communication with health care facilities in case of emergency and to submit community health data	45 000 CHWs
Child growth monitoring	Regular follow-up of nutrition status of children aged under five years and identification of malnutrition cases for early treatment	All U5 children
Community-based FP services	Increased use of contraception by facilitating access to FP commodities; CHWs trained on the provision of FP methods at community level	CHWs, women
MoU with external specialized services to treat patients	Heart surgery, treatment of genital fistula, cleft palates, neuro-spinal surgery, and other diseases needing specialized health care	Patients in need of specialized services that are not available locally
Maternal and child death audits	Audit hospitals to identify the real causes of maternal death and take preventive measures	All hospitals
Patient's Charter of Rights and Responsibilities and customer care	Improve satisfaction of patients and other clients seeking services in health-care settings	All the population
Toll-free hotlines; use of social media	Improve satisfaction of patients and other clients seeking services in health-care settings	All the population

Financial and technical support to other countries

In Rwanda, there is currently a strong political and institutional orientation towards integration and information sharing with other countries for health development. The country has organized and hosted various conferences and summits in partnership with other stakeholders.

Collaborative meetings have included the fourth East African Community Health and Scientific Conference, International Trade Fair and Health Exhibition with a theme of regional health priorities and opportunities; a regional conference on social health protection in the EAC; Integrated Child and Adolescent Health Week during which a new combined measles/rubella vaccine was introduced making Rwanda the first African country to roll out this vaccine; the International Conference on Mental Health with the theme of mass violence, mental rehabilitation and social ties; the eighth annual National Paediatric Conference on children infected and affected by HIV and AIDS the theme of strengthening community ownership for equitable, effective and sustainable response to HIV among children in Rwanda; the 19th Conference of the International Union Against TB and Lung Diseases, Africa Region; NCD Synergies Network inaugural meeting.

In addition, there is the Centre of Excellence in the School of Public Health of Rwanda which is facilitating and coordinating many study tours from different countries to learn from Rwanda. Of special interest are the best practices in health financing.

2.7. Summary

There is a strong link between health and development; some achievements outside the health sector had a positive impact on health. Rwanda has made remarkable socioeconomic progress during the past decade with real GDP growth averaging 8.2% annually. The country is on track to achieve universal access to primary school education by 2015.

Within the health sector, Rwanda has recorded significant improvements in health outcomes over the last decade with both infant mortality and maternal mortality decreasing. There is a remarkable decrease in prevalence of wasting in children aged under five years. The HIV/AIDS national prevalence was 3% in people between ages 15 and 49; 97% of health facilities offer ART and PMTCT services across the country, and the number of patients on ART increased drastically from 2005 to 2014. The current TB prevalence is 114/100 000 people, and the TB mortality rate has been reduced by 78%. ART initiation among TB and HIV co-infected patients has increased to 91%. The malaria mortality rate has also decreased by 85% over the past ten years.

Various health challenges remain however and one is to increase the accessibility of family planning services as the demands also increase. There remains a shortage of skilled health professionals countrywide, and there is growing need for specialist doctors. Another challenge is financial sustainability of health facilities and services. The country also needs to develop the coordination and capacity to respond to disasters and epidemics.

Various opportunities have prevailed in the health sector. Rwanda benefits from strong political will and good leadership which is citizen-centred and encourages inclusiveness and multisector participation. Performance contracts support and ensure accountability at each decision-making level through performance contracts. Finally, the chief executive has promoted home-grown solutions to national problems based on local culture and history.

3. Development cooperation and partnerships

3.1. Aid environment

The Government of Rwanda (GoR) is committed to pursuing the Paris Declaration on aid effectiveness, harmonization and alignment and the Accra Agenda. Clear government objectives are stated in the Aid Policy and supporting strategies.

Mutual accountability is institutionalized, and development partner (DP) performance is measured regularly according to the agreed indicators in the Common Performance Assessment Framework for general budget support (GBS) and sector budget support (SBS) partners. The health sector holds regular joint sector review meetings at both national and district levels between government and DPs. The Ministry of Health coordinates the national health review meeting while at the district level the Joint Development Action Forum is coordinated by the district authorities.

The development partners engaged in the health sector are broadly aligned to the HSSP III priorities. HSSP III is a jointly agreed plan between the GoR/MoH and most DPs. This arrangement is designed to facilitate in-depth dialogue between the GoR and DPs at sector and subsector level with a view to ensuring joint planning, coordination of support, monitoring, evaluation and ownership.

3.2. Stakeholder analysis

The new Division of Labour (DoL) arrangements have also resulted in some agencies such as DFID, GIZ and JICA moving to other sectors. Under current arrangements, the GoR established a division of labor arrangement for coordination of development activities and partnership in all sectors including health. The DoL clearly defines roles and responsibilities and ensures that development activities including investment activities are aligned to the Paris Declaration and harmonized with national rules and regulations. The DoL has resulted in a dynamic scenario where DPs in the health sector are shifting from a vertical to a mainstream approach, aligning with government priorities and increasing the use of existing procedures and accountability mechanisms.

The health expenditure has grown from about US\$ 10 per capita in 1998 to almost US\$ 14 per capita in 2010. Most of this growth is due to an increase in funding from donors which

represented 61% of total health expenditure in 2010 (NHA, 2010). Financial contribution from partners to the health sector is important. In 2011-2012, DPs contributed a large proportion of the health sector budget; for example, PEPFAR, the Global Fund and Presidential Malaria Initiative contributed 59% of the total health expenditure (MoH, 2012b).

Development partners also play an active role in supporting the identification and response to health sector challenges. They actively participate in technical working groups and also in the Joint Health Sector Review where solutions to problems are identified and discussed. To ensure sustainability of support, the government and DPs signed a memorandum of understanding outlining the nature and scope of DP support.

