



Health Sector Policy

Government of Rwanda

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Foreword

Current health indicators reveal the precarious health situation that exists for the majority of Rwandan households, restricting the ability of the population to take part fully in the economic development of the country. The situation is most visible by the large number of the people who fall ill without receiving any medical attention, by the high number of absent days from work, by the large sums of money spent on health care and by the constant funeral ceremonies taking place in the hills. Indicators of children mortality, pregnant mother's mortality are particularly worrying. This situation is worsened by other cross cutting factors related to the poverty in general stigmatised by the low GDP resulting in context proper to accommodate the diseases particularly transmissible diseases, malnutrition and now the AIDS and its spread.

The few number of medical practitioners (doctors and nurses) has been exaggerated by the genocide of 1994 during which many of them were killed, others fled away and we are watching now to a brain drain either retaining a growing number of those practitioners abroad or moving them from the public sector to the new demanding sector of NGOs. These realities constitute a genuine barrier to the development at a moment which Rwanda is leaving the emergency period of post war instability and is embarking in an ambitious phase of sustainable development as detailed in its 2020 vision and in its commitments to numerous other international plans of development such as the MDGs, the NEPAD,.....

The new policy is expected to come as a real deep reform as to address the major traditional problems of health, the new challenges set by the pandemic of HIV/AIDS. This reform comes at an opportune moment when the Government has begun the process of decentralisation and planning based upon Vision 2020 and the Poverty Reduction Strategy Paper in the context of good governance.

One can expect better results since the MOH is resolved to capitalize on these opportunities of poverty reduction, good governance..., to approach the health problems in the angle of sector strategy as programs views, evidence based medicine, to innovate by introducing notion of adding value by using concepts of results orientation, quality and performance based techniques, interacting teaching in medical and nursing schools, use of ICT as a revolutionary method for improving quality of care and management.

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The Minister of Health

Acronyms and Abbreviations

AIDS	: Acquired immune deficiency syndrome
BCC	: Behaviour Change Communication
CAMERWA	: Central Purchasing Agency of Essential Drugs
CHK	: Kigali Teaching Hospital
CHU	: University Teaching Hospital (Kigali and Butare)
CNLS	: National Commission on AIDS Control
CNTS	: National Blood Transfusion Centre
DHS	: Demographic Health Survey
EICV	: Integrated household living conditions survey
HIV	: Human Immuno-Deficiency Virus
HMIS	: Health Management Information System
ICT	: Information Communication Technology
IEC	: Information, Education, Communication
IMCI	: Integrated Management of Childhood Illnesses
LABOPHAR	: Pharmaceutical Laboratory of Rwanda
MINALOC	: Ministry of Local Government and Social Affairs
MOD	: Ministry of Defence
MOH	: Ministry of Health
NGO	: Non-Governmental Organisation
PLWA	: People Living with HIV\AIDS
PMTCT	: Prevention of Mother-to-Child Transmission of HIV
PNILT	: National Integrated Programme for Tuberculosis
PRSP	: Poverty Reduction Strategy Paper
SPA	: Service Provision Assessment Survey
SWAp	: Sector-Wide Approach
VCT	: Voluntary Counselling and Testing
WHO	: World Health Organisation

1. Introduction

1.1 The Health Sector Policy elaborates the Government of Rwanda's overall vision of development in the health sector, as set out in Vision 2020 and the Poverty Reduction Strategy Paper, building on lessons learned from the implementation of the health sector policy adopted in 1996. Furthermore, the Health Sector Policy takes account of changes in the institutional environment resulting from the implementation of the national decentralisation policy.

1.2 The Health Sector Policy is the basis of national health planning and the first point of reference for all actors working in the health sector. It sets the health policy objectives, identifies the priority health interventions for meeting these objectives, outlines the role of each level in the health system, and provides guidelines for improved planning and evaluation of activities in the health sector. A companion health sector strategic plan elaborates the strategic directions defined in the Health Sector Policy in order to support the implementation of the policy.

