Republic of Rwanda

Ministry of Health

Health Sector Strategic Plan V

July 2024 - June 2029

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List of Acronyms

AI	Artificial Intelligence
AIDS	Acquired Immunodeficiency Syndrome
AMR	Antimicrobial Resistance
ART	Antiretroviral Therapy
CBHI	Community-Based Health Insurance
CHS	Community Health Services
CRVS	Civil Registration and Vital Statistics
CSOs	Civil Society Organizations
DHMT	District Health Management Team
DHU	District Health Unit
DPs	Development Partners
DRG	Disease-Related Grouping
EAC	East African Community
eIDSR	Electronic Integrated Disease Surveillance And Response
eLMIS	Electronic Logistics Management Information System
EMS	Emergency Medical Services
FDA	Food and Drugs Authority
GBV	Gender-Based Violence
GDP	Gross Domestic Product
HC	Health Center
HIV	Human Immunodeficiency Virus
HRTT	Health Resource Tracking Tool
HSSP	Health Sector Strategic Plan
HSWG	Health Sector Working Group
IRS	Indoor Residual Spraying
LLIN	Long-Lasting Insecticidal Net
M&E	Monitoring And Evaluation
MDA	Mass Drug Administration
MINECOFIN	Ministry of Finance and Economic Planning
MOH	Ministry of Health
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NRL	National Reference Laboratory
NST2	National Strategy for Transformation 2
NTD	Neglected Tropical Diseases
OOP	Out Of Pocket
PHC	Primary Health Care
PHEM	Public Health Emergency Management
PPP	Public-Private Partnership
RBC	Rwanda Biomedical Center
RMS	Rwanda Medical Services
SDG	Sustainable Development Goal
SRHR	Sexual And Reproductive Health And Rights
STH	Soil-Transmitted Helminthiasis
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TWG	Technical Working Group
UHC	Universal Health Coverage
UN	United Nations
WASH	Water, Sanitation And Hygiene
WHO	World Health Organization

Foreword

The pillars, objectives, priorities, and key initiatives that form the foundation of the Health Sector Strategic Plan (HSSP) V aim to build on the successes of HSSP IV. Over the next five years, the Ministry of Health, in collaboration with its affiliated institutions and partners, seeks to enhance healthcare service delivery nationwide, leveraging advancements in science and service delivery, many of which are enabled by technology.

In alignment with the National Strategy for Transformation 2 and Vision 2050, HSSP V presents a framework designed to ensure that the people of Rwanda lead healthy and productive lives

We aim to achieve key outcomes, such as reducing the maternal mortality ratio to 60 per 100,000 live births, achieving an under-five mortality rate of 20 deaths per 1,000 live births, and lowering the prevalence of stunting among children under five to 15%.

An investment of approximately 4.2 billion USD will be required to successfully implement the goals of HSSP V.

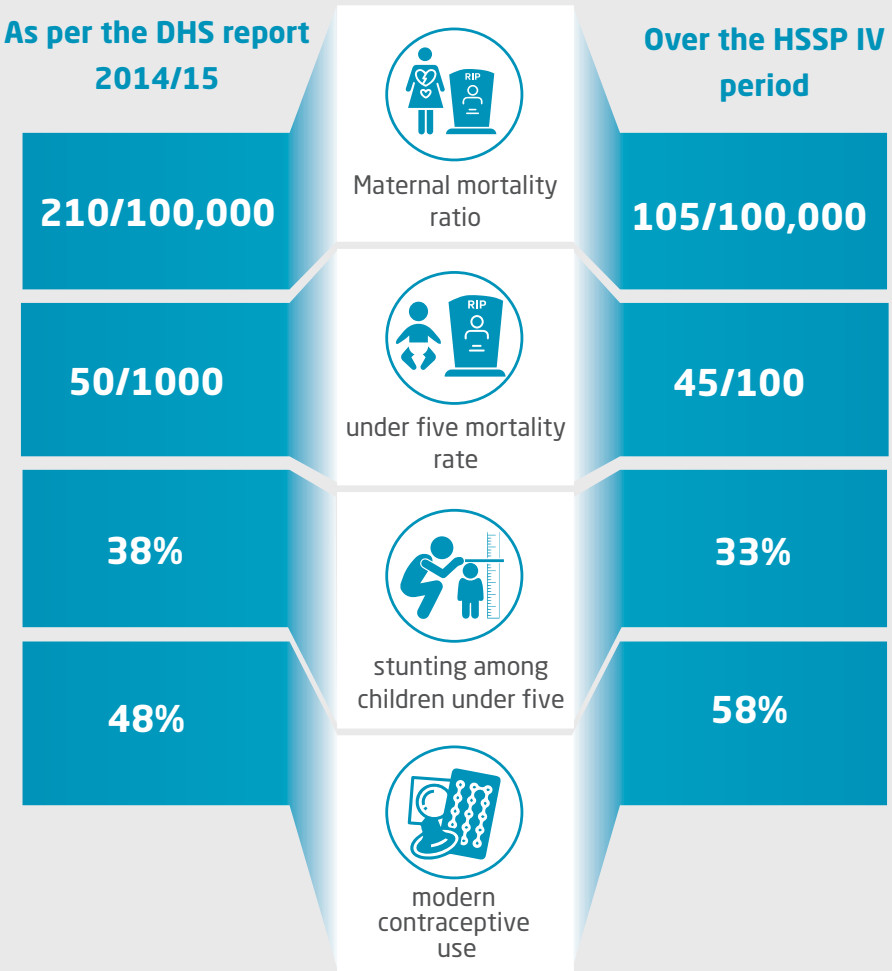
The collective strength of leadership, accountability, resource management, collaboration, and innovation will be the driving force behind our success.

Digitally signed by MOH(Minister)

Dr. Sabin NSANZIMANA
Minister of Health

Executive summary

Health Sector Strategic Plan (HSSP) V 2024/25–2028/29 is a comprehensive blueprint aimed at advancing the Rwanda health sector's progress toward universal health coverage by 2030, in alignment with Rwanda's Vision 2050, the National Strategy for Transformation 2, and the United Nations' Sustainable Development Goals. The development of HSSP V was based on a deep-dive analysis of the health sector data that informed the prioritization and built on new reforms in the health sector. It considered lessons learned from the COVID-19 pandemic response and the implementation of HSSP IV. It was developed through a consultative process engaging all that included MoH and affiliated agencies, development partners, private sector and civil society organizations and adhering to principles of one plan, one budget and one report.



The implementation of HSS IV showed progress in advancing service utilizing and improving the health of the population. As per the DHS report 2014/15, the baselines pertaining to maternal mortality ratio, under five mortality rate, prevalence of stunting among children under five and the prevalence of modern contraceptive use were 210 per 100,000 live births; 50 per 1000 live births; 38%; and 48% respectively. Over the HSSP IV period, recorded progress pertaining to each of these indicators was 105 per 100,000 live births; 45 per 100 live births; 33% and 58%. As part of the health system strengthening top priorities, the human resources component was a top priority however, there are still challenges related to the number, skills mix, distribution and attrition rates.

The Strategic Framework of HSSP V is structured around five strategic pillars and two enablers, with 24 strategic objectives focusing on 138 interventions organized under 44 priority areas to be measured using 38 key performance indicators. The strategic pillars and enablers include:

a. Health Workforce: Prioritizes the creation of a robust health workforce that is well-trained, adequately supported, and optimally deployed to meet the health needs of the population. The primary focus of this pillar is the "4x4" reform, which aims to quadruple the number of health care workers during this strategic plan period by revamping health education policies and practices. In line with the reform, career development, empowerment, and welfare of the health workforce will be the center of attention.

b. Health Infrastructure Modernization: Targets the transformation of health facilities that are clean, safe, user-friendly, and climate-resilient and that meet applicable standards, accommodating innovations and new digital technologies and supported by an effective accreditation process. This pillar aims to establish the Kigali Health City, conduct construction of 10 existing hospitals and 23 health centers (HCs), and renovate 30% of existing facilities countrywide.

c. Quality of Health Care through Primary Health Care Aims to enhance and strengthen the six dimensions of quality—safety, effectiveness, person-centeredness, timeliness, efficiency, and equity—at all levels to ensure the population's access to health and wellbeing services. This pillar seeks to enhance the integration of health services and address broader health determinants through multi sectoral policies, empowering individuals, families, and communities to demand and increase their uptake of health services and manage their own health.

d. Health Security and Public Health Emergency Management: Prioritizes the building of a resilient health system to timely detect and effectively respond to any health emergency in order to protect the population from any public health threats. Through this pillar, the national action planning for health security will be updated and implemented, building on the high-level commitment witnessed during the COVID-19 pandemic response. The use of artificial intelligence for early detection of outbreaks and the integration of climate data for outbreak prediction will be scaled up, and a smart, integrated One Health system will be established.

e. Research, Innovation, Biomanufacturing, Regulation, and Digitalization: Establishes a comprehensive approach that integrates cutting edge research and innovation to improve knowledge and skills to advance health technology (medicines, vaccines, procedures, and systems), supported by robust regulation and digitalization. The strategic shift that is the focus of this pillar aims to enhance health care breakthroughs and technological innovations to contribute to high levels of quality and efficiency as well as practical outcomes such as research and innovation in biomanufacturing, with a special emphasis on local drug manufacturing.

f. Health Financing: Seeks to mobilize adequate resources through innovative financing mechanisms to achieve universal health coverage for citizens without financial hardship, with a clear target of transitioning from external to domestic sources and private sector investment. This enabler is supported by the implementation of strategic purchasing to enhance the efficiency of resource use through strategic allocation, cost effective analysis, informed benefits packages, and affordable and sustainable health insurance schemes.

g. Leadership and Governance: Aims to enhance the achievement of HSSP V priorities, with a robust and effective framework of leadership and governance to strengthen existing sector coordination structures (Health Sector Working Group, Technical Working Groups). This enabler also ensures alignment and harmonization among all stakeholders (government, development partners, civil society organizations, and the private sector) in strategic plan development and implementation and regular performance reviews. Operationalization of HSSP V will be implemented through the annual health sector planning cycle, which aligns with the national annual planning and budgeting processes under the Ministry of Finance and Economic Planning. Leadership capacity building will be emphasized at all levels, although mainly at the health facility level.

The results under HSSP V will be monitored and evaluated based on key performance indicators over the next five years using monitoring and evaluation systems under the Ministry of Health. The strategic information from the routine data will be analyzed and visualized on a real time basis through the newly established Health Intelligence Center at the Ministry of Health. Joint Sector Review Meetings (backward- and forward-looking), which will bring together all sector working group stakeholders, will be the main platform for reviewing sector performance to inform priorities for the next implementation period.

Topline indicators pertaining to HSSP V and aligned with NST-2 include maternal mortality ratio whose target is 60 per 100,000 live births, under five mortality rate 20 deaths per 1000 live births, prevalence of stunting among children under five 15% and quadrupling the number of health workforce.

The implementation of HSSP V requires significant financial investment. The total estimated HSSP V cost is 5.9 trillion Rwandan francs (RWF) ($4.2 billion) under scenario 1 and RWF 6.9 trillion ($4.9 billion) under scenario 2. The projected available resources from different sources are estimated to be RWF 4.7 trillion ($3.4 billion), showing a financing gap of RWF 1.2 trillion ($878.4 million) in scenario 1 and RWF 2.2 trillion ($1.6 billion) in scenario 2 in the next five years. The overall estimated financing gap is 21% and 32%, respectively, under scenarios 1 and 2.

1. Introduction

1.1 Purpose

Rwanda has come a long way in its national transformation journey, and it is rapidly approaching its expected achievement of the United Nation's Sustainable Development Goals (SDGs) by 2030. Realizing universal health coverage (UHC) and other health-related SDGs is a key component of Rwanda's Vision 2050 ("The Rwanda We Want"), in which all people enjoy universal access to equitable, high-quality health care according to their needs and without financial hardship. The purpose of HSSP V therefore is to accelerate progress toward that goal and ensure equitable improvement of health outcomes through evidence-based prioritization of high-impact interventions. The development of HSSP V was based on a deep-dive analysis of the health sector data that informed the prioritization of and built on new reforms in the health sector. It considered the lessons learned from the COVID-19 pandemic response and the implementation of HSSP IV.