3.3. Coordination and aid effectiveness

Development activities in the country are coordinated by the Development Partners Coordination Group (DPCG) which is the highest-level coordination body in the country. Each government line ministry and donor agency in the country has a primary and secondary representative to the DPCG to ensure adequate representation and institutional memory. The primary representatives are usually the in-country heads of donor organizations or the permanent secretaries in the respective ministries.

The Government has undertaken a number of reforms and other initiatives including the Division of Labour 2011 to facilitate better implementation of the Aid Policy. The overall shift is to encourage DP confidence, use existing financial and accountability systems, and decrease transaction costs.

The on-going changes in the SWAP and aid coordination architecture have resulted in DPs signing MoUs in their respective sectors. This arrangement has also facilitated decreased fragmentation among partners in the country. In addition, to minimize duplication, decrease transaction cost and improve greater government ownership, the government has established a Single Project Implementation Unit in each ministry (Abbott and Rwirahira, 2012).

WHO co-chairs the Country Coordinating Mechanism (CCM) for the Global Fund to fight AIDS, Tuberculosis and Malaria and is also active in the various DPCG mechanisms in the sector.

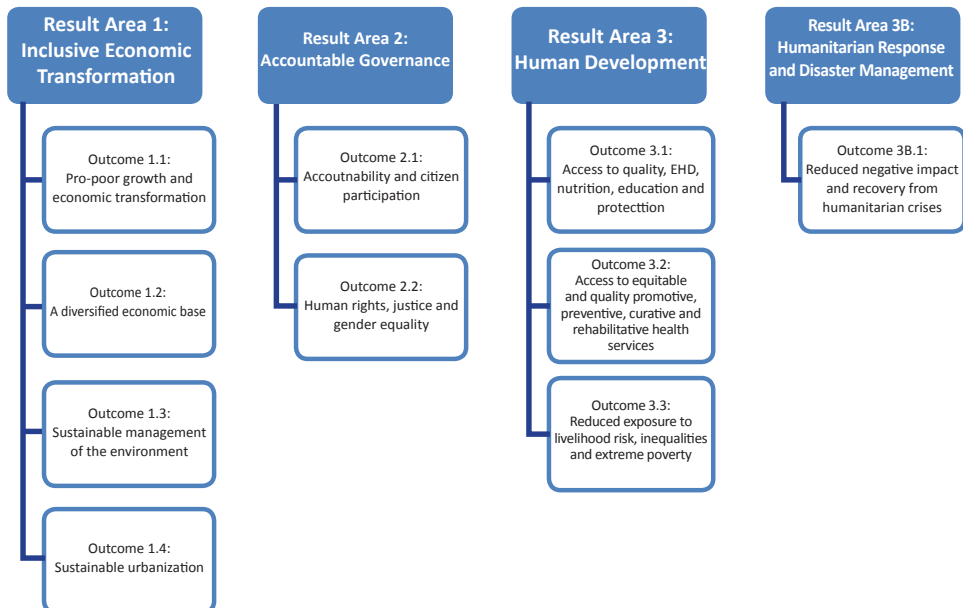
3.4. UN Reform status and CCA/UNDAP process

The United Nations in Rwanda is committed to the vision of Delivering as One. The UN Rwanda Country Team has developed in partnership with GoR the Rwanda UN Development Assistance Plan (UNDAP) 2013-2018 drawing on lessons from the past cooperation framework (UNDAF).

The UNDAP 2013-2018 is strategic and results oriented and reflects the UN's increased focus on delivering upstream technical support in national planning and implementation processes, capacity development, high quality policy advice and technical expertise based on best practices. UNDAP has captured comprehensive health priorities for support by the UN which is aligned to desired health outcomes for the country. UNDAP identified priority areas including health. Within UNDAP, the health sector priorities are reflected in the flagship programme document for 2013-2018 entitled "Strengthening health and population systems with improved governance, analysis and monitoring of results" and developed in partnership with the Ministry of Health. Activities outlined in the document are coordinated through the Development Results Group (DRG) working groups.

The UNDAP 2013-2018 programme result areas and outcomes are highlighted in Figure 3.

Figure 3: UNDAP 2013-2018 Programme Result Areas and Outcomes



Most of the strategic priorities in the third CCS are well aligned to Result Area 3 and Result Area 3B as demonstrated in Section 5.4. WHO is playing an active role in implementation in partnership with other UN agencies. WHO coordinates health sector interventions within UNDAF on behalf of other UN agencies involved in the sector.

3.5. Summary

Key health achievements

Key health achievements have been made in the country. There is an agreed joint plan between the GoR MoH and development partners. A SWAP implementation manual and a road map were developed and endorsed in October 2010, and biennial joint health sector reviews have been held. The Development Partners Coordination Group as a joint mechanism between the GoR and DPs ensures aid coordination. The division of labour arrangement is operational.

Opportunities

Various opportunities prevail in the health sector. Universal health coverage has been adopted. The implementation of several health reforms is ongoing. Mutual accountability is institutionalized. DP performance is measured regularly according to the agreed indicators in the Common Performance Assessment Framework. The GoR is committed to addressing the unfinished MDG agenda and to implementing the post MDG 2015 development agenda. In addition, high level political commitment, enabling policy and institutional mechanisms are present to address the social determinants of health. WHO has ongoing strategic partnerships with key stakeholders in health and other sectors.

Challenges

Various challenges persist. Donor contributions to the health sector continue to decline while government contributions are still low. Comprehensive analysis of some challenges needs to be strengthened. Use of health information is limited, and information on health-related costs and expenditures is not fully captured.