2. Health Sector Analysis

2.1 *Historical Background.* Rwanda's health sector has undergone a fundamental transition in the last century: in the time before colonial era, health care consisted of traditional African healing methods. The German and later Belgian colonial period saw the emergence of faith-based health care, and with it the introduction of modern treatment methods.

2.2 In the second half of the 20th century, before the war and genocide, Rwanda's health system was characterised by a high degree of centralisation and free provision of services. Most of the country's infrastructure was destroyed in the tragic events. The first years following the war were spent with rebuilding basic health care and human resources; now the health system is ready for the next phase of its development.

2.3 *Demographic and socio-economic situation.* Rwanda is a largely mountainous and landlocked country of 26 338 km² in the Great Lakes region of Central Africa. It has a moderate climate with an average temperature of 18°C. There are two rainy seasons and two dry seasons throughout the farming year. Annual rainfall varies from 700 to

2000 mm according to region. The country consists of 11 provinces and Kigali City, which are subdivided in 106 municipalities. Each municipality is divided into sectors, which are further divided into cells. Rwanda has a population of 8 272 000 and a population density of 300 habitants/km². The annual population growth rate is 2.8 %, the total fertility rate is 5.8, and 45% of the population is under 15 years of age.

2.4 The incidence of poverty is still high in the country: over 60 per cent of population live in poverty and 42 per cent in extreme poverty. The genocide of 1994 has left an horrific legacy and a specific profile of poverty in the country: a significant reduction in the number of adult men, a large number of orphans, many households without permanent shelter, a reduction in small-scale family farming, an increase in the prevalence of AIDS, and the loss of human resources and infrastructure. The performance of the country's economy is improving, however: after a fall of 50 per cent in 1994, gross domestic product (GDP) has gradually recovered since the war and resulted to a real GDP per capita of \$250; the average rate of expected annual growth is projected at 8 per cent over the 15 next years.

2.5 *Health situation analysis.* Health outcomes have worsened in the past decade as a consequence of the 1994 genocide. Life expectancy in good health at birth for the whole population is estimated at 38.3 years, while the percentage of life expectancy lost for men and for women is, respectively, 13.3 and 14.11. The maternal mortality rate has risen from 500/100,000 live births in 1992 to 1071/100,000 live births in 20002. The infant mortality rate has risen from 85/1000 live births in 19923 to 107/1000 live births in 20004. The principal causes of these levels of mortality in Rwanda remain communicable diseases, which, for the majority, can be prevented through better hygiene and behavioural change.

2.6 **AIDS** and **malaria** place the greatest burden on the health system and economy of the country. The prevalence of HIV/AIDS amongst the adult population is estimated at 13.2 percent in Kigali town, 6.3 percent in other urban areas and 3.1 percent in rural zones. **Malaria** accounts for at least 40 per cent of all consultations in health centres; in 2001, malaria was found to have a fatality rate of 10.12 per cent in district hospitals and 2.7 per cent in health centres.

¹ DHS 2000 and World Health Report 2003, WHO.

² DHS (2000).

³ DHS (1992).

⁴ DHS (2000).

2.7 Apart from these two major diseases, **diseases associated with childbirth** are responsible for high rates of maternal mortality: these high rates are facilitated by low rates of female literacy, and under-utilization of family planning services, pre-natal and delivery services. The combination of neonatal causes, pneumonia, malaria, diarrhoea, HIV/AIDS and malnutrition accounts for a large part of the levels of infant and child mortality in the country.

2.8 The number of cases of **tuberculosis** increase year by year, partly as a result of an outbreak in the disease, linked to the spread of HIV/AIDS, but also because of improvements in the identification of cases. The events of 1994 had a considerable impact on the **mental health** of the Rwanda's population. Children were particularly affected by these traumatic events. The state of **malnutrition** remains worrying. A study carried out during the course of 2000, found that, amongst children of 0 to 5 years of age, the proportion underweight was 29 per cent, the proportion stunted was 42 per cent and acute malnutrition had risen to 7 per cent. Besides children, the nutritional status of mothers remains precarious and deficiencies in micronutrients (iodine, vitamin A and iron) are widespread.