1.2 Contribution to National Strategy for Transformation and Vision 2050

HSSP V is aligned with the National Strategy for Transformation 2 (2024/25–2028/29) (NST2) and Vision 2050, which aims to ensure that Rwanda has a healthy and productive population to attain upper-middle- and high-income country status by 2035 and 2050, respectively. HSSP V will focus on quality of care and increasing human resources for health aiming to reduce maternal & child mortality, stunting and major communicable and non-communicable diseases. HSSP V also responds to the cross-cutting areas emerging from other sectors that are enshrined in NST2 by embedding them within the HSSP V strategic interventions, including the following: capacity development; environment and climate change; disaster management; disability and social inclusion; gender and family promotion, including teenage pregnancy reduction; nutrition; innovation, technology, and digitalization; research and development; and regional and international positioning.

1.3 Methodology of Developing HSSP V

HSSP V was developed through an inclusive, evidence-based process led by the Ministry of Health (MOH), with the active participation of civil society organizations (CSOs) and non-governmental organizations (NGOs), United Nations (UN) agencies, health facility representatives, academic institutions, development partners, and other government organizations. The process began with a deep-dive, sector-wide situational analysis using a wide range of data sources and inputs from stakeholders. The findings identified gaps and informed priorities and strategic interventions in a series of consultative workshops involving all stakeholders. These strategic interventions were further analyzed and costed, and the associated impact was modeled to generate the targets over time. The final version of HSSP V was reviewed at the wider stakeholder consultative workshop, validated by the Health Sector Working Group, and approved by the MOH.

2. Health Sector Situation Analysis

The main sources of information were routinely collected from health data, surveys, international statistics reports, and global research findings.

2.1 Country Context

Rwanda's administrative structure comprises six hierarchical levels: national; four provinces and the City of Kigali; 30 districts including 3 in the City of Kigali; 416 sectors; 2,148 cells; and 14,837 villages. According to the 2022 5th Rwanda Population and Housing Census, Rwanda's population was 13,246,394 and is projected to increase to 15,732,629 by 2030.[1] Rwanda's economy has experienced robust growth, with an average Gross Domestic Product (GDP) growth of 8% per year over the last two decades. The GDP per capita in 2022–23 was $1,060, per the report from the Ministry of Finance and Economic Planning (MINECOFIN). The government remains committed to furthering economic development and improving living standards for all citizens. The UN Human Development Index for both Rwanda and Sub-Saharan Africa stood at 0.55 for 2022, while the global average was 0.739.[2] Access to essential services such as drinking water and sanitation has significantly improved in Rwanda, with 82% of households having access to improved water sources in 2022 compared to 72% in 2012. The country also has made notable progress in improving literacy rates, with approximately 79% of adults aged 15 and above being literate in 2022 compared to 71% in 2012. However, ensuring universal access to schooling remains a challenge, as the net enrollment rates for pre-primary, primary, and secondary schools were 24.2%, 87.3%, and 25.4%, respectively, in the 2021–22 school year (Ministry of Education, May 2023).

2.2 The Health Status of the Population

Life expectancy at birth increased by nearly 8% in a decade, rising from 64.5 in 2012 to 69.6 in 2022.[3] This is above average for African countries. These gains can be explained by a rising standard of living, improved lifestyles and education, and better access to health care. However, there is still room to increase life expectancy by reducing neonatal mortality. In addition, recent data indicate an epidemiologic transition from communicable diseases to non-communicable diseases (NCDs). The 2021 Global Burden of Disease report showed an increasing trend of deaths related to stroke, ischemic heart diseases, and liver cirrhosis, along with a reduction in communicable diseases.[4] The major risk factors that are likely to have a negative impact on population health are biochemical factors such as high blood pressure, blood glucose level, and body mass index, which are increasing and pose a challenge.

2.3 Performance of the Health Sector

2.3.1 Reproductive, Maternal, Neonatal, and Child Health; and Nutrition

Rwanda has made notable progress in reducing the maternal mortality ratio—deaths per 100,000 live births—from 210 in 2014/15 to 105 deaths in 2023, according to recent estimates. The maternal mortality ratio could have been reduced further, as 72% of the causes of death are highly preventable: obstetric hemorrhage (45% of all direct causes), of which over half are following cesarean section; hypertensive disorders (14%); and pregnancy-related infections (13%). Abortion accounts for 10% of maternal deaths, despite the increase in safe abortions from 89 in 2019 to 2,152 in 2023. Cesarean section increased 10% in the past five years, and 94% of post-cesarean-section deaths were due to unanticipated complications.

1. 5th Rwanda Population and Housing Census 2022, Thematic Report: Population Projection | National Institute of Statistics Rwanda
2. Human Development Index | Human Development Reports (undp.org)
3. 5th Rwanda Population and Housing Census 2022, Thematic Report: Mortality
4. Rwanda | Institute for Health Metrics and Evaluation (healthdata.org)

Delays in receiving care or receiving inadequate quality care were identified in 54% of all maternal deaths, followed by delays in seeking care (38%) and delays in reaching the right facility (7.9%). About 83% of all maternal deaths occurred in hospitals, with the remaining 17% divided almost equally between health centers and communities—which indicates that the quality of care in hospitals is questionable. There was no improvement in infant mortality as the value recorded in DHS 2014/15 was 32 deaths per 1,000 live births compared to 33 deaths per 1,000 live births reported in DHS 2020. In the 2022 census, this value slightly reduced to 28.9 per 1,000 live births.

During the 2019–23 timeframe, most neonatal deaths occurred in hospitals (85.9%), followed by community (7.3%), health centers (6.7%) and private facilities (0.1%). The major drivers of these gaps appear to be inadequate quality of care/workforce skills, non-adherence to guidelines and protocols, and non-timely referrals. Stunting remains high among children, and inadequate follow up is identified as the main challenge to addressing it. Teenage pregnancy prevalence remains stagnant and high. The contraceptive prevalence rate among currently married women aged 15–49 is 64%, and14% of those women say their family planning needs remain unmet.

2.3.2 Major Communicable Diseases

The total number of tuberculosis (TB) cases recorded from 2019–23 was 26,182, with 1,813 deaths recorded during the same period. The 25–35-year age group had the highest proportion of TB cases, thus affecting the workforce. Health workers, including community health workers, were at-risk populations, with 167 and 119 TB cases reported in 2019 and 2023, respectively. The major challenges identified with respect to TB are cases missed due to the use of less-sensitive screening diagnostic tools, limited skills among health care providers, and COVID-19-related disruptions of TB services that led to a rise in number of cases among key populations. Childhood TB diagnosis and treatment was at 74%, while multi-drug-resistant TB diagnosis and treatment in the overall population was at 48%. The overall treatment success rate for TB is below 90%, and treatment coverage needs to be extended to contacts of identified TB cases.

Over the past five years, Rwanda has implemented various interventions aimed at combating malaria, including distributing long-lasting insecticide-treated nets (LLINs), conducting indoor residual spraying, and improving access to diagnosis and treatment. The major gaps in the malaria program are insecticide/drug resistance affecting the effectiveness of indoor residual spraying, bed nets, and medications; the persistence of malaria hotspots despite sustained interventions; changes in mosquito behavior (outdoor biting); gaps in stock management of commodities; and delays in implementation of cross-border activities with neighboring countries. LLINs are distributed to all pregnant women at antenatal care visits, and uptake increased from 56% in 2019 to 100% in 2023—with a corresponding decline in cases of malaria in pregnancy from 7% to <1%.

In FY 2022/23, 2,072,366 HIV tests were performed, and the overall positivity yield was 0.7%. The number of people on antiretroviral therapy (ART) in Rwanda was 218,314 as of June 2023, when the country's 92.3% treatment rate fell short of the 95% target. The major gaps in combating HIV are inadequate utilization of HIV prevention and sexual and reproductive health and rights (SRHR) services, especially among youth; low treatment outcomes among children and adolescents (adherence, ART coverage, and viral load suppression); limited services integration to address HIV and emerging NCDs; low voluntary male medical circumcision coverage among older men; limited digitalization and interoperability of systems and diagnosis; low levels of drug resistance monitoring; and lack of a sustainability plan to maintain gains made.

2.3.3 Non-Communicable Diseases

The burden of NCDs is increasing in Rwanda. Prevalence rates are 16% for hypertension diseases and 2.9% for diabetes type 2. The majority of patients with NCDs are managed at health centers (77%). Reported cancer

cases have increased from 633 in 2007 to 5,263 in 2022, with a mortality rate of 23%. The risk factors for the main causes of NCDs are tobacco smoking (7.1%), alcohol consumption (48.1%), and overweight and obesity (18.6%) (STEPS survey, 2022). Women are disproportionately impacted by this last factor, with 26% classified as overweight and 7.4% as obese. Major gaps in taking the NCD achievements forward include a low level of awareness in the community about NCDs; limited capacity and readiness of the health care system for screening, accurate diagnosis, and treatment; lack of structured home-based NCD care services; and weak data systems to monitor and evaluate the implementation of interventions. The main challenge to mental health service delivery is a high treatment gap, as the prevalence of mental health problems in the population is 20.5% while the service utilization rate is only 5%—which shows that 75% of individuals who require treatment do not receive it. Mental health facilities are fully decentralized and lack integration with other services as well as adequate infrastructure, equipment, and medications.

2.3.4 Public Health Surveillance and Response

Rwanda has experienced outbreaks of cholera, measles, seasonal influenza, food poisoning, Rift Valley Fever, H1N1, and COVID-19. Most of these outbreaks have been managed using a multisectoral approach. A total of 133,518 COVID-19 cases were reported and 1,468 COVID-19-related deaths were registered as of the end of 2023. Public health emergency operations have been decentralized from the national to the provincial and district levels. Rwanda has been recognized among countries that effectively managed to keep the COVID-19 pandemic under control. Public health facilities with low laboratory capabilities have the capacity to collect, package, and transport the samples to the national reference laboratory (NRL) or satellite laboratories for sequencing and/or extended analysis. A collaborative framework was established for private laboratories to assist public laboratories during emergencies. Rwanda developed and used a National Risk Communication and Community Engagement strategy and continues to implement the Field Epidemiology Training Program to establish a self-sustaining institutionalized capacity. Rwanda has proactively strengthened its public health emergency preparedness capacity by leveraging lessons learned from previous outbreak responses, including but not limited to conducting risk assessments, enhancing surveillance systems, building health care worker capabilities, implementing risk communication strategies, and establishing cross-border coordination mechanisms. Emergency operations centers prepositioned medical supplies, and designated treatment facilities have been activated to respond rapidly to outbreak threats. The electronic community event-based surveillance system has achieved nationwide coverage across all 30 districts, with at least 2 community health care workers trained per district to report events occurring in their communities via mobile phones.

2.3.5 Health Workforce Development

The estimate of the ratio of skilled health professionals with active licenses as of December 2023 is 1.2 per 1,000 population, which is much lower than the World Health Organization's (WHO's) minimum density, which identified an "SDG index threshold" of 4.45 doctors, nurses, and midwives per 1,000 population. The public sector absorbs 66% (15,966) of all the health care professionals (24,047) with active licenses. The categories of medical professions that are less present in the public clinical sector are pharmacists (4%), specialists (37%), and general practitioners (40%). The number of total available staff in public health facilities is 20,550 against an overall staffing structure of 27,345, resulting in a gap of 6,695 and a staffing rate of 75.2%. However, if only appointed staff is considered (excluding contractual staff), the staffing rate is only 61.3%. The average workload across all hospitals is about 15 cases per day per doctor. Many challenges regarding human resources for health remain, including but not limited to the following: inadequate numbers of health care workers, especially specialized health workers; insufficient numbers of specialized faculty to boost local programs and ensure sustainability; lack of modern equipment and infrastructure to match training needs; weak compatibility between health education curriculums and current

advancements in management information systems and telemedicine; high staff attrition rates and existence of unmotivated staff; and inequitable workload distribution across health systems (public and private).