4. Review of WHO cooperation over the past CCS cycle

4.1. Review process

This review process is based on findings, lessons learnt and emerging issues to guide the development of the strategic agenda for 2014-2018. The review of WHO CCS cycle 2009-2013 was undertaken through a consultative process involving the Ministry of Health, development partners, NGOs, UN agencies and WHO. The review process used the WHO Country Cooperation Strategies Guide 2010, key informant interviews, questionnaires and stakeholder consultation sessions. Relevant documents were reviewed and senior MoH officials were consulted. The review process included analysis of trends revealed in the various Rwanda Demographic and Health Surveys (2005 and 2010) and other national documents.

4.2. Framework for analysing partner perceptions

WHO contribution to enhancing national ownership

WHO works in partnership with the government to ensure better planning, implementation and monitoring of programmes including strengthening existing coordination such as health sector working groups and the Country Coordination Mechanism (CCM). WHO provides technical expertise and works closely with the Ministry of Health to develop and review health policies, strategic plans and national guidelines such as the development of the HSSP III and other subsector policies and strategies. The WHO also supports the MoH in capacity-building in various areas of need.

WHO alignment with national health priorities

WHO is well aligned to national health priorities and national health targets as set in EDPRS II, Vision 2020 and HSSP III. WHO has led efforts to develop most of the strategies in coordination with the various departments of the MoH and other DPs. The CCS 2009-2013 was implemented through biennial plans which were prepared in consultation with the MoH and aligned with national priorities. Technical experts in the WHO Country Office played an active role in the preparation of MoH annual and strategic plans.

Harmonization of WHO and national procedures and processes

WHO programmes harmonize well with Government of Rwanda rules and procedures to enhance aid effectiveness. The GoR is committed to pursue the Paris Declaration on aid effectiveness on ownership, harmonization and alignment, results and mutual accountability as well as the Accra Agenda for Action on aid effectiveness. Mutual accountability is institutionalized, and DP performance is measured regularly according to the agreed indicators in the Common Performance Assessment Framework for general budget support (GBS) and sector budget support (SBS). In addition, WHO systems align with the national procurement system. In the mid-term review of HSSP II, the One UN approach was recognized as advanced in harmonization streamlining UN agency procedures, reducing specific procurement requirements and thus becoming more aligned compared to other DPs.

WHO and the UN Country Team

WHO is a member of the UNCT and is a broker for health development among all partners and across sectors. WHO collaborated effectively with other UNCT partners to identify and implement health sector priorities including those outlined in UNDAP 2013-2018. The priorities implemented are within the core functions and priorities of WHO. WHO also works with DPs to strengthen their support to identified health sector priorities.

WHO's comparative advantage

WHO focuses on consolidating its areas of comparative advantage including provision of norms and standards, guidelines, policy development, research and evidence generation; the Organization has also supported programme intervention areas such as health emergency preparedness and other service delivery priorities outlined in HSSP III. WHO has played a key role in supporting important government health programmes including GFATM and immunization activities. It has also supported planning, implementation, programme monitoring and evaluation, and advocacy for resource mobilization.

4.3. Internal review

The internal review and reflection exercise was undertaken to assess the degree of implementation and internal capacity to implement the CCS. The exercise demonstrated that implementation of the CCS supported strengthening of the WHO Country Office. In the period of implementation of the CCS, the CO grew through the recruitment of additional national and international staff members to augment capacity. As part of on-going capacity-building, WHO Country Office staff members benefited from training in

important health development areas such as advocacy, communication skills and data management. The CO also facilitated several missions from the WHO Regional Office and Headquarters to support national authorities.

Key findings

Key achievements include reduction in maternal and child mortality arising from sustained gains, increased immunization and assisted deliveries. In the control of communicable diseases, the country recorded successes in the burden of malaria; high treatment success rate for TB; and increased coverage of VCT, ART and PMTCT. In NCDs, implementation of activities is ongoing including the national STEPS survey. In addition, the country recorded improved access to health services. Successful multisectoral preventive interventions include health promotion with an emphasis on nutrition, environment and the social determinants of health. Several improvements in health system performance resulted in the completion of the health sector strategic plan and review of other important plans.

Emerging issues

During the period covered by the CCS 2009-2013, important issues and changes in the health sector emerged with implications for future programming. These include the need to enhance universal health coverage; promote sustainability especially of health sector funding; prevent, manage and control NCDs and chronic malnutrition in children; harmonize information gathering, data analysis and data use; and increase involvement of the private sector. Other issues include increasing community participation in the management of health services (governance); integrating decentralized health services; integrating IT platforms for information gathering as well as data analysis, display, dissemination and use; and strengthening knowledge management and research, including eHealth.

To ensure alignment and harmonization of rules and procedures, the Government of Rwanda developed key strategic documents including EDPRS II and HSSP III that clearly outline strategies and priorities to achieve health goals. UN agencies in Rwanda have also transitioned in the implementation period from vertical institutional programming to a mainstreamed comprehensive strategic approach. In addition, each of these processes is well aligned with the three guiding principles of the 2014 health sector policy: people-centred care, integrated services and sustainability.

To enhance programme effectiveness and coordination, the GoR adopted the Division of Labour (DoL) 2013 policy; at the same time, the Global Fund introduced the results-

based funding model. Both shifts in approach have resulted in necessary changes by development agencies. The new DoL arrangements have also resulted in some agencies such as DFID, GIZ, JICA moving to other sectors. Some agencies have modified their technical support focus using a comprehensive assistance approach including SBS, basket funding, the Capacity Development Pooled Fund and institutional strengthening project support.

In order to reduce the country's dependency on foreign aid (40% of the current budget), the GoR mobilized domestic resources and has successfully increased the domestic revenues to GDP ratio in the past several years. However, the level is still far below the regional average. To address the unpredictability of external support and overall sustainability, the GoR has introduced a number of positive initiatives. These include increasing the domestic revenue to GDP ratio; increasing the use of local revenue for health to complement ongoing external investments; improving efficiency and effectiveness of interventions including managerial reforms; and promoting the principles of value for money and accountability. Moreover, the GoR has taken additional actions to promote favourable policy incentives to enhance local and external private investment in health including Public Private Community Partnership.