2.9 Finally, Rwanda is regularly confronted with epidemics of cholera, meningitis, bacillary dysentery and typhus. Other diseases, such as schistosomiasis, onchocercosis and trypanosomiasis are subject to close monitoring. Lastly, there is a whole list of diseases, including arterial hypertension, diabetes and cancer, which are often associated with smoking and alcohol abuse, remain a cause for concern in the Ministry of Health.

2.10 *Health system performance.* The performance of health services over the course of the last five years is rather mixed. Utilisation of curative services in health centres has declined between 1997 and 2003. The country has achieved, however, high levels of vaccination coverage above 80%. In the reproductive health area, the proportion of women who had at least the recommended four prenatal consultations is only 10 per cent; the attendance rate for assisted deliveries has improved 14 per cent in 1997 to 31 per cent in 2000; but too few pregnancies are ultimately referred to hospitals where adequate care can be provided. Finally, the use of modern methods of contraception shows a sharp fall from 13 per cent in 1992 to 4 per cent in 2000.

2.11 The level of health care for malnutrition at the peripheral level remains very limited: around 4 per cent for severe malnutrition and 22 per cent for moderate malnutrition in 2000. On the other hand, the quality of chronic malnutrition case management has improved as shown by an increase in the rate of recovery from 51.2 per cent in 1998 to 70.9 per cent in 2000.

2.12 Basic health infrastructure and the availability of human, material and financial resources have improved over the past nine years, but there are remaining challenges. At the end of 2002, there were 34 district hospitals in the country and 375 peripheral health facilities of which 262 are health centres and 113 are health posts and dispensaries. Standards regarding infrastructures and equipment have been developed and the report on the mapping of health facilities is currently being finalised. The national policy on maintenance and engineering is near completion.

2.13 The scarcity of human resources has worsened since 1994 as a result of the war and has yet to be fully addressed. As a consequence of the policy to reduce public expenditure, the numbers of unqualified staff have been reduced and the proportion of qualified personnel has increased considerably from 26 per cent in 1997 to 64 per cent into 2000. The need for more doctors and A1 nurses remains significant: nonetheless, the existing training capacities should make it possible gradually to make up this shortfall. However, problems still exist in terms of the recruitment policy and motivation of personnel: indeed, the most talented and highly qualified staff are often not attracted to a career in the public health system where salaries are lower, choosing to migrate to the private sector or go abroad.

2.14 Drugs play an important role in determining the quality and accessibility of health care. A central purchasing agency, CAMERWA, was created to ensure there is a regular supply of quality, low-price drugs: it has contributed to the reduction in the retail price of drugs and the reduction of stock-outs in health facilities. However, the problem of accessing essential drugs remains acute due to the low purchasing power of the population and weak pricing regulatory system.

2.15 The dependency of the health sector on external financial assistance remains significant. About 50 per cent of total financial resources in the sector come from international co-operation, 10 per cent from the government and 33 per cent from the population.⁵ The contribution of the State to the functioning of the health sector remains limited, receiving an allocation around 8 per cent of the national budget, which is equivalent to 2.50 USD/capita/year; nevertheless, the budget of the Ministry of Health has increased over the years. The question of the long-term financial sustainability of the health system, given the financial burden already placed on the population, remains among the main challenges of the health system.

⁵ National Health Accounts

3. Policy Context

3.1 *Historical context.* Since the 1980s, the Government of Rwanda has been implementing primary health care as the key strategy for improving the health of the population. In February 1995, the Ministry of Health began making reforms in the health sector according to the Lusaka declaration, which were later adopted by the Government of National Unity in March 1996. The declared goal of this policy was to contribute to the well being of the population by providing quality health services that were acceptable and accessible to the majority of people and provided with their participation. The policy was based upon three main strategies: (1) the decentralisation of the health system using the health district as the basic operational unit of the system, (2) the development of the primary health care system through its eight core components, and (3) the reinforcement of community participation in the management and financing of services.