2.3.6 Health Infrastructure, including Laboratories

A total of 1,848 public health facilities are providing services all over the country, out of which 1,276 health posts (including 96 second-generation), 507 HCs, and 8 medicalized HCs are under level one, 34 district hospitals and 5 specialized hospitals are under level two, and 18 national referral and teaching hospitals and provincial hospitals are under level three. During HSSP IV, there was construction of 4 new hospitals (Gatunda, Gatonde, Nyabikenke and Nyarugenge); 12 new health centres; and 771 new health posts. The private sector has 371 health facilities, out of which 114 are dispensaries, 127 are general clinics, 21 are paramedical clinics, 28 are polyclinics, 31 are private specialized clinics, 3 are private laboratories, 38 are specialized clinics, and 9 are private hospitals. The overall bed capacity is 22,252—with an estimated density of hospital beds of 0.01 per 10,000 population—out of which 48% are at health centers, 38% are at district and specialized hospitals, 8% are at tertiary care hospitals, and 6% are at private hospitals. Most health facilities are old and do not satisfy standards of health facility designs, such as having safe and quality electrical, heating, ventilation, air conditioning, or waste management systems; adequate internet connectivity; or proper access roads. This also affects the facilities' capacity to motivate and retain health care workers. The current medical equipment acquisition and management approach is fragmented, and no systematic mechanism for the replacement of medical equipment in existing health facilities, based on equipment lifetime, is in place. The situation is further complicated by long downtime and maintenance issues as well as lack of medical device calibration, control, and monitoring for quality assurance. Furthermore, the investments in medical equipment do not match the capacity of health facilities (number of staff and skills) to manage maintenance of that equipment and related infrastructure. Due to gaps in the quality of laboratories, increasing numbers of specialized tests are being performed abroad. The gaps include the lack of a high- to maximum-containment laboratory to diagnose highly contagious pathogens; limited availability of bacteriology services in hospitals; limited capacity to diagnose vector-borne diseases; and low accreditation rates for laboratories.

2.3.7 Research, Innovation, and Digitalization

The major gaps in digitalization are related to inadequate IT-infrastructure capacity and system operability. For instance, there is limited interoperability between systems and a lack of unified interoperability standards to overcome siloing of the different systems supporting service delivery, insufficient IT infrastructure in health facilities, and a lack of both a centralized data warehouse and operational electronic medical records at health facilities. The lack of established health data governance, leadership, and funding mechanism frameworks further compromise the efforts being made.

2.3.8 Supply Chain

The availability of essential medicines and the response to stock orders increased from 85% to 95% and from 79% to 87%, respectively, between 2020 and 2023. Several strategies have been used to increase affordability and access to medicines, such as regional partnerships for bulk procurement and price negotiation. Accuracy of drug ordering increased from 53% to 86%, while timely delivery of drugs from the Rwanda Medical Services (RMS) to health facilities was reduced from 89% to 86% between 2021 and 2023. Rwanda established initiatives to motivate local manufacturers to invest in producing pharmaceutical products and licensed three such manufacturers. In addition, Rwanda is working toward achieving WHO's Global Benchmarking Tool maturity level 3 to produce pharmaceutical products and health commodities, including vaccines. The major gaps identified in ensuring the

availability of medicines and medical supplies include non-optimized procurement, inventory management, and distribution to the last mile; the disruption of cash flow due to long outstanding receivables; inadequate numbers of trained supply chain operators and pharmacists; non-standardized and non-interoperable electronic Logistics Management Information System (eLMIS) tools; and lack of infrastructure for optimal stocking of critical inventory.

2.3.9 Food and Drug Regulation

The Rwanda Food and Drugs Authority (Rwanda FDA) is a regulatory body dedicated to ensuring the safety, efficacy, and quality of food, medicines, and medical products in Rwanda. Established in 2018 to protect public health, the Rwanda FDA implements rigorous standards and guidelines for the registration, inspection, and control of these products. By enforcing compliance with these regulations, the authority aims to safeguard consumers from substandard and counterfeit products. Additionally, the Rwanda FDA plays a crucial role in promoting public awareness about safe food and drug practices, contributing to the overall well-being of the population. Despite these achievements, the Rwanda FDA faces challenges, including the low quality and safety of drugs in the market due to a limited capacity to track and trace health commodities from manufacture through storage and on to end users as well as inadequate monitoring of rational drug use and research in the food and pharmaceutical sector.

2.3.10 Health Financing

Overall health expenditure has increased over the years. However, the current level of spending of $60 per capita (2022/2023) is lower than the $86 per capita spending required to achieve UHC. The share of external resources out of total spending is still significant (38.7%, compared to a public contribution of 42%), showing continued reliance on external financing, and the contribution of the private sector is limited to 19.3%. Community-based health insurance (CBHI), which covers the majority of the population, is being financed through additional sources (research fees, levies, pharmaceutical fees, gaming fees, motor vehicle inspections, and traffic fines), but their effectiveness in mobilizing additional funding varies. This initiative should be reviewed and an innovative financing strategy developed and implemented as part of the new health care financing strategy for financing not only CBHI but also other priority programs. Out-of-pocket (OOP) expenditure accounted for merely 10.3% of health expenditure, reflecting a favorable trend towards more equitable health care financing. The continued use of fee-for-service to reimburse health care providers within the insurance system maintains a passive approach to purchasing health care. This approach is linked to over-servicing and hence increases overall health insurance spending as strategic approaches such as capitation and disease-related groupings (DRGs) are yet to be initiated. Although insurance coverage is high, significant gaps/inequities in financial protection remain as the benefits package is not applied uniformly across health facilities, the scope of benefits differs by schemes, and the number of health care services in the public sector that are not reimbursed by health insurance schemes appears to be growing.

2.3.11. Leadership and Governance

The Rwandan health sector is governed by clear national health policies and strategic plans, translated into annual implementation plans. These policies, supported by legal frameworks and guidelines, aim to provide quality promotive, preventive, curative, and rehabilitative health care and to reduce financial risk. Over the last five years, several strategic plans and legal frameworks have been developed, and the National Health Policy of 2015 is currently being revised.

Governance in the health sector is expressed both vertically and horizontally. Vertically, the MOH sets national policies and provides support for health programs at the central level. At the district level, health facilities are accountable to the District Health Management Team (DHMT), while managers are responsible for resource management and service delivery at the facility level. Horizontally, the Ministry coordinates through the Health Sector Working Group (HSWG), Technical Working Groups (TWGs), and the Joint Health Sector Review with various stakeholders for improved effectiveness. Despite some progress being made, more skilled leadership and management professionals are needed in public health facilities, as only 79% of 823 management positions are filled and staff at the decentralized levels have limited skills.

3. HSSP V Strategic Framework

3.1. Health Sector Vision and Mission

Vision:

To have a healthy and productive population that contributes to the realization of Rwanda's development goals.

Mission:

To provide and continually improve promotive, preventive, curative, rehabilitative, and palliative health care services of the highest quality equitably to enhance the well-being of the population in Rwanda.

3.2. HSSP V Pillars, Enablers, and Objectives

To realize the health sector vision and mission, HSSP V is organized into five strategic pillars and two enablers. The five pillars are as follows: health workforce; health infrastructure modernization; quality of health care through primary health care (PHC); health security and public health emergency management; and research, innovation, biomanufacturing, regulation, and digitalization (figure 1). In addition, the two enablers—health financing, along with leadership and governance—will contribute to implementing priority interventions and achieving pillar objectives

Pillar 1

Health Workforce

Aims to create a robust health workforce that is well-trained, adequately supported, and optimally deployed to meet the population's health needs. By investing in quality education, career development, and workforce empowerment and welfare, the pillar seeks to expand the number of health workers and significantly enhance their quality and job satisfaction.

Pillar 2

Health Infrastructure Modernization

Aims to transform the provision of health services through fully functional health facilities that are equipped according to standards, are clean, safe, user-friendly and climate-resilient, and have a flexible design that accommodates innovations and new digital technologies. It also aims to ensure the availability of accredited health facilities.

Pillar 3

Quality of Health Care through Primary Health Care

Aims to ensure that health services to individuals, families, and the population provided at all levels of the health care system are effective, efficient, safe, person-centered, and timely. It employs a primary health care approach to guarantee equitable access to essential health services and high coverage of interventions. This approach focuses on meeting people's health needs through community empowerment and integrating services along the health care continuum, from health promotion and disease prevention to curative, rehabilitative, and palliative care.

Pillar 4

Health Security and Public Health Emergency Management

Aims to rapidly detect and effectively respond to any health emergency to protect people from any public health threats. As part of the public health emergency response, the pillar focuses on building a resilient health system, improving disaster management, responding to the impact of climate change on health, and following the One Health approach, including its focus on fighting antimicrobial resistance.

Pillar 5

Research, Innovation, Biomanufacturing, Regulation, and Digitalization

Aims to set a comprehensive approach to applying knowledge and skills to advance health technology (medicines, vaccines, procedures, and systems). It also aims to integrate cutting-edge research with innovations in health technology, supported by robust regulation and digitalization. The pillar enables the health sector to lead in sustainable solutions, health care breakthroughs, and technological innovations, ensuring high standards of quality and efficiency. This pillar also seeks to enhance practical outcomes of research and innovations in biomanufacturing, with special emphasis on promoting local drug manufacturing.

Figure1: Health Sector Strategic Plan V Pillars

3.3. Mainstreaming of NST2

The HSSP V strategic framework (figure 2) responds to the required cross-cutting areas emerging from other sectors that are enshrined in the NST2 and must be incorporated into all sector strategic plans, including capacity development, environment and climate change, disaster management, disability and social inclusion, gender and family promotion, nutrition, regional integration and international positioning, Research & Development, Data & Statistics and Innovation and Digitalization.

- **Capacity Development:** HSSP V capacity development will focus on improving the quality and increasing the size of the health workforce through pre-service and in-service training, mentoring of health workers according to need, and strengthening of health professional bodies and training institutions.
- **Environment and Climate Change:** The health sector will promote a green environment and address climate change by implementing climate-friendly health infrastructure, climate-resilient health services, and environmental health and sanitation and by mitigating adverse effects of climate change on population health.
- **Disaster Management:** The health sector will continue to build resilient health systems to reduce the impact of disease outbreaks and natural disasters through prevention, detection, response, and recovery. In addition, a Multi-Hazard Early Warning System will be implemented at the health sector level to save lives and property in communities at risk of disaster.
- **Disability and Social Inclusion:** The health sector will continue to facilitate access to health services for people living with disabilities and marginalized groups to promote social inclusion. A national community awareness on early detection and reporting of disabilities among children will be designed and implemented.
- **Gender & Family Promotion:** The health sector will mainstream gender equity by promoting equal opportunity and diversity in leadership and gender-sensitive mentorship and sponsorship programs in health workforce development. The sector will ensure gender-equitable health care services and strengthen adolescent and youth-friendly health services.
- **Nutrition:** The health sector will revamp nutritional centers at health centers and improve coordination with community health services to facilitate easier referral and follow-up. The health sector will enhance community-based screening of nutritional status to allow early identification and timely management of malnutrition in children and pregnant women and ensure the availability of nutrition commodities.
- **Regional integration and international positioning:** The health sector will ensure harmonization of regional health insurance policies and mechanisms at the East African Community (EAC) level to facilitate the free movement of labor and people.
- **Research and Development:** The health sector will promote scientific research pertaining to health-related issues including drug discovery and production, all of which are inherently linked to development.
- **Data & Statistics:** To inform policy and decision making, the health sector will invest in data and statistics. Among other data-driven initiatives, this will be underpinned by the establishment and operationalization of the Health Intelligence Centre.
- **Innovation and Digitalization:** To meet evolving health care needs, improve service delivery, and harness data for policy and decision making, the Ministry of Health in collaboration with partners will invest in innovation and foster digitalization of services in the sector.