In the meantime, while the country has achieved positive progress in the attainment of most of the MDG targets, some unfinished MDG agenda items remain and require action. Rwanda has played a leadership role in articulating concrete actions to implement the post 2015 development agenda. Meanwhile, the country is also accelerating actions to implement the Rwanda Social Protection Strategy (2011) and achievement of UHC targets including outlined priority targets in the 12th WHO General Programme of Work 2014-2019 (approved by the Sixty-sixth World Health Assembly).

Overall, the review acknowledged that WHO achieved useful progress within the context of stated

objectives including the progress achieved in the areas highlighted above. However, some health system challenges persist.

The achievement recorded in reduction of the burden of communicable diseases has increased awareness of the urgent need to address challenges associated with the growing burden of NCDs. There is a need to take action to address known challenges associated with the social determinants of health including the vulnerabilities of communities to climate change, epidemics and disasters.

4.4. Summary

The WHO Country Cooperation Strategy 2014-2018 in partnership with the Government of Rwanda is designed to be implemented around the following five key strategic priorities:

- a) Support health system strengthening towards health service integration and universal health coverage;
- b) Contribute to the reduction of morbidity and mortality from major diseases and thus contribute to the achievement of the health-related Millennium Development Goals;
- c) Contribute to the reduction of maternal, newborn and child morbidity and mortality;
- d) Promote health by addressing the social determinants of health, health and environment, nutrition and food safety;
- e) Strengthen disaster risk management and epidemic emergency preparedness and response; and implementation of the International Health Regulations.

The outlined strategic priorities are expected to generate clear actions to achieve health goals and objectives including alignment with three guiding principles of the 2014 Rwanda health sector policy: people-centred care, integrated services and sustainability.

The prioritization of strategies also factored existing opportunities in the health sector including the Division of Labour (DoL) 2011 among development partners and existing HSSP priorities; the UNDP plan 2013-2018 and ongoing efforts by GoR to address SDH and social protection. The document builds on important lessons learnt, is aligned to the impressive achievements of the GoR second Economic Development and Poverty Reduction Strategy (EDPRS II) and considers objectives of the WHO 12th General Programme of Work 2014-2019.

5. Strategic agenda for WHO cooperation

The formulation of the strategic agenda for WHO cooperation for the period 2014-2018 benefited from an interactive process of dialogue with key stakeholders including government, civil society, development partners and UN agencies. The interaction with stakeholders generated identification of important health and development challenges in the health sector including sustainability of investment; constraints in scaling up essential services for the population; and complementarities and alignment of the CCS and HSSP.

To address some identified challenges, several opportunities for developing national capacities including opportunities to strengthen workforce managerial and performance capacity were considered especially data collection, analysis and use. Given the experience and achievements recorded, attention will be given to prevention, management and control of NCDs and chronic childhood malnutrition; health system strengthening towards health services integration; and achievement of universal health coverage.

Overall, on-going activities in the following WHO leadership priorities 2014-2019 will be consolidated:

- a) Advancing universal health coverage: enabling countries to sustain or expand access to essential health services and financial protection, and promoting universal health coverage as a unifying concept in global health;
- b) Addressing unfinished and future challenges of health-related MDGs: accelerating the achievement of the current health-related goals up to and beyond 2015 including the eradication of polio and selected neglected tropical diseases;
- c) Addressing the challenges of NCDs, mental health, violence, injuries and disabilities;
- d) Implementing the provisions of the International Health Regulations: ensuring that all countries can meet the capacity requirements specified in the International Health Regulations (2005) and support implementation of the Disaster Risk Management Strategy for the health sector in the African Region;

- e) Increasing access to essential, high-quality and affordable medical products (medicines, vaccines, diagnostics and other health technologies);
- f) Addressing the social, economic and environmental determinants of health as a means of reducing health inequities within and between countries.

5.1. Strategic agenda for Government of Rwanda and WHO cooperation

The Rwanda CCS identifies five strategic priorities, the main focus areas and the strategic approaches for implementation. While the scope of outlined priorities is broad, the WCO is very cognizant of current global resource scarcity; hence, activities to be implemented will benefit from further realistic assessment given the prevailing resource situation.

5.2. Rwanda CCS strategic priorities

- a) Support health system strengthening towards health service integration and universal health coverage;
- b) Contribute to the reduction of morbidity and mortality from major communicable and noncommunicable diseases and conditions towards consolidation of health-related MDG gains and achievements of post 2015 development goals;
- c) Contribute to the reduction of maternal, newborn and child morbidity and mortality;
- d) Promote health by addressing the social determinants of health, health and environment, nutrition and food safety;
- e) Strengthen disaster risk management and epidemic emergency preparedness and response; and implementation of the International Health Regulations.

Strategic priority 1: Support health system strengthening towards health service integration and universal health coverage

Main focus 1.1: *Support the Ministry of Health to strengthen capacity for health system governance and stewardship*

- a) Provide technical support to strengthen capacity to develop and implement policies as well as legislative, regulatory and financial frameworks through generation and use of evidence, norms and standards for a robust planning, monitoring and evaluation cycle;
- b) Provide technical support to strengthen capacity of managers of health services and programmes at all levels (including private sector) for effective management and delivery of health services;
- c) Provide technical support to improve coordination and effectiveness of the health sector in respect of sectorwide approach principles (central and decentralized);
- d) Provide support for joint monitoring and evaluation of progress towards universal health coverage including joint sector reviews.

Main focus 1.2: *Support the Ministry of Health to improve service delivery*

- a) Provide technical support to develop guidelines, tools and support for improved patient safety and quality of services for patient empowerment;
- b) Provide technical support to review and develop norms, standards and protocols ensuring health-care quality assurance with better harmonization of existing quality assurance tools (integrated supervision, PBF quality assessment and accreditation).