3.2 *Mission statement.* The global vision of the Government of Rwanda set out in Vision 2020 is to guarantee the well being of the population by increasing production and reducing poverty within an environment of good governance. As part of this vision, the Government seeks to overcome the illnesses linked with poverty and ignorance, and to develop a proactive and well performing health system capable of anticipating and appropriately responding to the health needs of the population. Within this context, the mission of the Ministry of Health is to ensure and promote the health status of the population of Rwanda. This mission will be achieved by providing quality preventative, curative, rehabilitative and promotional services.

3.3 The fulfilment of this mission assumes that a certain number of conditions are met: the mobilisation, equitable distribution and efficient management of resources; and the reduction in the dependency of the health system on external finance through an increase in the Government contribution to the health sector. Individuals and communities will have to be convinced of the role that they play in safeguarding their status of health as well as in the management and financing of health services.

3.4 *Policy objectives.* In order to carry out its mission, the Ministry of Health has laid down the following major policy objectives for the health sector: (i) to improve the availability of human resources, (ii) to improve the availability of quality drugs, vaccines and consumables, (iii) to expand geographical accessibility to health services, (iv) to improve the financial accessibility to health services, (v) to improve the quality of and

demand for services in the control of disease, (vi) to strengthen national referral hospitals and research and treatment institutions, and (vii) to reinforce institutional capacity.

3.5 *Values and guiding principles.* The Ministry of Health adheres to a number of values in its effort to fulfil its mission: solidarity, equity, ethics, cultural identity, and gender-specific respect. The Ministry of Health is also guided by a number of principles: acceptability and quality of health care, effectiveness and efficiency, inter-sectoral coordination, community participation, decentralisation, and integration.

3.6 *Characteristics of health care and services.* In recognition of the values and principles stated above, the Ministry of Health has identified desirable characteristics of health care and service provision that are necessary to fulfill its mission. Characteristics of health care include continuity, integration, social awareness, and relevance of health care. Characteristics of services include decentralization, continuous provision, flexibility, and efficiency of health services.

4. Priority Interventions

4.1 Seven programmes are elaborated to reach respectively the health sector policy objectives based on the values and guiding principles and the desired characteristics of health care and health services identified above.

4.2 *Human resources.* The policy objective of the first programme is to improve the availability of well-qualified health professionals throughout the country, particularly in rural and other poorly served areas. In pursuit of the above policy objective, the Government of Rwanda shall develop a human resource development plan; strengthen basic training of medical and paramedical personnel and in-service training of personnel during employment. In addition, the Government of Rwanda will develop incentive structures in order to encourage working health professionals to further their qualifications and become more specialised and to ensure there is an equitable distribution of qualified personnel across the country. Finally, the Government will ensure the certification of personnel and encourage the expansion of professional councils or associations.

4.3 *Drugs, vaccines and consumables.* The policy objective of the second programme is to improve the availability of quality drugs, vaccines and consumables, particularly essential drugs, routine vaccines and family planning products. To reach this policy objective, the Government of Rwanda shall purchase generic and essential drugs

so that resources are used optimally and rationally, ensure drugs, vaccines and consumables are available, accessible, affordable and used sensibly by the majority of the population, support the provision of drugs, vaccines and consumables by non-profit associations in the public and not-for-profit sectors, and provide locally produced low-cost drugs using LABOPHAR and the promotion of other initiatives. The Government will implement a system of cost recovery at health centres according to which drugs are bought in district pharmacies and then sold to patients at the lowest possible price. Finally, the Government will disseminate pharmaceutical information to encourage the rational and sensible use of drugs, implement a system of quality assurance and ensure that new drugs pass a preliminary registration procedure, and monitor the private pharmaceutical sector.

4.4 *Geographical accessibility of health services.* The policy objective of the third programme is to improve geographical accessibility to health services in accordance with the health infrastructure development plan. In pursuit of this policy objective, the Government of Rwanda shall establish equipment standards for the peripheral level, which are adapted according to the functional needs of each facility, establish and adhere to standards for the construction of health infrastructures, construct hospitals only according to a detailed specific plan. The Government will ensure that public health facilities are equipped according to established equipment standards, provide support to the national referral laboratory, and strengthen the regulation of laboratories. Finally, the Government will build on the mapping of health facilities to support planning and management in the geographical allocation of facilities and resources.