3.4 Alignment with Global and Regional Initiatives

- **Health-related SDGs:** The HSSP V priorities and interventions are planned to help the country attain health-related SDG targets. Emphasis is given to UHC to ensure equitable access to essential health services without financial hardship.
- **The Africa Union Agenda 2063:** The vision and mission of HSSP V are aligned with the aspirations of The Africa We Want, which aims to foster a prosperous Africa based on inclusive growth, sustainable development, and people-centered health services.
- **EAC:** HSSP V aligns with EAC regional integration, which promotes joint disease surveillance and response and standardized health care regulations and facilitates the free movement of health professionals and medical supplies as well as access to health care services across member states.

Vision Mission	**Vision: To have a healthy and productive population that contributes to the realization of Rwanda's development goals**				
	Mission: To provide and continually improve promotive, preventive, curative, rehabilitative, and palliative health care services of the highest quality equitably to enhance the well-being of the population in Rwanda				
HSSP V Pillars	Health Workforce	Health Infrastructure Modernization	Quality of Health Care Through PHC	Health Security and Public Health Emergency Management	Research, Innovation, Biomanufacturing, Regulation, and Digitalization
Objectives	P1.01: Quadruple skilled health workforce	P2.01: Build, upgrade, and maintain health facilities up to standard	P3.01: Attain universal health coverage of essential health services	P4.01: Protect the public from public health threats	P5.01: Advance scientific knowledge
	P1.02: Enhance quality of education for health workforce	P2.02: Aptly equip health facilities	P3.02: Improve level of population health literacy and healthy behaviors	P4.02: Enhance capacity for early detection, timely notification, and rapid response	P5.02: Promote research and drug discovery
	P1.03: Improve health workers' fulfillment and satisfaction	P2.03: Establish a high-tech and innovative health city – "Kigali Health City"	P3.03: Enhance availability of quality health services	P4.03: Strengthen local and international partnerships in health security	P5.03: Promote health-related innovations
		P2.04: Maximize the readiness and operationalization of health facilities			P5.05: Ensure strong regulatory system is in place
HSSP V Priorities	P1.P1: Health professional career guidance & recruitment P1.P2: Health training capacity development P1.P3: Fostering regional and global partnerships among medical training institutions P1.P4: Resource mobilization for training and upskilling P1.P5: Health workforce deployment optimization P1.P6: Health workforce retention P1.P7: Health workforce empowerment	P2.P1: Health facility expansion, renovation, and rehabilitation P2.P2: Strategic acquisition of medical equipment P2.P3: Investment in and attraction of investment for the operationalization of the Kigali Health City and promotion of medical tourism P2.P4: Optimal health facility use P2.P5: Health facility standardization and accreditation	P3.P1: Maternal, neonatal, child health; nutrition P3.P2: Sexual and reproductive health and rights and gender-based violence P3.P3: Adolescent and youth health services P3.P4: Infectious disease prevention and control P3.P5: Non-communicable disease prevention and control P3.P6: Mental health P3.P7: Emergency medical services and trauma P3.P8: WASH and Environmental health P3.P9: Health promotion and behavioral change communication P3.P10: Specialized medical services P3.P11: Community-based health services P3.P12: Availability of medicine and medical consumables	P4.P1: AI-driven disease surveillance and outbreak prediction P4.P2: Pioneering next generation point of entry surveillance P4.P3: Epidemic Intelligence Hub: P4.P4: Smart integrated One Health system P4.P5: Multi-pathogen genome sequencing to identify public health threats P4.P6: Strengthened local and international partnerships in health security P4.P7: Early response and adaptation to, and mitigation of, climate change effects for the health and well-being of the community	P5.P1: Increased research and innovation capacity P5.P2: Collaboration between industry and academia P5.P3: Genomics and precision medicine research P5.P4: Data for decision-making and policymaking P5.P5: Investment in drug manufacturing and technology transfer P5.P6: Digitalization of the health sector P5.P7: Food and drug regulation

Crosscutting enablers	**Objectives**	**E1: Health Financing**				**E2: Leadership and Governance**	
	HSSP V Priorities	E1.01 Resource mobilization	E1.02 Improved Efficiency	E1.03 Financial risk protection	E1.04 Increased private investment in health	E2.02: Improved community satisfaction and ownership	E2.01: Improved accountability and transparency
		E1.P1: Increase domestic resources mobilization capacity E1.P2: Enhance efficiency E1.P3: Improve financial protection of citizens				E2.P1: Enhance good governance E2.P2: Well-functioning coordination mechanisms at all levels E2.P3: Conducive environment for private sector engagement	

Figure 2: Health Sector Strategic Plan V Framework

4. Priorities and Interventions

Pillar I: Health Workforce

The core business of this pillar is fast-tracking health workforce development, with the goal of quadrupling the number of health care workers in the next four years (4x4 reform) to bring Rwanda closer to the WHO-recommended target of health workforce density. The reform relies heavily on revamping related health education policies and practices to ensure a health workforce pipeline that will meet the needs of the population. The pillar will also ensure an effective deployment and retention strategy for the health workforce. The expected result of the pillar is achieving the following three key objectives:

Objective (P1.01): Quadruple skilled health workforce
Objective (P1.02): Enhance quality of education for health workforce
Objective (P1.03): Improve health workers' fulfillment and satisfaction

Priorities and Key Actions

P1.P1 Health professional career guidance and recruitment:
A robust career guidance and strategic recruitment guideline will be designed and implemented to enhance the attraction of new student enrollment to health professions to ensure a sustained inflow of talent into the health sector. This will be integrated with active support to eligible trainees across priority cadres, including scholarship support.

P1.P2 Health training capacity development:
This includes expanding the training capacity of both public and private institutions by arranging need-based support, including with respect to faculty and infrastructure. There will be public-private partnerships (PPPs) to allow for scaling educational infrastructure and resources, which is vital to quadrupling the health workforce. A conducive environment will be created for engaging the private sector, with respect to both expertise and funding, to play that sector's role in enhancing the quality and quantity of training facilities. In addition, harmonizing and standardizing curricula, redeploying experienced clinicians to training institutions, and expanding the number of level-2 teaching hospitals are actions that will be strengthened to enhance the production of new health workers. The health training capacity synergizes the efforts across sectors and maximizes efficiency (quality and quantity).

P1.P3 Fostering regional and global partnerships among medical training institutions:
Fostering partnerships, both regionally and globally, with medical training institutions will facilitate the exchange of knowledge, faculty, curricular innovations, and best practices. To close gaps in access to specialized training and raise the standard of medical education to the level of global benchmarks, the current partnership will be scaled up to more institutions and countries.

P1.P4 Resource mobilization for training and upskilling:
Securing resources for continuous training and upskilling of the health workforce will include optimizing the use of available resources and identifying and mobilizing resources from new potential sources by attracting private sector investment in health education. In addition, the health sector will maximize efficiency across other sectors, such as education, to train, license, and employ new health workers and retain senior rare-skilled health workers.

P1.P5 Health workforce deployment optimization:
A health workforce deployment optimization system will be developed that leverages technology and innovation. The system will enable data-driven policy decision-making with visualization tools of health workforce needs based on workload and end-to-end management of the health workforce information system, from pre-service training to retirement, that links to relevant stakeholders, such as professional councils that are responsible for licensing different cadres. The optimization will include strengthened processes for workforce recruitment, deployment, and performance monitoring and for promoting ethical practices in the workplace.

P1.P6 Health workforce retention:
To address high rates of attrition, a health worker-centered retention approach will be strengthened. Key interventions include increasing incentives; investing in continuing professional development, in-service training, and mentorship to enable career growth and advancement, both clinically and academically; and increasing remuneration per grade acquired. To attract more health workers to the public sector, the MOH will advocate for health workers' saving schemes to be capitalized through the Government of Rwanda budget, strengthening the management of those schemes, and improving borrowing terms to incentivize health care professional retention.

P1.P7 Health workforce empowerment:
Another strategy for reducing attrition will be empowering the health workforce by strengthening the mechanisms for staff engagement in decision-making at all levels of the sector, in both managerial and clinical practices. In addition, focus will be placed on strengthening occupational health, safety, and well-being.

Pillar 2: Health Infrastructure Modernization

This pillar will transform health service provision by ensuring the standardization, construction, expansion, renovation, equipping, and accreditation of health and health-related facilities. The results of this pillar will be achieved through the following strategic objectives:

Objective (P2.01): Build, upgrade, and maintain health facilities up to standards
Objective (P2.02): Aptly equip health facilities
Objective (P2.03): Establish a high-tech and innovation health city—"Kigali Health City"
Objective (P2.04): Maximize the readiness and operationalization of health facilities

Priorities and Key Actions

P2.P1 Health facility expansion, renovation, and rehabilitation:
To improve access to and the quality of health service packages and address citizens' health needs, health and health-related facilities will be standardized, expanded, and renovated. All health facilities, existing and new, will be equipped, furnished, and supplied with the necessary utilities (water, electricity, sanitation facilities) and information and communication technology infrastructure to meet minimum standards. Additionally, quality construction standards will be enforced.

The major strategic shift is to develop a comprehensive infrastructure plan and design for the rehabilitation and expansion of existing facilities and the construction of new facilities. The design will be based on a comprehensive health infrastructure assessment and will consider the current and future health needs of the population and capability for accommodating innovations and new digital technologies. The designs will be climate-resilient and disability-friendly. In addition, equipment and furniture standards and guidelines will be revised to inform the development and implementation of an investment plan that aims to enhance health facilities' functionality.

During the strategic plan period, 10 existing hospitals, 23 health centers, 100 health posts, and an NRL will be constructed and operationalized to increase access and quality of care.

Existing health facilities will be rehabilitated and/or renovated, including include 420 health posts, 155 health centers, 10 district hospitals, 2 teaching hospitals, and 1 specialized hospital.

P2.P2 Strategic acquisition of medical equipment:
Access to good quality, affordable, and appropriate medical equipment is indispensable to enhance quality of health care and advance health service coverage.

The major strategic shifts are implementing strategic acquisitions from manufacturers and building the capacity of the system (human resources, workshops, regulation) to maintain available devices. Through addressing gaps in procurement efficiency and preventive and corrective maintenance, as well as effective forecasting of inputs, the availability and functionality of medical equipment in all health facilities will be enhanced. This will be informed by undertaking regular assessments of the status of health facilities and technical specifications to guide equipment acquisition and management.

The sector will work with manufacturers, not only to establish and implement strategic acquisition mechanisms but also to increase their contribution to capacity building. In line with this, equipment workshop capacities will be reviewed and strengthened by enhancing the availability of adequate tools to facilitate the management and maintenance of equipment. The current structures of clinical engineering at health facilities, at both central and decentralized levels, will be reviewed, and better structures will be established to ensure that end users are able to properly manage and maintain the high-end medical technology. These will be fostered by building a strong collaboration among and reforming the current practices of the Rwanda Utility Regulatory Agency, Rwanda FDA, and Rwanda Standards Board on equipment calibration/testing and regulations as well as establishing partnerships with academic institutions to improve biomedical engineering and health-infrastructure workforce development programs and prioritize medical device manufacturing. The health facility construction will be based on climate-resilient building design and green building standards using renewable energy and energy efficiency.

P2.P3 Investment in and attraction of investment for the operationalization of the Kigali Health City and promotion of medical tourism:
The strategic shift for using advanced health technologies, enhancing quality of health care, and making Rwanda a center for medical tourism in Africa is the establishment of the Kigali Health City through joint government-private investment.

The Kigali Health City is a project that aims to create a green, clean, and healthy environment for health professionals, researchers, academicians, patients, caregivers, and others in need or seeking to contribute to the betterment of health-related services. It will also address the rising number of patients that need to be referred abroad. The Government of Rwanda has secured 500 hectares of land in Kigali that have been dedicated to the establishment of the Health City and developed a master plan. Various institutions are currently under construction, including a new teaching hospital and an NRL. Joint government and private sector financing will be used as a mechanism to finance this flagship initiative, and investors will be encouraged to explore opportunities for infrastructure development in the area.