Main focus 1.3: *Strengthen country capacity to develop strategies and mechanisms to improve production and management of human resources for health*

- a) Provide technical support to plan and implement strategies that are in line with the global strategy on HRH and the Global Code of Practice on the International Recruitment of Health Personnel;
- b) Promote accreditation of training programmes and institutions according to international standards;
- c) Emphasize capacity-building in specialized skills in health-care technology management including biomedical engineering and hospital infrastructure engineering;
- d) Provide technical guidance to strengthen legislation and policy to promote the development, retention and sustainability of a sufficiently skilled health workforce as well as implement guidelines for the transformation and scaling up of education and accreditation of health personnel.

Main focus 1.4: *Strengthen country capacity to develop and implement a health financing system which ensures that quality essential health services are accessible to the whole population in an equitable, efficient, and sustainable manner*

- a) Identify needs and provide support to strengthen country capacity in developing and implementing legislative and regulatory frameworks;
- b) Provide technical support to promote, develop and strengthen a sustainable health financing system that advances the goal of universal health coverage;
- c) Provide technical support to improve efficiency in the allocation and use of health resources and coverage of high impact interventions;
- d) Provide technical support to increase internal resource mobilization for sustainable funding of the health sector;

- e) Provide technical support to improve coordination and effectiveness of external assistance and national resources for the health sector.

Main focus area 1.5: *Promote improved access to health products and health-care technologies based on primary health care*

- a) Provide technical support to revise and implement national policies for the pricing, procurement and management of health products and technologies;
- b) Strengthen capacity for regular, evidence-based updating of basic documents to promote rational use of health products and technologies including the national list of essential medicines and therapeutics protocols;
- c) Provide technical support for the regulation, quality assurance and management of essential health products and technologies.

Main focus area 1.6: *Promote health system information and evidence sharing, monitoring of trends, data generation and analysis of health priorities, eHealth, health research and knowledge management*

- a) Support the development and strengthening of data sources including civil registration and vital statistics;
- b) Support the availability and use of routine health information systems (HIS) to inform implementation policies as well as initiate and promote research based on the HIS;
- c) Support development and use of knowledge management policies, tools, networks, assets and resources and promote systematic use of evidence in the formulation of national policies and decision-making;
- d) Provide technical support to strengthen health systems research, monitoring and evaluation; and support implementation of an eHealth strategy;
- e) Provide technical support to keep national authorities and stakeholders informed about emerging knowledge in order to strengthen delivery among potential users;

- f) Build the capacity of health professionals and MoH personnel to synthesize and disseminate lessons learnt and good practices from implementation of innovative policy initiatives, research findings and pilot programmes.

Strategic priority 2: Contribute to the reduction of morbidity and mortality from major communicable and noncommunicable diseases and conditions towards consolidation of health-related MDG gains and achievement of post 2015 development goals

Main focus 2.1: *Support the health sector to prevent and control HIV and AIDS, malaria, tuberculosis, neglected tropical diseases and other communicable diseases*

- a) Provide technical support to maintain adequate national response to HIV towards universal access to HIV and AIDS prevention, care and treatment;
- b) Provide technical support to accelerate and scale up cost-effective malaria interventions towards universal coverage and attainment of malaria pre-elimination by 2018;
- c) Provide technical support to accelerate the implementation of Stop TB by expanding and enhancing implementation of DOTS and strengthening capacity of the National Tuberculosis Programme;
- d) Provide technical support to strengthen the capacity of NTD programme managers to develop and implement an NTD budget master plan;
- e) Provide support to enhance NTD monitoring and evaluation, surveillance, and operations research including the mapping of lymphatic filariasis in the country;
- f) Provide technical support to improve community access to uptake of EPI/VPD services through the Reach Every Child (REC) approach and supplementary immunization activities (SIAs) and to reinforce the capacity of VPD and AEFI surveillance at all levels.

Main focus 2.2: *Support prevention and control of noncommunicable diseases*

- a) Provide technical support in the development and implementation of protocols and guidelines for NCD prevention and control;
- b) Provide technical support to strengthen NCD surveillance systems, monitoring and evaluation;
- c) Support research towards integration of NCDs in service delivery.

Strategic priority 3: *Contribute to the reduction of maternal, newborn and child morbidity and mortality*

Main focus 3.1: *Support Ministry of Health to improve access to sexual and reproductive health information and quality services with focus on the life cycle approach*

- a) Provide support for the development, review and update of policy and strategies, norms, standards, tools and guidelines to improve the quality of SRH and adolescent-friendly SRH services;
- b) Provide support to MoH for advocacy, research, use of evidence, monitoring and evaluation for relevant areas pertaining to SRH issues.

Main focus 3.2: *Strengthen national capacity to improve maternal and child health interventions including access to skilled attendance at deliveries and to scale up high impact child survival interventions*

- a) Provide support for strengthening partnerships, evidence generation, norms and standards, advocacy, resource mobilization and innovation including ensuring quality child and newborn health services especially community-based integrated services;
- b) Provide support to build capacity of health-care providers for quality essential and emergency maternal and newborn care including ECD and PMTCT through interventions that reach from household and community levels to tertiary level;

- c) Provide support for capacity-building on key child health interventions including Integrated Management of Childhood Illness, quality paediatric referral care and management of severe acute malnutrition for health-care providers, tutors and programme managers;
- d) Provide support to move from a maternal death audit and a newborn and child death audit to maternal, newborn and child death surveillance and response with focus on strengthening response.