4.5 *Community lead health structure development.* The initiative of communities is recognised as a crucial component in successful delivery of health services. The government will facilitate this by supporting community lead initiatives, such as the creation of community demanded dispensaries. To ensure a coordinated and viable approach, the Ministry of Health will be in charge of supervising and validating such activities.

4.6 *Financial accessibility of health services.* The policy objective of the fourth programme is to improve financial accessibility to health services, particularly amongst the poorest and most vulnerable groups in society. In pursuit of the above policy objective, the Government of Rwanda shall increase the level of funding of health services from public sources. The Government shall promote community financing mechanisms that strengthen solidarity and risk sharing such as *mutuelles*, systems of pre-payment, and health insurance. The Government shall organise the financing of the sector in the most rational and equitable way so as to generate the greatest benefit from

the limited resources available. The Government will put in place control mechanisms to ensure the best utilisation of allocated funds, define the pricing policy of services and drugs to guide health service providers at the peripheral level, and subsidise essential services to ensure vulnerable groups have access to health services.

4.7 *Quality of and demand for health services in the control of diseases.* The policy objective of the fifth programme is to improve the quality of and demand for health services in the control of diseases. This programme is elaborated further in major components focused on the strengthening of high impact interventions on the control of diseases which are the main contributors to the burden of morbidity and mortality, and the loss of productivity in the country, the main determinants and causes of reproductive and child health, and other determinants of health at the community level.

4.6.1 In the fight against **HIV/AIDS**, the Government of Rwanda shall reinforce measures to reduce the incidence of the infection, to improve the clinical, psychological and social care of patients, and to reduce the socio-economic impact of the disease. Reinforcing the fight against HIV/AIDS will be based on five strategic directions: (i) strengthening of measures to prevent HIV transmission, (ii) strengthening of surveillance of the epidemic, (iii) improvement of the quality of care for people infected or affected with HIV, (iv) strengthening of poverty-reduction measures and integration of gender in the fight against HIV/AIDS, and (v) strengthening of multi-sectoral response, promotion of partnerships, and collaboration.

4.6.2 The fight against **malaria** will be based on the strengthening of measures of prevention and the improvement of the management of cases building on the multi-sectoral approach of « *Roll Back Malaria* ». The approach consists of: (i) the rapid diagnosis and treatment of cases, (ii) increasing the protection of individuals and communities using preventative methods (impregnated mosquito nets, intermittent presumptive chemo-prophylaxis treatment for pregnant mothers, management of the environment, including vector control), (iii) making decision based on evidence, monitoring, community sensitisation and adapted interventions, (iv) targeted research and (v) coordinated activities aimed at reinforcing existing health services.

4.6.3 To reduce the mortality, morbidity and transmission of **tuberculosis** (TB), the Government of Rwanda shall reinforce its national TB control programme and its collaboration with the HIV/AIDS and malaria programmes. The Government will integrate TB activities into all levels of the health system based on the implementation of the DOTS strategy through (i) awareness and behavioural change through intensive IEC and social mobilisation, (ii) development and implementation of a community-based DOTS,

(iii) training of health personnel and laboratory technicians for early detections (iv) training of health personnel in DOTS for treatment at facility level, and (v) strengthening of the referral system and its linkages with HIV/AIDS testing facilities.

4.6.4 Reproductive health services contribute positively to the health status of the family, by reducing maternal and infant mortality and morbidity; hence, the highest priority translated by the adoption of a national reproductive health policy by the Government of Rwanda. The national reproductive health policy is based on six priority areas: (i) safe motherhood and infant health; (ii) family planning; (iii) prevention and care of genital infections and HIV/AIDS/STI; (iv) adolescent reproductive health; (v) prevention and care of sexual violence; and (vi) social change for the empowerment of women.