For medical tourism, the key actions include identifying priorities and opportunities and developing and implementing a medical tourism strategy. The implementation will be executed using a specialty-by-specialty approach, such as by giving priority to oncology, interventional cardiology, and nephrology as starting points. To

ensure proper design and implementation, a dedicated structure will be established in the MOH that works in collaboration with other relevant sectors.

P2.P4 Optimal health facility use:
The primary goal is to enhance the readiness of health care facilities to deliver safe, high-quality care, ensuring that they operate according to established standards. Key actions include developing and revising facility standards for various levels of care, focusing on improving patient care, facility management, and staff capacity to utilize health infrastructure effectively; actively involving health facilities in continuous improvement processes and enforcing standardization through regular inspections and external reviews; and implementing robust procedures for proper waste management and infection prevention to maintain a safe environment for patients and staff.

P2.P5 Health facility standardization and accreditation:
The strategic shift is to develop comprehensive infrastructure standards for different types of health facilities that address the current and future health needs of citizens. Following the development of the standards, implementation of rigorous accreditation processes to ensure high-quality and consistent health care services will be executed. This will include setting clear benchmarks for facility performance and conducting regular audits to assess compliance with health regulations and standards. In addition, inspections of health facilities will be reorganized for quality assurance.

Pillar 3: Quality of Care Through Primary Health Care:

Pillar 3 employs a PHC approach to guarantee equitable access to essential health services and high coverage of interventions. This approach focuses on meeting people's health needs through community empowerment and integrating services along the health care continuum, from health promotion and disease prevention to curative, rehabilitative, and palliative care. The results of this pillar will be achieved through the following objectives:

Objective (P3.01): Attain universal health coverage of essential health services
Objective (P3.02): Improve level of population health literacy and healthy behaviors
Objective (P3.03): Enhanced availability of quality health services

Priorities and Key Actions

P3.P1 Maternal, neonatal, and child health; nutrition:
The strategic shift to improve maternal, newborn, child health will be focused on ensuring universal coverage and enhancing quality of antenatal, delivery, postnatal, child health care and immunization services. Digital tools to enhance follow-up for high-risk pregnancies will be rolled out nationwide.

High-impact interventions, such as calcium and multiple micronutrient supplementation for all pregnant women and intravenous iron treatment for anemic women, will be introduced during and after childbirth as needed. Postpartum hemorrhage will be timely identified and properly managed using calibrated obstetric drapes, heat-stable uterotonics, and tranexamic acid. Hospitals will introduce/strengthen the practices of using post-delivery prophylactic antibiotics as well as employing strict infection prevention and control measures. For newborn health, the focus will be on ensuring that neonatal services in all hospitals are fully functional. There will be an expansion in the use of continuous positive airway pressure, caffeine citrate, probiotics, antenatal corticosteroids, and surfactants.

Enforcement of adherence to protocols will be implemented to reduce the incidence of maternal and neonatal complications. The referral system between health care facilities at all levels will be strengthened to avoid delays and to ensure that Emergency Obstetric and Newborn Care (EmONC) services are functional.

Capacity will be reinforced through practical training and task shifting of essential life-saving interventions/skills—such as emergency peripartum hysterectomy, comprehensive abortion care, and vacuum extraction—to general practitioners, midwives, and nurses.

Immunization services will be enhanced to maintain high coverage in routine immunization, to reduce zero dose children in all districts by expanding vaccination services in health posts, improving vaccination in the second year of life and reach the elimination of measles. Immunization will be integrated in primary health care for children and life saving vaccines will be introduced including hepatitis-B birth dose. Strategies will be designed and implemented to reduce the long wait for services so to improve client (caregiver/parent) experience during service uptake at health facilities and community outreaches. Interpersonal Communication (IPC) channels will be used as a main source of information about immunization to reduce vaccine hesitancies, drop-out rates and to tackle other misconceptions and beliefs including gender barriers towards immunization. HPV vaccination and revitalization remain a key initiative with strengthened school-based (health facility out of school), community mobilization, resource optimization via single-dose use, and strengthened life-course immunization for adolescents and adults.

Integrated management of childhood illnesses will be strengthened at all levels. Multi-sectoral collaboration and community engagement strategic interventions will be developed and implemented to reduce child illness and deaths. Capacity building will be prioritized to enhance the quality of newborn and child health services for health care providers and parents/caregivers.

The strategy for nutrition entails reinforcing a multisectoral approach to eliminate all forms of malnutrition, including enhancing community-based screening of nutritional status and educating on maternal and child malnutrition, exclusive breastfeeding, complementary feeding, micronutrients, and therapeutic feeding. Revamping nutritional centers at health centers and strengthening their connections with community health services (CHS) will also be prioritized.

P3.P2 Sexual and reproductive health and rights and gender-based violence:

Targeted awareness campaigns promoting the use of modern contraceptive methods and continuous introduction of new methods will be enhanced. The optimized postpartum and post-abortion family planning strategies in all health facilities will be continued and strengthened to ensure comprehensive care and maximize the benefits of family planning services across the health care continuum

Family planning will be integrated with other health care services, such as HIV care and NCD services, including cancer screenings to address high unmet needs.

Access to and availability of comprehensive abortion services will be expanded by revising the existing ministerial order on abortion to allow the provision of comprehensive abortion care services in health centers, facilitated through tele-health and task-shifting strategies.

The prevention of and response to gender-based violence (GBV) will be strengthened by expanding knowledge and utilization of, as well as access to, GBV-related services. GBV screening and services capacities of health care providers at health centers will be strengthened. Intersectoral collaboration will be promoted, with an emphasis on linking schools and health centers to better provide GBV services for adolescents.

P3.P3 Adolescent and youth health services:

The strategic shift is to address the rising trend of teenage pregnancies and improve health outcomes for adolescents and youth. The existing legal framework will be revised to enhance accessibility to contraception by adjusting the age for accessing contraceptives without parental consent.

Each health center will designate trained health care providers to deliver inclusive adolescent and youth-friendly health services, including sexual and reproductive health services, with a special focus on pregnant adolescents. Psychological and mental health support for affected and at-risk adolescents will be integrated into these services.

School health services will be strengthened in collaboration with the education sector and referral mechanisms from schools to adolescent and youth-friendly health services will be established. School outreach programs offering single-dose human papillomavirus vaccines will also be initiated and strengthened.

To enhance the demand and uptake of adolescent SRHR services, innovative strategies, including the use of digital tools and social media, will be utilized to provide adequate information and increase the use of services. Additionally, the community health program will include scaling up urinary pregnancy tests and deploying condom dispensers at community hotspots.

P3.P4 Infectious disease prevention and control:

This strategic plan aims to maintain the momentum achieved so far and strengthen HIV and sexually transmitted infection services utilization among adolescents and key populations. High-priority interventions include implementing targeted and customized HIV prevention awareness campaigns and ensuring the availability of high-quality treatment and prevention commodities. Integration of HIV and SRHR services in all health facilities and communities will continue. High adherence to ART will be maintained through the continued expansion of community treatment support programs and engagement of schools in treatment support for adolescents and children. To continue the elimination of viral hepatitis, vaccination and effective case management efforts will continue.

HIV surveillance will be strengthened through digitalization and interoperability of information systems. Laboratory capacity will be enhanced to address drug resistance for HIV, hepatitis, and sexually transmitted infections, complemented by innovations such as HIV genotyping, to ensure early drug resistant testing and management.

TB incidence and case fatality rates have both declined in recent years due to early detection, screening of at-risk individuals, and adequate treatment. In the next five years, focus will shift to community detection of TB cases using digital tools and new technologies to reach high-risk populations (health care workers, including community health workers, prisoners, miners, and individuals with immune-compromising conditions such as HIV and malnutrition) early, thus preventing spread among close contacts. Accurate testing for diagnosis and treatment completion will be enhanced through laboratory upgrades, including improved infrastructure, high-tech equipment, and staff training in new technologies. Examples of these technologies include computer-aided detection for screening, GeneXpert for initial diagnostic testing, and diagnostic techniques for extrapulmonary TB. Additionally, nutritional support will be provided to TB patients with malnutrition to support full recovery.

Malaria control has made big gains over the last five years, as illustrated by the reduction in both incidence and case fatality rates. In the next five years, focus will be on integrated surveillance of vectors and cases while monitoring the effects of climate change on mosquito breeding. Individual-based digital information systems and new approaches for community-based malaria surveillance and response will be introduced to accelerate malaria elimination. As resistance to essential malaria treatments is increasing, this strategy will prioritize combating drug resistance through strict drug use monitoring.

There is a sustained high prevalence of soil-transmitted helminthiasis (STH) in some districts, despite the high coverage of mass drug administration (MDA). To combat this, evidence-based MDA will be conducted for STHs for children and adults by piloting interruption of transmission of STHs and schistosomiasis interventions. In addition, podoconiosis management services will be scaled up and integrated into routine clinical care. In the next five years, integrating care for neglected tropical diseases (NTDs) into the lowest level of health facilities, as well as strengthening multisectoral water, sanitation, and hygiene (WASH) coordination for NTD control through home grown solutions, will be priorities.

P3.P5 Non-communicable disease prevention and control:

This strategic plan envisions a Rwanda free from the avoidable burden of NCDs, including injuries and disabilities. To achieve this goal, priority interventions will be built on the foundation of community action and engagement through community health workers. The major focus/priority is to reduce the prevalence of major risk factors in the population by raising awareness and educating the public using innovative and targeted strategies, integrating risk factor education into school health programs, and establishing wellness programs through occupational safety and health initiatives in the workplace. Policies and regulations addressing risk factors will be established and strengthened along with ensuring immunization and early treatment of infections that lead to NCD.

Another strategic focus is to strengthen the health care system to deliver quality NCD services, including early detection and timely management of NCDs. Strengthening the capacity of the health system for NCD screening, diagnosis, and management is one of the priorities and strategic shifts of HSSP V. Key strategic shifts include capacity building for human resources, implementing community screening, and strengthening the linkage between community- and facility-based health services. Health facilities will be restructured to accommodate a dedicated department for chronic diseases. Specialized NCD diagnostic and treatment centers will also be enhanced through investments in infrastructure, equipment, and human resources. CBHI benefits packages will be reviewed and revised to include NCD interventions. Home-based NCD care services will be promoted. The availability of NCD medications and commodities will be improved. Artificial intelligence (AI) and telemedicine will be leveraged to enhance NCD care and treatment. Disability and rehabilitation services will be integrated into the health system, not only in primary and community settings but also in secondary and tertiary care facilities.

P3.P6 Mental health:

The school-based mental health program currently operational in seven districts will be scaled up nationwide to reach more students. In collaboration with other ministries, responsive mental health services will be introduced for at-risk families. Community-based mental health services and post-rehabilitation programs will be developed to provide proximate, ongoing support and social protection, particularly for high-risk groups such as genocide survivors. To further strengthen access to and utilization of mental health services, all health centers will be staffed with mental health professionals, and mental health screening will be integrated into all services. The incorporation of digital mental health solutions will enhance screening, diagnosis, treatment, and monitoring processes. Ensuring the availability of essential psychotropic medications and expanding the mental health workforce by increasing the number of trained specialists and mentorship programs will be a priority. Mental health centers will be scaled up to one per province to improve service coverage.

To develop evidence-based interventions, further research and data collection are essential, along with the testing of novel drugs and therapies. These efforts will ensure that mental health strategies are effective and responsive to the needs of the population.

P3.P7 Emergency medical services and trauma:
A strengthened emergency medical services (EMS) system, spanning from pre-hospital to emergency services and critical and operative care, provides an effective platform for delivering accessible, quality, and timely health care for acute illness and injury.