Main focus 3.3: *Strengthen immunization systems including preventable disease surveillance and cold chain management, and support the introduction of new vaccines*

- a) Provide support to increase immunization coverage nationally and reduce the number of unvaccinated children by extending REC to poorly performing zones; and to improve monitoring by providing high quality data, increasing supportive supervision and improving internal and external reporting systems;
- b) Support the introduction of new vaccines by encouraging the government to increase co financing and provide technical support to research disease burdens;
- c) Provide support to develop policy and strategies for the provision of cold chain maintenance, monitoring and reporting;
- d) Provide support for the implementation of immunization and surveillance activities towards achieving global and regional accelerated disease control targets (polio eradication, measles elimination, and maintaining maternal and newborn tetanus elimination) by developing clear SOPs for VPD surveillance, increasing capacity of laboratories and increasing community involvement in detection and reporting of VPD.

Main focus 3.4: *Strengthen surveillance, prevention and management of malnutrition in mothers, infants and young children*

- a) Provide support to develop a multisectoral and decentralized food and nutrition policy as well as strategy and national standards aimed at reducing all forms of malnutrition;

- b) Provide support to strengthen nutrition surveillance based on social clusters in existing systems and to conduct a national survey determining the causes of stunting;
- c) Provide support to build capacity at all levels to proactively prevent and manage malnutrition in mothers and children through improved counselling to families on maternal, infant and young child nutrition; growth monitoring; and use of innovative approaches;
- d) Provide support to build the capacity of health providers in operational research aimed at reducing malnutrition.

Strategic priority 4: Promote health by addressing social determinants of health, health and environment, nutrition and food safety

Main focus 4.1: *Promote health and the social determinants of health*

- a) Support implementation, monitoring and evaluation of health promotion activities at decentralized level based on empowerment and full participation of communities in a multisectoral approach;
- b) Promote healthy lifestyles addressing NCD risk factors including tobacco, alcohol and substance abuse; physical inactivity; and malnutrition; target school ages and other vulnerable groups.

Main focus 4.2: *Promote a safer and healthier environment, improved nutrition and food safety*

- a) Provide technical support for improving water, sanitation and hygiene services;
- b) Provide technical support for multisectoral interventions and collaboration in addressing the environmental determinants to human health (air pollution, water pollution, climate change, chemicals) and ecosystem integrity;
- c) Provide technical support to strengthen national and decentralized systems for food safety inspection and risk analysis;

- d) Provide technical support to build capacity on nutritional care for prevention and management of NCDs; and contribute to the national first thousand days campaign to prevent stunting through capacity-building of health-care providers at all levels on maternal, infant and young child nutrition.

Strategic priority 5: Strengthen disaster and epidemic emergency preparedness and response as well as implementation of the International Health Regulations

Main focus 5.1: *Support the Ministry of Health to strengthen the capacity for implementation of the Integrated Disease Surveillance and Response through IHRs and One Health strategy frameworks*

- a) Provide technical support to strengthen and implement an effective, efficient national disease surveillance and response system;
- b) Provide support to strengthen surveillance, prevention, early detection, rapid response and control of zoonoses in both humans and animals;
- c) Provide support to implement the International Health Regulations;
- d) Provide technical support to monitor and evaluate standards and quality measures for a surveillance and response system;
- e) Provide technical support to conduct operational research to inform policies, advocacy and best practices.

Main focus 5.2: *Support Ministry of Health and MIDIMAR to develop and implement preparedness and response measures for disaster risk management, prevention and control epidemics, and other emergencies*

- a) Provide technical support to assess country risks and capacities for disaster risk management and develop a road map for strengthening capacities;
- b) Provide support to develop preparedness for the control of disaster, epidemics and other emergencies;

- c) Contribute to strengthen disaster preparedness for effective response that includes response planning, training and education programmes, early warning, pre-positioning of essential supplies, and simulations based on all risks prevalent in the country;
- d) Provide support to assess the safety and preparedness of hospitals and health facilities and to implement resilience-building interventions in health facilities and communities;
- e) Provide support and participate in response and recovery to disasters, epidemics and other emergencies based on national standard operating procedures.

5.3. Validation of the CCS strategic agenda with the third Health Sector Strategic Plan

The CCS strategic priorities were derived from the challenges identified during implementation of HSSP II; review of WHO cooperation for the second CCS; and national, regional and global commitments including the post 2015 development agenda. The CCS strategic priorities are also aligned to the third Health Sector Strategic Plan 2012-2018 priorities as highlighted in Table 2.

Table 2: Alignment of Country Cooperation Strategy and Health Sector Strategic Plan III priorities

CCS strategic priorities	HSSP III Priorities				
	1	2	3	4	5
	Sustain the achievements in MCH and the fight against infectious diseases	Improve accessibility to health services (financial, geographical, community health)	Improve quality of health provision (quality assurance, training, medical equipment, supervision)	Reinforce institutional strengthening (especially toward district health services units)	Improve quantity and quality of HRH
• Support health system strengthening towards health service integration and universal health coverage	•	•	•	•	•
• Contribute to the reduction of morbidity and mortality from major diseases and conditions and thus contribute to the achievement of health-related MDGs	•	•	•		•
• Contribute to the reduction of maternal, newborn and child morbidity and mortality					
• Promote health by addressing the SDH, health and environment, nutrition and food safety	•	•	•	•	•
• Promote better disaster risk management, epidemic and emergency preparedness and response, and implementation of IHRs		•	•	•	•

5.4. Validation of the CCS strategic agenda with the Rwanda UN Development Assistance Plan

The WHO Country Cooperation Strategy 2014-2018 Rwanda is aligned to the UNDAF 2013-2018 which is the five-year programme for cooperation developed to enhance the UN Delivering as One. UNDAF is fully aligned to the government's EDPRS II; Vision 2020; and regional, continental and global commitments. More specifically, the CCS III is aligned to Result Area 1 on inclusive economic transformation; Result Area 3 on human development focusing on holistic child, youth and family development; and Result Area 3B on humanitarian response and disaster management. Priorities, areas, outcomes and outputs are highlighted in Table 3.