4.6.5 To improve **child health**, the Government will build on two components: the **Integrated Management of Childhood Illnesses (IMCI)** strategy, the **Expanded Programme on Immunization (EPI)** strategy. Through the IMCI strategy, the quality of care given to children under five in health facilities and in the community will be improved to reduce morbidity and mortality caused by malaria, acute respiratory infections, diarrhoea, malnutrition and measles in children less than five years of age. Through the EPI strategy, the high vaccination coverage against childhood illnesses will be maintained. Major priorities under the EPI strategy include the eradication of poliomyelitis by the year 2005, the elimination of neonatal tetanus and the control of measles by 2005.

4.6.6 To reduce mortality and morbidity linked to malnutrition, the **nutrition** strategy will build on a multisectoral approach. Nutritional monitoring and the promotion of good eating practices to improve nutrition will be intensified. Growth monitoring of children at the community level will be expanded gradually across the whole country as to improve the overall coverage of growth monitoring activities. Health professionals will be trained in severe malnutrition case management, control of Vitamine A and Iron deficiencies, and reduction of anaemia. Breast-feeding among mothers and household consumption of iodised salt will be encouraged. Food security will be ensured through inter-sectoral collaboration with other sectors involved.

4.6.7 Through the **mental health** component, the Government of Rwanda will revise the Mental Health Policy and elaborate a comprehensive mental health strategic plan in order to ensure that mental health services are integrated into all health facilities of the national system and mental health problems are managed at the community level. The Government will develop standards and guidelines for the integration of mental health

into primary health care, and establish a mental health service for children. Intersectoral collaboration between sectoral ministries and between Government and NGO sectors will be strengthened. The legislation regarding mental health will be revised.

4.6.8 To maintain a ready state of preparedness and a swift response to **diseases with epidemic potential**, the Government of Rwanda will reinforce the epidemiological surveillance system so there is effective detection of cholera, cerebral meningitis and bacillary dysentery. The monitoring of diseases both emerging and reappearing such as erythematic typhus or hemorrhagic fevers will be strengthened. Disaster management requires a multi-sectoral approach: hence, the Ministry of Health will take the necessary measures to ensure there is an adequate level of preparedness and ability to respond to those disasters.

4.6.9 There is a risk of the health system being confronted by an increase in the number of cases of **non-communicable diseases** and as such adequate measures are being taken to alert those responsible for the prevention, diagnosis and management of such diseases. These diseases are commonly cancer, diabetes, arterial hypertension and those associated with tobacco consumption, alcohol abuse, an inactive life style and environmental pollution. Oral health, the prevention of blindness and physical rehabilitation services for handicapped people are to be improved.

4.6.10 There is a variety of determinants which contribute to health improvement. Even though most of these **health determinants** are the responsibility of the Ministry of Health, certain are the responsibility of other Departments or services. Assuring these activities necessarily requires close inter-sectoral collaboration between these Departments, and the Ministry of Health. These activities include, among others: water distribution and sanitation systems to meet essential health needs, training of medical and paramedical personnel, including specialised training, and health research, including biomedical and epidemiological research, as well as research on health system operations, public hygiene activities (trash collection, removal of household waste, and health inspections), traffic safety, prevention of road accidents, workplace safety; prevention of work-related injuries and illnesses, activities providing supplemental food to people who need it and medico-social activities for vulnerable groups.

4.7 *National referral hospitals, treatment and research centres.* The policy objective of this programme is to reinforce national referral hospitals and specialised treatment and research centres. In pursuit of the above policy objective, the Government of Rwanda shall support the functioning of the public national referral hospitals, supply the technical equipment required of the national referral hospitals, and provide the

necessary infrastructure for the national referral hospitals to carry out their activities. Medical research capacity and specialised training will be reinforced according to national priorities.

4.8 *Institutional capacity.* The policy objective of this programme is to strengthen institutional capacity within the health sector. Institutional capacity covers a number of areas including management and planning, monitoring and evaluation, ICT, the health management information system, and training of administrative staff: each of the programmes presented above include specific institutional capacity strengthening components which are complementary to the current programme.