Key priorities include implementing efficient coordination across the health system that involves developing an EMS policy and restructuring and updating ambulance service tariffs to enhance revenue recovery. In addition, service packages for emergency care across different levels of the health care system will be developed and implemented.

For pre-hospital services, securing new ambulances to achieve a rate of one ambulance per 20,000 population—an increase from the current one per 50,000—is essential. New EMS IT solutions should be established to improve caller location identification, ambulance dispatching, and overall data management to meet national response time targets. Community-level first responders trained in first aid will be introduced to enhance accessibility and initial response to emergency cases.

Pre-service training will be introduced, continuing education for emergency care providers will be strengthened, and national clinical protocols will be implemented. Effective communication protocols between patients and primary care, ambulance diversion policies, and strategies to manage overcrowding and bed blockages will be established. Moreover, access to emergency surgical and acute-care rehabilitation services will be expanded and aligned with national plans.

Nationally, a poison information center to provide vital resources for managing poison-related emergencies will be established. The national standardized triage system will be bolstered with clear waiting time targets and compliance tracking mechanisms for efficient patient care. Furthermore, expanding infrastructure revitalization projects and training programs for mass casualty management will be pursued.

P3.P8 WASH and Environmental health:
The strategy will focus on promoting WASH and environmental health in collaboration with relevant sectors and using CHS as a first point of contact for the community. The interventions include the proper use and storage of safe drinking water, use of improved latrines/toilets, and the safe management of generated wastes (segregation, collection, transportation, treatment, and final disposal). In addition, the use of clean cooking technologies that are relatively more efficient and produce less smoke will be promoted.

P3.P9 Health promotion and behavioral change communication:
The strategy will focus on promoting health using multiple mechanisms to ensure that the population is aware of health and health-related conditions. The main purpose of conducting health promotion and behavioral change communication is to enhance the health literacy of the community to create self-reliant citizens.

P3.P10 Specialized medical services:
Different strategic initiatives will be introduced and strengthened to enhance the quality of health care at all levels, with an emphasis on specialized medicine. A quality health care strategy with smart indicators to track the proper implementation of interventions will be put into place. Specialized health care services such as ophthalmology will be strengthened, and a corneal tissue bank will be established to improve the availability and accessibility of corneal transplantation. New services such as positron emission tomography, or PET, scans and bone marrow transplant will be established. Advanced surgical care will be introduced in 10 level 2 teaching hospitals. Monitoring of patients' complaints will be enhanced through the digitalization of information systems. A policy and strategic plan on infection prevention and control will be developed and implemented.

Different regulations and guidelines will be developed to improve quality of care services. For instance, a new law on health services will be established to address the lack of proper and up-to-date regulatory frameworks for clinical care, the Essential Medicine Lists will be revised every two years, and the Standard Treatment Guidelines will be revised every four years.

To address safety concerns about and the organization of traditional medicine, regular nationwide inspections, explorative research, and collaborations will be organized.

Blood Transfusion Service: Blood donor enrollment for people under 25 years of age (Club 25) will be expanded using various sensitization mechanisms and screening for transfusion-transmitted infections. The new strategic focus includes the development of intra-facility Blood Bank Management Systems that will reduce wastage and enhance proper use. To further reduce wastage, excess plasma from the blood banks will be exported for fractionation. A back-up blood bank at the Rwanda Military Hospital will be established, and emergency blood delivery within Kigali using electric bikes will be introduced to reduce turnaround time for delivery of blood and blood components to hospitals. In other areas, the use of drone technology for timely blood and blood component delivery will continue.

P3.P11 Community-based health services:
A thorough revision of community service packages and their input requirements will be designed to ensure that current and future citizens' health needs are met. The strategic focus is to increase the recruitment, training, and deployment of professional community health cadres, consistent with the revised package. By enhancing the engagement of volunteer community health workers, communities will be empowered, and their voices will be amplified to positively influence the health system.

To improve service delivery, a comprehensive digitalization of CHS will be implemented, facilitating data-sharing across various levels of health facilities. Additionally, the leadership and coordination of CHS will transition from health centers to health posts, with the deployment of CHS coordinators at the cell level.

P3.P12 Availability of medicine and medical consumables:
In the coming five years, a pooled procurement mechanism will be established to leverage bulk purchasing and negotiate lower prices. The storage infrastructure at all levels will be expanded. Rwanda has invested in a digital system, eLMIS, to facilitate timely ordering, monitoring, and reporting along with easy visualization of stock levels to inform decision-making. Monitoring and improving the eLMIS' correct use at all levels, as well as ensuring that the medicines and supplies reach the clients, will be a key priority for the next five years.

Pillar 4: Health Security and Public Health Emergency Management

As part of the public health emergency response, a high-level commitment to build a resilient health system exists, as witnessed during the COVID19 pandemic response, and this will continue throughout the strategic period. To that end, an up-to-date national action planning for health security (NAPHS), guided by the following priorities and key actions, will be in place. The results of this pillar will be achieved through the following objectives:

Objective (P4.01): Protect the public from public health threats
Objective (P4.02): Enhance capacity for early detection, timely notification, and rapid response
Objective (P4.03): Strengthen local and international partnerships in health security

Priorities and Key Actions

P4.P1 AI-driven disease surveillance and outbreak prediction:
The strategic shift in disease surveillance and outbreak prediction is the plan to use AI for early detection of outbreaks and the integration of climate data for outbreak prediction. As a result, robust public health threat monitoring systems, including indicator-based and event-based surveillance systems such as Impuruza, electronic medical records, and electronic integrated disease surveillance and response (eIDSR) systems will be implemented. An innovation of AI-enabled symptom-screening systems for travelers will be in place. In addition, AI-based data triangulation of human, animal, and climate data will be implemented and linked to the development of an interactive dashboard.

P4.P2 Pioneering next generation point of entry surveillance:
Pioneering next generation point-of-entry surveillance, the health system capacity to test for priority highly pathogenic diseases at the point-of-entry, including airports and land borders, will be strengthened. With respect to land borders, this capacity will be decentralized to points of entry and, as such, necessary equipment, reagents, and other consumables will be available there. This will also be accompanied by deployment or training of requisite lab specialists and transportation systems to the NRL when needed.

P4.P3 Epidemic Intelligence Hub:
To manage and use the data generated by point-of-care testing, an integrated One Health laboratory will be constructed and equipped, a National Epidemic Intelligence Hub will be implemented, and a One Health Emergency Operation Center will be established. This will help develop diagnostic capacity and enhance data for making decisions and policies, leading to improved health outcomes. Data triangulation in the National One Health Emergency Operation Center will enable pin-pointing and immediate response. In addition, the One Health surveillance tool will be rolled out in all sectors countrywide, up from the current 50% coverage.

P4.P4 Smart integrated One Health system:
The MOH will establish a smart integrated One Health system to effectively prepare for, detect, respond to, and recover from animal diseases transmissible to humans. This will also lean on the analytic capabilities enabled by the Epidemic Intelligence Hub. All tier levels (frontline, intermediate, and advanced) of Field Epidemiology and Training Program participants will be trained on the One Health approach and the One Health surveillance tool. In addition, a surge team on public health emergency management (PHEM) will be trained and deployed.

Antimicrobial resistance (AMR) surveillance will be strengthened through the establishment of a Center of Excellence for AMR surveillance, training, and research as well as by scaling up the number of sentinel sites from 12 to 20.

P4.P5 Multi-pathogen genome sequencing to identify public health threats:
In shaping communicable disease surveillance, the potential to identify unexpected microorganisms and infer their susceptibility to antimicrobials will be strengthened to enhance infection prevention and control and case management for highly pathogenic diseases. The Center of Excellence for Isolation, which is currently under construction, will conduct countrywide training and simulation exercises. Partnerships to establish domestic capacity to conduct multi-pathogen genome sequencing and clinical metagenomics to identify public health threats, especially in areas beyond COVID-19 (e.g. RSV, influenza, klebsiella, measles and typhoid), will be strengthened.

P4.P6 Strengthen local and international partnerships in health security:
Multisectoral collaboration and international partnership will be one of the major strategic shifts of the strategic period to effectively detect and respond to public health emergencies. The collaboration and partnership legal framework will guide the implementation, and regular joint monitoring will be carried out to explore its effectiveness.

P4.P7 Early response and adaptation to, and mitigation of, to climate change effects for the health and well-being of the community:
Climate and health policy will be developed and systems will be established to monitor the health- and well-being-related effects of climate change on communities, such as flooding that causes the resurgence of malaria in some communities, and capacity will be developed for early response, adaptation, and mitigation. Linkages will be established with AI-based disease projection using climate data as well as with surge capacity for PHEM.

Pillar 5: Research, Innovation, Biomanufacturing, Regulation, and Digitalization

This pillar will integrate cutting-edge research with innovations in health technology, supported by robust regulation and digitalization. It positions the health sector to lead in sustainable solutions, health care breakthroughs, and technological innovations, ensuring high standards of quality and efficiency. This pillar also seeks to enhance practical outcomes of research and innovation in biomanufacturing, with special emphasis on promoting local drug manufacturing. The results of this pillar will be achieved through the following objectives:

Objective (P5.01): Advance scientific knowledge
Objective (P5.02): Promote research and drug discovery
Objective (P5.03): Promote health-related innovations
Objective (P5.04): Enhance digital health
Objective (P5.05): Ensure strong regulatory system is in place

Priorities and Key Actions

P5.P1 Increased research and innovation capacity:
The national research capacity will be strengthened to understand root causes and find effective solutions; to conduct clinical trials to fuel innovations that lead to new products, technologies, and services; and to provide data and facts necessary for making informed decisions in policymaking. To that end, the sector will develop a research implementation framework that includes the health sector research policy and regulatory framework, national health research agenda, and research strategic plan. An intensive training program (short-term training for specific skills, master's level programs, and fellowship programs) will be designed and implemented in the coming five years.

P5.P2 Collaboration between industry and academia:
Collaboration between the health sector and academia will be strengthened by establishing joint research projects, holding regular networking forums, and creating advisory bodies. Additionally, collaborative publications, processes for technology transfer, and joint funding applications will ensure both sectors benefit mutually, enhancing economic development and technological advancement.

P5.P3. Genomics and precision medicine research:
Clinical trials will be conducted and supported by capacity building, including the certification of at least 30 clinical trial sites at national- and subnational-level health facilities. Observational studies based on program surveillance in selected disease areas, pandemic surveillance (genomic surveillance, antimicrobial resistance, climate change, and other priority agendas), impact evaluation, and basic research capabilities will be enhanced.

P5.P4 Data for decision-making and policymaking
The strategic focus will be to harness data and analytics to drive informed decisions and policymaking. Practical research, and research conducted at the peripheral level/in the workplace, will be emphasized. Establishment of a health intelligence center where data-driven insights will be specifically translated into innovative policy proposals will be a focus. Regular training sessions and workshops will be conducted to enhance the data literacy of all stakeholders, including researchers and policymakers, to empower them to effectively use data in their respective roles. Continuous feedback systems to evaluate the effectiveness of data-driven decisions and policies will be instituted.

P5.P5. Investment in drug manufacturing and technology transfer:
Promotion of investments in local manufacturing of health and food commodities and technologies will be a strategic priority. Investment promotion to attract international vaccine and drug manufacturing companies; using timely and adequate data to inform manufacturing; and strengthening collaboration with relevant sectors to create an attractive environment for investment in these sectors and relevant workforce development to fulfill the demand in these areas will be part of the strategic shift.

P5.P6 Digitalization of the health sector:
The strategic shift on digitization of the health sector will focus on eight priorities. These priorities involve the establishment of a health insurance portal system, health intelligence room, emergency response information system, community health workers information system, enhanced electronic medical record system, citizen health app, national medical laboratory information system, and genomic surveillance information system. The proposed interventions will build on and scale up existing systems by strengthening their interoperability. New technologies will include AI and machine-learning techniques to provide decision support and opportunities for telemedicine. Health analytics and predictive modeling tools will support evidence-based planning of resource allocation. Capacity building on digital health skills is included to match the ambitions for a digitized health sector.