Table 3: Alignment of CCS priorities and UNDAF outcomes and outputs

CCS strategic priorities	UNDAF 2013-2018 result areas and outcomes	UNDAF 2013-2018 outputs
<ul style="list-style-type: none"> CCS Strategic Priority 1: Support health system strengthening towards health service integration and universal health coverage 	Result Area 1: Outcome 2: Diversified economic base allows Rwandans to tap into and benefit from expanded international, regional and local markets, and improved agriculture value-chains	Output 1.2.2: Strengthened national regulatory frameworks for quality standards compliance
<ul style="list-style-type: none"> CCS Strategic Priority 3: Contribute to the reduction of maternal, newborn and child morbidity and mortality CCS Strategic Priority 4: Promote health by addressing social determinants of health, health and environment, nutrition and food safety 	Result Area 3: Outcome 3.1: All Rwandan children, youth and families, especially the most vulnerable, access quality early childhood development, nutrition, education and protection	Output 3.1.1: Improved capacity of government institutions and communities to expand equitable access to quality integrated child and family services Output 3.1.2: Strengthened, coordinated and monitored multisectoral strategies for sustained reduction of child and maternal malnutrition Output 3.1.3: Strengthened capacities of the education sector to deliver inclusive quality basic education
<ul style="list-style-type: none"> CCS Strategic Priority 1: Support health system strengthening towards health service integration and universal health coverage CCS Strategic Priority 4: Contribute to the reduction of morbidity and mortality from major communicable and noncommunicable diseases and conditions towards consolidation of health-related MDGs gains and achievements of post 2015 development goals 	Result Area 3: Outcome 3.2: All people in Rwanda have improved and equitable access to and utilize high quality promotional, preventive, curative and rehabilitative health services	Output 3.2.1: Strengthened national capacities for health governance (policies, tools, plans, strategies, and standards), management, financing, human resources and management of information systems Output 3.2.2: Strengthened national and subnational capacity to provide quality integrated health services Output 3.2.3: Strengthened community capacity to demand quality health services at all levels Output 3.2.4: Increased capacity of national service providers, civil society and private sector to accelerate development and implementation of evidence-oriented integrated HIV/AIDS prevention, treatment, care and support programmes for key populations

CCS strategic priorities	UNDAP 2013-2018 result areas and outcomes	UNDAP 2013-2018 outputs
<ul style="list-style-type: none"> CCS Strategic Priority 4: Promote health by addressing social determinants of health, health and environment, nutrition and food safety 	Result Area 3: Outcome 3.3: Vulnerable groups have reduced exposure to livelihood risk, inequalities and extreme poverty	Output 3.3.1: Strengthened capacity of national and subnational institutions in targeting, delivery, M&E of equitable and holistic social protection services to vulnerable groups
		Output 3.3.2: Strengthened national and sub national capacity to increase access to social security services especially for youth and women
		Output 3.3.4: Capacity of planners, decision-makers, and key stakeholders strengthened to ensure a protective legal and policy environment for PLHIV and their families
<ul style="list-style-type: none"> CCS Strategic Priority 5: Promote better disaster risk management and emergency, disaster and epidemic preparedness and response, and implement the International Health Regulations 	Result Area 3: Outcome 3b.1: Reduced negative impact and improved recovery of affected populations due to humanitarian crises	Output 3B.1.1: Strengthened national capacities for emergency/humanitarian preparedness and response at all levels Output 3B.1.2: Improved protection and self-reliance of refugees and other affected populations especially children, adolescents and women
<ul style="list-style-type: none"> CCS Strategic Priority 4: Promote health by addressing social determinants of health, health and environment, nutrition and food safety 	Result Area 1: Outcome 3: Rwanda has in place improved systems for: sustainable management of the environment, natural resources and renewable energy resources, energy access and security for environmental and climate change resilience in line with Rio+20 recommendations for sustainable development	Output 1.3.2: Strengthened capacity for sustainable environment, natural resources management, climate change mitigation and adaptation
		Output 1.3.3: Strengthened capacity of national and local institutions to reduce disasters and risks
		Output 1.3.5: Strengthened national capacities for planning and management of green villages

5.5. Validation of the CCS strategic agenda with the WHO 12th General Programme of Work

Table 4: Alignment of CCS priorities and main focus areas with the WHO 12th GPW categories, 2014-2019

CCS strategic priorities	12 th WHO GPW categories 2014-2019				
	1: CD control	2: NCD control	3: Health in the life course	4: Health systems	5: Disaster preparedness and response
Strategic Priority 1: Support health system strengthening towards health service integration and universal health coverage					
Strategic Priority 2: Contribute to the reduction of morbidity and mortality from major communicable and noncommunicable diseases and conditions towards consolidation of health-related MDG gains and achievements of post 2015 development goals					
Strategic Priority 3: Contribute to the reduction of maternal, newborn and child morbidity and mortality					
Strategic Priority 4: Promote health by addressing social determinants of health, health and environment, nutrition and food safety					
Strategic Priority 5: Promote better disaster risk management and emergency and epidemic preparedness and response and implementation of the International Health Regulations					

6. Implementing the strategic agenda: implications for the Secretariat

6.1. The role and presence of WHO

The programming and operational environment in the country is changing with implications for WHO on several fronts including how the Organization works and provides technical support to governments and partners. The approach and focus of technical support received from other WHO levels also require rethinking and some adjustments to better align and respond to the country's needs and realities.

WHO will need to consolidate its partnership and relationship-building strategies to better position itself in the fast-evolving, large and diverse partnership environment in the country. Hence there is increased need for focus on areas of WHO clear comparative advantage. In addition, concrete actions are needed to enhance resource mobilization and ensure availability of skilled staff that will contribute to better strategic alignment with identified CCS priorities using the acknowledged principles.