4.9 In pursuit of the above policy objective, the Government of Rwanda shall adopt a sector-wide approach in the management and coordination of internal and external interventions in the health sector. The Medium Term Expenditure Framework (MTEF) will be used as a tool for planning and management of the health sector. The Government shall adopt a system of planning and management that is decentralised with the close involvement of the community and which takes account of Ministry of Health programme priorities, resource availability and capacity absorption in the sector. Managerial and administrative capacity will be developed at all levels within the context of decentralisation. The Government shall put in place mechanisms to supervise, monitor and evaluate the implementation of the Health Sector Policy with a focus on specified input and process indicators (human and financial resources, utilisation of services etc) : evaluation will be conducted both internally, and externally in collaboration with the Ministry of Health's partners. Finally, the Health Management Information System (HMIS) will be reinforced to better inform decision-making in the health sector.

5. Implementation and management framework

5.1 The implementation of the Health Sector Policy is based on a health sector strategic plan and the associated medium term expenditure framework. Every year, operational action plans are elaborated at all levels of the health system in order to coordinate activities of all actors and to reach the objectives of the Health Sector Policy. The roles of actors in the implementation of the Health Sector Policy are defined relative to the organization of the health system and the packages of activities defined for different levels of the health care delivery system.

5.2 *Organisation of the health system.* The health system has a pyramidal structure, consisting of three levels: central, intermediary and peripheral. The central level includes the central directorates and programmes of the Ministry of Health and the national referral hospitals. The central level elaborates policies and strategies, ensure monitoring and evaluation, and regulation in the health sector. It organises and coordinates the intermediary and peripheral levels of the health system, and provides them with administrative, technical and logistical support.

5.3 Relative to health care delivery⁶, the central level has three national referral hospitals including Butare hospital and Kigali hospital (CHK) which together make up the University Hospital (CHU) and Ndera mental health hospital. The King Fayçal hospital was created to provide a higher level of technical expertise than that available in the national referral hospitals to both the private and public sector; its role is also to ensure that there is a reduction in the number of transfers abroad.

5.4 The intermediary level is found at the Province, which deals with management and policy issues but is not a provider of health services. The Provincial Directorate in charge of Health is responsible for implementation of health policies, the coordination of activities, and the provision of technical, administrative and logistical support. It ensures there is an equitable distribution and an efficient utilisation of resources. As part of the responsibilities of this position, the director advises the Préfet on matters relating to health.

5.5 The peripheral level is represented by the health district and consists of an administrative office, a district hospital and a network of health centres that are either public, government assisted not-for-profit, or private. The health district deals with the health problems of its target population. The functions of the health district include: (i) the organisation of health services in health centres and the district hospital in terms of the minimum and complementary package of activities, (ii) administrative functioning and logistics, including the management of resources and supply of drugs, under the responsibility of the district management team, and (iii) the supervision of community health workers.

5.6 At all levels of the health district, decisions are made collectively through various committees, which serve as vehicles of community participation in the health sector. Community participation is a key element in the implementation of the primary health

⁶ The military hospital of Kanombe provides health services to the army but also provides a certain number of services to the local population and occasionally accepts cases referred by public health facilities.

care strategy: it plays a role in the planning, execution and monitoring of primary health care activities, including the provision of certain services at the grass roots level (nutrition, mental health, family planning etc) and the search for appropriate solutions to local health problems and the mobilisation of resources.

5.7 The Government of Rwanda's application of its decentralisation policy, starting in 2000, was well received by the health system since it came to reinforce decentralisation reforms already implemented in the health sector based on the primary health care strategy⁷. Based on the dynamic nature of decentralization policy, general principles of decentralisation have been elaborated in order to reinforce the institutional arrangements of local health services in the context of decentralisation: no health district can exceed the geographical limits of the province; a health district corresponds to an administrative district; on a purely transitory basis, two or more administrative districts together can be covered by a health district; the resource allocation of a district hospital is determined by coverage and capacity.