P5.P7 Food and drug regulation:
The strategy will focus on enhancing product registration and information control, establishing surveillance mechanisms, and implementing comprehensive tracking systems. The registration process for food and drug products will be strengthened and streamlined by updating and optimizing regulatory frameworks. This will not only expedite access to essential products but will also ensure they adhere to high-quality standards. The product registration and information control processes will be enhanced using best practices aligned with international standards to facilitate smoother and more efficient market entries for new products, ensuring they meet rigorous safety and efficacy criteria.

Surveillance mechanisms will be established to monitor the quality of medical and food products to quickly identify and address any product issues. In addition, quality control laboratory testing capacity will be expanded to enable comprehensive testing of products and ensure continuous compliance with safety standards before those products reach consumers.

To ensure a well-functioning regulatory process, significant investments will be made in training programs for Rwanda FDA staff to enhance their skills and ensure they remain at the forefront of regulatory science and practices. Capacity-building initiatives will also be extended to stakeholders involved in the production, distribution, and regulation of food and drugs, ensuring that all parties meet required regulatory standards.

The regulatory process becomes more effective when it is supported by the public. Therefore, awareness campaigns will be undertaken through different communication mechanisms to educate the public about regulatory processes and encourage compliance with health and safety regulations. Moreover, consumer feedback channels will gather valuable insights that can be used to further refine regulatory practices.

In addition to the regulatory process, advocacy and promotion activities will improve the rational use of medicines and health commodities and investment in local manufacturing of health and food commodities and technologies.

Enabler 1: Health Financing

The overall objective of this enabler is to mobilize adequate and sustainable funds to achieve UHC without financially burdening citizens. It also focuses on efficiently allocating resources to maximize health outputs and outcomes. This requires transitioning to a more sustainable health financing arrangement by shifting from external to domestic sources and improving strategic purchasing. It is prioritized under four major strategic objectives:

Objective (E1.01) Resource mobilization
Objective (E1.02) Improved efficiency
Objective (E1.03) Financial risk protection
Objective (E1.04) Increased private investment in health

Priorities and Key Actions

E1.P1 Increase domestic resources mobilization capacity:
The strategic focus will be to advocate and work with stakeholders for increased allocation of resources from the government. Current practices of mobilizing additional funding to CBHI through innovative financing will be revised and built upon by engaging and working with MINECOFIN.

The MOH will continue to work with the HSWG and advocate for better alignment and harmonization to increase the share of external resources that are on-budget.

Tariffs of health interventions/services will be regularly reviewed and updated to ensure they are aligned to their cost, and revenue-generating capacities of health facilities will be enhanced by revising their manuals and business plans to enable the mobilization of additional resources.

Enhancing the engagement of the private sector and its financing mechanisms to ensure that it increases its contribution will also be a priority. The main intervention in this regard is developing clear policy guidelines that incentivize the private sector to invest in health, not only in medical tourism but also in health promotion, disease prevention, and curative, rehabilitative, and palliative care services. Promoting the use of PPPs and other mechanisms to encourage private investment in health infrastructure, direct health commodity supply from manufacturers, and

service provision, for instance, will also be a focus.

E1.P2 Enhance Efficiency:
Reforms to the provider payment mechanism, such as capitation and DRGs, will be designed and implemented. This will be complemented by strengthening facility-level financial management capacities as well as implementing integrated electronic health system payment platforms to streamline the reimbursement process.

Enhancing the quality of health services through a revised performance-based financing mechanism will be an additional focus of this strategy. Strengthening the health economic evaluation capacity, in collaboration with the academic institutions and research centers, to avail the health economic analysis reports will help inform policy decision-making.

The Health Resource Tracking Tool (HRTT) will be made functional to enhance data use for efficiency. This process of revitalization requires a clear accountability mechanism (capturing all sources of funding) and will mobilize resources to build adequate institutional capacity of all stakeholders (including CSOs and the private sector).

E1.P3 Improve financial protection of citizens:
The major strategic interventions are regularly reviewing and revising the benefits package to ensure the inclusion of high cost/high impact interventions to reduce catastrophic health expenditures. Actuarial studies will also be conducted to introduce limitations on co-payments or high-cost health services/interventions. The different benefits packages, along with their premiums and copayments, will be reviewed and adjusted to ensure that fair financial contribution and uniform benefits across social health insurance schemes are put in place in the medium term and move towards integration in the long term.

Enabler 2: Leadership and Governance

To enhance the achievement of HSSP V priorities, a robust framework of leadership, governance, and regulation is essential. This framework facilitates seamless communication and collaboration across all levels of the health care system in Rwanda. By prioritizing innovative, sustainable, and adaptable solutions, this approach aims to address health challenges while promoting accountability and transparency at every level. It is prioritized under two major strategic objectives:

Objective (E2.01): Improved accountability and transparency
Objective (E2.02): Improved community satisfaction and ownership

Priorities and Key Actions

E2.P1 Enhance good governance:

The key interventions to enhance good governance in HSSP V will be to improve the leadership and management capacity of health sector leaders at all levels. This includes providing targeted training and skills development, such as the implementation of a master's program in hospital management as well as the establishment of a mentorship and coaching scheme between new and experienced leaders. Leadership will be strengthened to increase accountability by availing up-to-date policies, laws, guidelines, and regulations and adhering to the implementation plan.

Engagement of all stakeholders in the government planning and monitoring and evaluation (M&E) processes will be strengthened, and mechanisms for active engagement of the community in decision-making, such as the health

committees at decentralized levels, will be defined and implemented. A digitalized patient feedback mechanism will be developed and implemented to empower the community, ensuring that complaints or suggestions are addressed. In addition, collaboration with the Rwanda Governance Board will be strengthened for the generation and use of a community scorecard.

The MOH will engage stakeholders to ensure that the sector has a transparent, timely, and reliable mechanism for resource commitment to support the implementation of the HSSP V strategic priorities and interventions. Development partners will be mutually responsible for transparent resource allocation and utilization through the revitalization and effective implementation of the HRTT.

HSSP V will guide the development of sub-sector (maternal and child health, TB, malaria, HIV, NCDs, mental health, etc.,) strategies and ensure their goals are aligned and contributing to the HSSP V objectives. Each strategy will clearly highlight multi-sectoral activities and budget requirements toward an integrated approach and reduce fragmentation.

E2.P2 Well functioning coordination mechanisms at all levels:

HSSP V will focus on effective partnership arrangements and collective engagement guided by the sector-wide approach. The different vertical and horizontal coordination structures will be strengthened, with clear guidelines to improve adherence to agreed-upon coordination structures.

The horizontal coordination mechanism between the MOH, Rwanda Biomedical Center (RBC), RMS, FDA, and teaching and referral hospitals will be strengthened and a bi-annual coordination mechanism between the MOH and its agencies and the district hospitals and DHMTs will be institutionalize. Efforts to strengthen the HSWG and TWGs at the central level, as well as DHMTs and health committees at decentralized levels, will be extended. The implementation of cross-cutting agendas using the existing platform, such as social clusters, will be facilitated and bilateral coordination mechanism will be established when needed.

E2.P3 Conducive environment for private sector engagement:

The major shift is to review the current processes and procedures and make them more flexible and attractive for the private sector to engage in areas such as biomanufacturing, high quality health service delivery, and health workforce development and to contribute to making Rwanda a health tourism center. Prudent incentive mechanisms, including PPP, will be designed and implemented.

5. Implementation Arrangements

The implementation of HSSP V will be a collaborative effort spearheaded by the MOH in partnership with various stakeholders, including socio-economic sectors, academia, the private sector, development partners, NGOs, faith-based organizations, and CSOs.

Senior management within the MOH will ensure that all investment by stakeholders is aligned with the priorities and interventions, as defined in conjunction with MINECOFIN, the Ministry of Local Government, and other relevant ministries, based on Vision 2050, NST2, and HSSP V priorities.

The Planning, M&E, and Health Financing Department of the MOH will play a leading role in the preparation and approval of the annual planning and budgeting process aligned to this plan. That department will ensure that the interventions, priorities, and investments of all stakeholders are part of the annual planning and budgeting process. In revitalizing this process, the following key milestones will be reviewed and strengthened: signing of performance contracts (Imihigo); strengthening mutual accountability mechanisms between MINECOFIN, development partners, and stakeholders within the health sector; strengthening the annual planning and budgeting process; undertaking annual and mid-term external reviews; and aligning program strategic plans with HSSP V.

5.1. Health Service Delivery Tier

As seen in figure 3, the Rwanda health service delivery has three tiers:

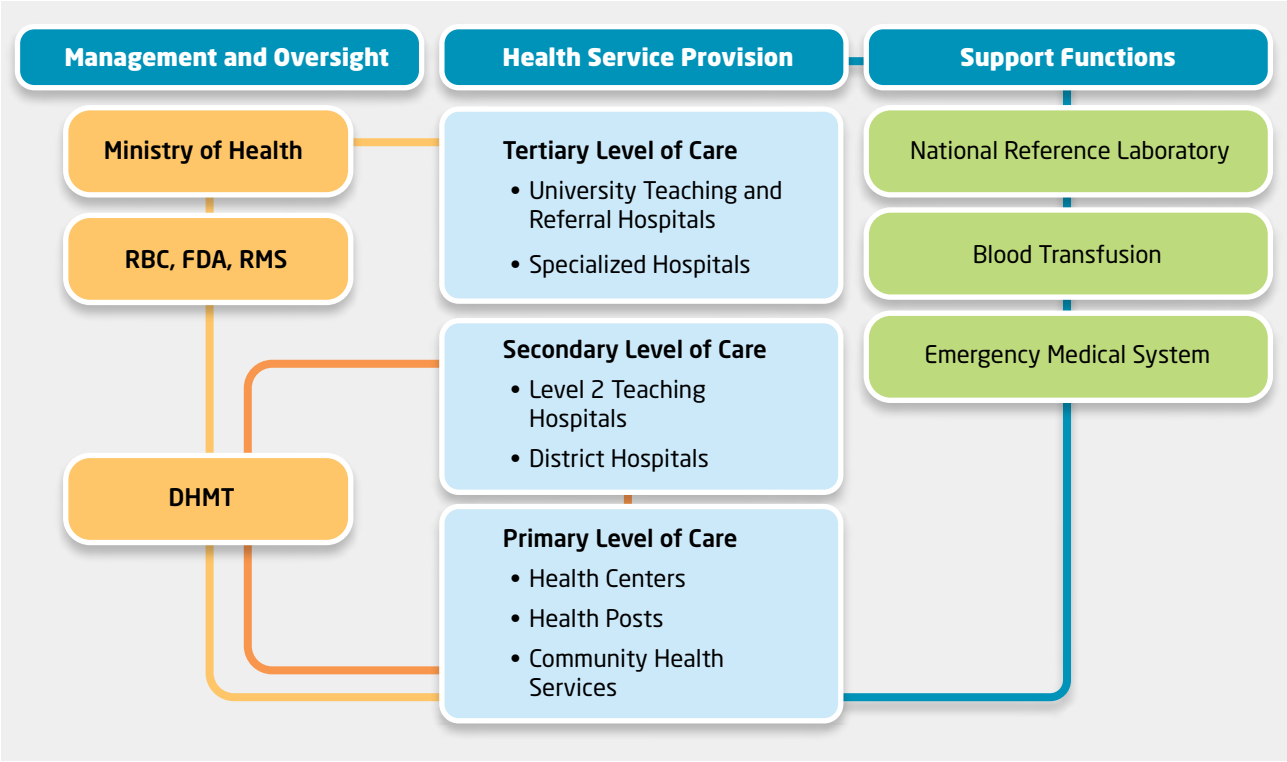


Figure 3: Rwanda health service delivery tier

Health care services are provided via three delivery levels: the primary, secondary, and tertiary levels of care.