The desired role of WHO in the implementation of the strategic agenda is based on the country's needs for support in implementing national health sector priorities. WHO will consolidate its role as a policy adviser on major health issues.

Normative functions will be strengthened, and efforts will be made to mobilize additional funding, particularly for health system strengthening, health information systems, health-care financing, implementation of IHRs, and addressing various issues that have arisen due to structural changes in the country. WHO leadership and partnership in matters critical to health will be provided along with technical support thereby catalysing change and building sustainable institutional capacity. Support will be provided to strengthen monitoring and evaluation of health system performance, monitoring of the health situation and assessing health trends.

The WHO Country Office needs to be equipped with adequate staff and financial resources to achieve the strategic objectives mentioned in the CCS. Currently, the staff includes three international members, namely the WHO Representative, a technical

officer in charge of HIS and a technical officer in charge of NCDs and nutrition. There are nine national professional officers and a national operations officer. For the next CCS period, the focus will be on staff performance improvement through capacity-building as well as enhanced performance management and development.

6.2. Using the Country Cooperation Strategy

The new Country Cooperation Strategy will guide WHO Secretariat work with Rwanda from 2014 to 2018; in particular, the CCS will guide the work of WHO at all levels including preparation of biennial plans. The WHO Rwanda Country Office will widely disseminate the CCS document to the government and other partners.

The CO will use CCS priorities to guide future workplans. In addition, the CO will use CCS content to coordinate the health component of UNDAF and other partnership platforms while recognizing partners' contributions. The CCS also serves as a guide for resource mobilization and advocacy.

6.3. Monitoring and evaluation

WHO will monitor CCS implementation using established procedures in partnership with the Government of Rwanda and other stakeholders. Efforts will be made to align the monitoring of priority programmes with the agreed-upon processes for their oversight and accountability. These procedures will include a mid-term review and end-of-biennium review of collaborative programmes. These will also contribute to the WHO biennial programme budget performance assessment. The mid-term review may consider curtailing or phasing out some programmes, while identifying and initiating activities in new priority areas, in which case WHO will adjust collaborative activities accordingly. WHO will undertake a mid-term review of the CCS cycle in 2016-2017 in order to ensure that collaborative workplans and activities are in line with the strategic priorities and with any emerging needs and lessons learnt.

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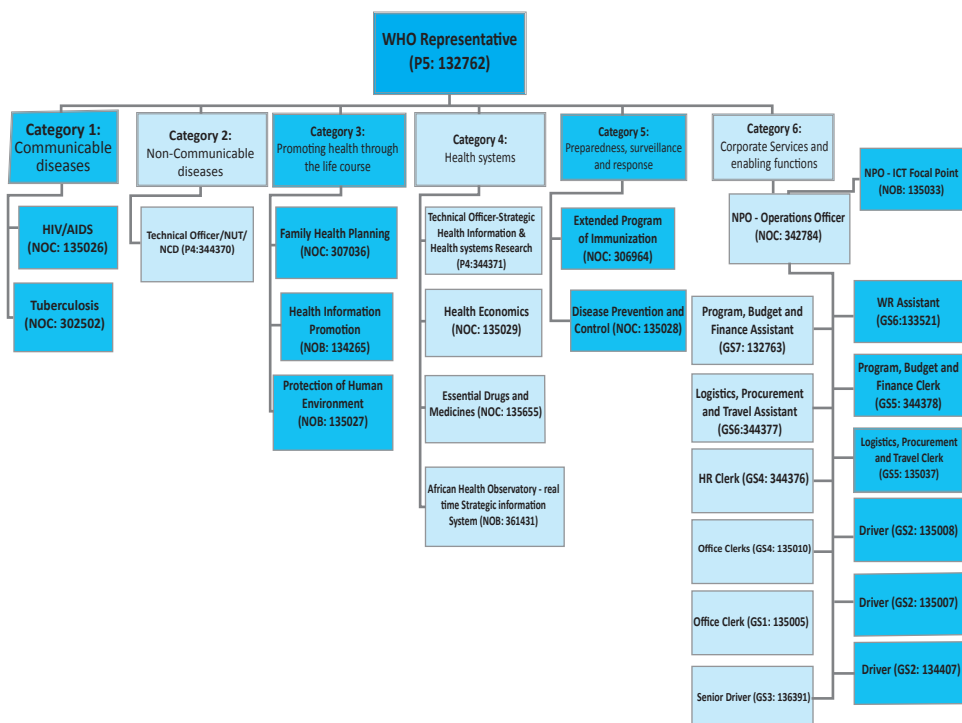
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Annexes

Annex 1. Organogram of WHO Rwanda Country Office



Annex 2. List of stakeholders contacted for CCS III development

Ministry of Health and line ministries	Institutions	UN agencies
Planning, M&E and HMIS Division	World Relief	WHO
Human Resources	Belgian Technical Cooperation	UNFPA
Mother and Child Health	Rwanda Health Family Project	UNICEF
Pharmacy	Embassy of Belgium	UN Dispensary
RBC/HIV	Management Sciences for Health	UN Women
RBC/TB/Other Respiratory Diseases	National Paralympic Council	UNAIDS
RBC/IHDPC	World Vision	WFP
RBC/Malaria and Other Parasitic Diseases	Rwanda Association of Allied Health Professionals Council	
RBC/NCD	Rwanda Medical Association	
Vaccine Preventable Diseases		
RBC/Maintenance Medical Equipment		
Community Health		
RBC/HIV/Early Infant Dignosis		
Decentralization and Integration		
Human Resources for Health		
Ministry of Disasters Management and Refugees		
Ministry of Local Government		
Ministry of Education		
Ministry of Gender and Family Promotion		
Ministry of Education		
Ministry of Gender and Family Promotion		