5.8 The Minister of Health carries out the assignment and movement of qualified health professionals. The provincial management team is defined according to the management structure of the province, and the Minister of Health in consultation with the Prefect and the Minister responsible for civil service assure its nomination. The health district management team is defined according to the management structure of the district; service providers have a specific professional status. The health centre depends administratively on the district within which it is situated. The district hospital depends administratively on the district within which it is situated. If a district hospital serves two or more districts, the province names its administrative body.

5.9 *Packages of activities.* Different packages of activities have been defined according to each of the levels in the health pyramid in order to provide equitable and quality care across the country, to ensure that there are procedural standards for operation and management, to allow for better planning and management of resources, and to provide the basis for establishing and evaluating the quality of health services.

5.10 The minimum package of activities is a common list of priority activities for all health centres, intended to cover basic health problems in an equitable, effective and efficient manner. The package takes into account the health needs and demands of the

⁷ Autonomous management of health centres had already been instituted since 1992, and since 1996 health districts have been designated the basic operational unit for primary health care.

population, but equally recognises the financial constraints of the Ministry of Health and the population.⁸

5.11 The complementary package of activities is a common list of priority activities for all district hospitals, intended to provide curative health care in an equitable, effective and efficient way using techniques unavailable at the primary level. The demands of the population as well as the financial resources of the Ministry of Health and the population determine the package.⁹

6. Partnerships

6.1 *Sector-wide approach.* Building on the national poverty reduction strategy, actions in the health sector will have more of a sustainable impact if they are integrated and fundamentally incorporated into the national development programmes. Inter-sectoral consultation and collaboration with ministerial partners is essential in the implementation of major health strategies.

6.2 The creation of an institutional framework is necessary in order to allow intersectoral collaboration at the various levels of the health system. The central, intermediary and peripheral levels can, depending on the need, put in place a framework for collaboration adapted along the line of the norms of the Ministry of Health.

6.3 *National and international cooperation.* National, regional and international cooperation is in line with the activities of the health sector strategic plan, to be set out by the Ministry of Health for the implementation of the Health Sector Policy. Multilateral, bilateral and non-governmental cooperation is founded on the basis of mutual agreement between the Government and the donor country or organisation. Mechanisms for the joint management and evaluation of resources to support the functioning of health services are to be strengthened. The mechanisms for national and international coordination, as initiated by the Ministry of Health and certain partners, are to be put in place under the umbrella of a sector-wide approach.

6.4 *Professional councils.* The existence of professional health associations helps the Ministry of Health to better organise the medical, dental, pharmaceutical, nursing and paramedical professions. The reinforcement of their structures will allow them to better

⁸ See the document 'Les Normes du District de Santé,' Ministry of Health, 1998.

understand their role, most notably in: the recognition of qualifications, the registration of diplomas, the management of problems relating to professional ethics, and the elaboration and revision of professional classifications according to qualification and specialisation. Equally, they must support the Ministry of Health in the accreditation of services and the certification of professionals.

6.5 *Private and not-for-profit sectors.* The Ministry of Health is strengthening its relationship with the private and not-for-profit sectors. Collaboration is based on (1) a greater participation of the private sector in the provision of services to the entire population, (2) improved accessibility of this sector to facilities offered by the Ministry of Health, (3) improved supervision of the sector particularly in terms of health information, and (4) a reinforcement of the unit in charge within the Ministry. A formal agreement detailing the nature of cooperation between the Ministry of Health and the private sector has been established.

6.6 Government assisted health facilities fulfil all the functions of publicly owned facilities (as defined by the Ministry of Health) and have official management structures. They are fully integrated into the structure of the health district. The not-for-profit sector adheres to a convention, and this formal agreement determines the respective obligations and rights of those working in the sector. Local partnership between NGOs, churches, private providers of health and the public sector are to be encouraged to ensure coordinated and integrated planning.

6.7 *Traditional health care sector.* The Government recognises that a large number of the population continue to use and encourage the provision of traditional medical services. A legal framework determines how traditional medical services can operate alongside health services within the district. Collaboration with the Butare Institute for Scientific and Technological Research ensures the rational development of traditional health care in the country.