The primary level of care is a mechanism for ensuring access to comprehensive and essential health services and is the first point of care. It comprises CHS, health posts, and health centers, including medicalized health centers. These primary care facilities will be staffed and equipped consistent with the minimum standards. CHS will be staffed with new certified professionals working together with the more than 60,000 volunteer community health workers. The volunteer community health workers are the backbone for community empowerment.

The second level of care comprises services at district hospitals. Among those hospitals, some will be selected to be teaching facilities (level-2 teaching hospitals) that will be provided with special support to integrate teaching and service provision.

The tertiary level of care comprises services provided at the highest referral level. Referrals can be vertical or horizontal, depending on the area of specialization.

The supportive functions (NRL, blood transfusion, and EMS) will be provided across all levels of service delivery by the respective units.

5.2. Roles and Responsibilities

5.2.1. Ministry of Health

The MOH will provide overall leadership, coordination, and technical guidance for the implementation of HSSP V. The MOH's Planning, M&E, and Health Financing Department will guide the overall planning process, ensuring coherence between national strategies and district-level plans as well as aligning the investments made by development partners, NGOs/CSOs, and the private sector to HSSP V. The MOH will coordinate implementation of the HSSP V strategy through all its agencies (RBC, RMS, and FDA) and will also engage and work with other government sectors by organizing regular meetings and including those sectors in the planning and advocacy of multisectoral interventions.

5.2.2. Local Government

Local governments are responsible for the provision and management of health services, including financial and human resources. They will coordinate, implement, and manage activities at the decentralized level to improve the quality of service delivery, coverage, cost-effectiveness, and ownership. The District Health Units (DHUs) will develop annual district plans that align with both district development strategies and HSSP V priorities.

5.2.3. Private Sector

The private sector will be engaged more vigorously through regular coordination meetings with the MOH. These meetings will address collaboration issues, such as investing in the health sector, health workforce development, tariffs, quality health service delivery, service delivery data reporting, facility inspections, adherence to regulations, and quality assurance norms.

5.2.4. Development Partners (DPs)

Development partners, including bilateral and multilateral donors, will support the health sector with a focus on aligning their support to HSSP V priorities. Their engagement in the HSWG and TWGs will be strengthened, not only to provide oversight and facilitate technical dialogue on policy and operational aspects of HSSP V but also to transparently show their contributions to its implementation. This includes sharing their priorities and

financial commitment as part of the one plan, one budget, and one report framework and advocating for sustained investments in health.

5.3. Coordination Mechanisms

The HSWG, chaired by the Permanent Secretary of the MOH, will meet quarterly to review and improve coordination, harmonization of procedures, and alignment of DPs with HSSP V and to ensure mutual accountability and effective implementation of health sector actions. TWGs operating under the auspices of the HSWG will serve as platforms for strengthening collaborative dialogue and advising on sub-sector strategies and policies, thereby enhancing efficiency and effectiveness within the sector. Comprising representatives from the MOH, development partners, NGOs, faith-based organizations, and CSOs, TWGs play an integral role in facilitating discussions, providing expert advice, and shaping the direction of health sector interventions to align efforts towards common objectives. The Single Project Implementation Unit, established to reduce the administrative burden on the MOH, will continue to manage and report on projects with off-budget resources and streamline implementation and monitoring of health programs.

5.3.1. Mutual Accountability Sessions

Regular mutual accountability sessions between MINECOFIN and DPs will focus on reviewing progress based on Common Performance Assessment Framework indicators, ensuring transparency and effectiveness in resource utilization and program implementation.

5.3.2. Annual Health Sector Planning and Budgeting Cycle

The MOH, through annual health sector planning and budgeting cycle processes, will coordinate the alignment of HSSP V priorities with specific internal program strategies and other stakeholders supporting the sector. This includes supporting planning and budgeting by DHUs, developing strategic plans for various programs (e.g., reproductive, maternal, newborn, and child health interventions; HIV; and malaria), and ensuring coordination with all stakeholders.

5.3.3 Joint Sector Review Meetings (backward- and forward-looking)

The MOH will organize a bi-annual joint sector performance review platform with all key stakeholders and pass policy-level recommendations for improvement.

6. Risks Analysis and Risk Mitigation

The risk analysis identified risks related to national level events, service delivery, access to health services, and behaviors influencing health. Risks linked to service delivery include those related to governance, health care providers, financial resources, and access to equipment, medications, supplies, and infrastructure. The identified potential risks and their respective risk mitigation mechanisms are summarized in table 1.

Table 1: HSSP V Risks and their Proposed Mitigation Mechanisms

Risk	Probability	Impact	Mitigation Measures
Climatic shocks	Medium	High	Strengthen surveillance and climate data analysis and enhance multisectoral response, including the minimum initial service package
Epidemics	Medium	High	Improve surveillance using new technologies/cross region communication, epidemic preparedness training and measures at all levels
Inadequate multi-sectoral collaboration	Low	Medium	Strengthen the existing multi-sectoral coordination platforms to address major cross-cutting public health challenges
Health provider shortages and lack of skills	High	High	Ensure adequate investment in implementation of the "4x4" strategy (training of health workers) and task shifting of some primary care activities
Inadequate leadership capacity at the health facility level, including adherence to national guidelines	Low	High	Capacitate the DHMTs; improve evidence-based planning; strengthen data use at decentralized levels; increase supervision, use of AI technology to ensure accountability and strengthening of the accreditation process
Funding gap to implement the HSSP V priorities	High	High	Optimize resource mobilization from all sources, evidence-based planning that prioritizes high-impact interventions and better use of resources (strategic purchasing); improve transparency and accountability of all stakeholders on health investment
Stock-out of medicines and commodities	Medium	High	Improve quantification of drugs and supplies; encourage investment in local manufacturing of vaccines and drugs; improve use of eLMIS for supply chain management of drugs and commodities
Inflation (local and global)	High	High	Implement evidence-based forecasting and planning
Barriers to citizens accessing health services such as financial, socio-cultural, and geographical	Low	High	Utilize risk pooling mechanism through CBHI; decentralize service delivery mechanism to primary health care level
Cultural beliefs, including the use of traditional healers; unhealthy lifestyles	Low	Medium	Implement media campaigns to increase health literacy as well as health prevention and promotion interventions (Social Behavioral Chance Communication activities) by community health workers
Regional and global social risks	Low	Medium	Forecast and enhance health system readiness

7. Monitoring and Evaluation

The M&E framework included in annex 1 guides the monitoring and evaluation of HSSS V implementation. The projected impact analysis developed through the different impact models of the One Health Tool is included there as well.

The Planning, M&E, and Health Financing Department will be responsible for the day-to-day monitoring of HSSP V implementation. This includes collecting, tracking, and analyzing data to determine what is happening where and to whom. The key elements to be monitored are as follows: resources (inputs); service statistics; service coverage/outcomes; client/patient outcomes (behavior change, service satisfaction); investment outputs; access to services; and impact assessments. Government systems will be used for data collection, triangulating data from Civil Registration and Vital Statistics (CRVS) with Health System Information System data and conducting data quality reviews using internal and external systems.

HSSP V has identified indicators (table 2) for monitoring and evaluating implementation of this strategic plan (annex 1). Inclusive and transparent mechanisms will be in place to monitor progress annually through backward- and forward-looking joint performance reviews as well as to evaluate performance at mid-term to inform progress and recommend necessary changes at central and decentralized levels.

The decentralized use of dashboards for the identification of errors and gaps as well as data-driven planning at district and community levels will be strengthened and supported by both central and subnational level leadership.

Joint assessments will be used at all levels to undertake regular reviews of Imihigo to assess performance against targets and determine priorities, action plans, and spending for the subsequent period. The Joint Sector Review Meetings (backward- and forward-looking) that will bring together all HSWG stakeholders, including representatives from government institutions and development partners, will be the main platform through which results of performance evaluations are deliberated upon by all stakeholders, including with respect to agreement on priorities for the next implementation period. The monitoring process includes a system for keeping track of the implementation status of the strategy, ensuring that agreed-upon follow-up actions are put into effect.

The midterm review will be used to determine the extent to which the objectives of this strategic plan have been met using the different indicator domains (inputs/processes, outputs, outcomes, and impact). Focus will be placed on high-quality research, mathematical/statistical modeling, and skills development for key officers to ensure effective interventions.

Table 2: HSSP V Monitoring and Evaluation Matrix

Indicator	Units	Baseline		Annual Targets				Data Sources
			2024/25	2025/26	2026/27	2027/28	2028/29	
Ratio of active licensed doctors (number per 100.000 of population)	Ratio	15.2	18.9	22.4	25.8	29.0	32.0	HR health facility records/ Annual Health Workforce Report/Council Reports

Indicator	Units	Baseline		Annual Targets				Data Sources
			2024/25	2025/26	2026/27	2027/28	2028/29	
Ratio of active licensed nurses (number per 100.000 of population)	Ratio	97.4	118.2	115.6	135.0	153.4	171.0	HR health facility records/ Annual Health Workforce Report/Council Reports
Ratio of active licensed midwives (number per 100.000 of population)	Ratio	58.1	85.8	112.4	137.7	161.9	185.0	HR health facility records/ Annual Health Workforce Report/Council Reports
Number of certified professional community health cadres deployed	Number	0	2540	5080	7620	10160	12,700	Annual Performance Report
Turnover rate among health care workers (doctors, nurses, midwives, pharmacists)	Percent	Doctors 44%; Nurses 26%; Midwives 14%; Pharmacists 85%	Doctors 35%; Nurses 15%; Midwives 12%; Pharmacists 75%	Doctors 25%; Nurses 10%; Midwives 10%; Pharmacists 60%	Doctors 20%; Nurses 10%; Midwives 8%; Pharmacists 50%	Doctors 15%; Nurses 8%; Midwives 7%; Pharmacists 30%	Doctors 10%; Nurses 5%; Midwives 5%; Pharmacists 20%	Annual Health Workforce Report
Health facilities fully equipped	Percent	65%	69%	73%	77%	81%	85%	Medical Equipment Management and Maintenance System Report
Health facilities with international accreditation (University Teaching Hospitals)	Number	2	2	3	3	4	5	Accreditation report
Health facilities with national level-3 accreditation	Percent	0	5%	15%	25%	35%	50%	Accreditation report
Maternal mortality ratio (maternal deaths per 100,000 live births)	Ratio	105	95.0	86	78	71	60.0	HMIS/CRVS
Neonatal mortality rate (neonatal deaths per 1,000 live births)	Rate	11.3	10.38	9.76	9.19	8.6	8.19	HMIS/CRVS
Under-five mortality rate (deaths per 1,000 live births)	Rate	45	40.6	36.2	31.8	27.4	20.0	HMIS/CRVS
Delivery at health facility	Percent	93	94.2	95.4	96.6	97.8	99.0	HMIS

Indicator	Units	Baseline		Annual Targets				Data Sources
			2024/25	2025/26	2026/27	2027/28	2028/29	
Teenage pregnancy rate (per 1000 teens)	Rate	29.3	28.62	25.45	18.85	15.68	15	HMIS/DHS
Unmet need for family planning	Percent	14.0%	13.8%	12.6%	11.4%	10.2%	8.0%	Unmet need for family planning
Children fully immunized	Percent	96	96.6	97.2	97.8	98.4	99.0	HMIS
Prevalence of stunting among children 6–24 months	Percent	24.30%	23%	22%	20%	18%	15%	MCH Week data
Prevalence of stunting among under five children	Percent	33	29.4	25.8	22.2	18.6	15	DHS
Annual incidence rate for malaria (cases per 1,000 population)	Rate	76.00	52	44.4	43.2	42.6	41.4	HMIS and Program Report
Annual Incidence rate for HIV (cases per 1,000 population)	Rate	0.243	0.241	0.24	0.239	0.238	0.238	HMIS and Program Report
People living with HIV who know their HIV status (goal is at least 95%)	Percent	95	96	97	98	99	100	HMIS and Program Report
People who know their HIV status who are on treatment (goal is at least 95%)	Percent	97	97.6	98.2	98.8	99.4	100	HMIS and Program Report
People who are on treatment who have a suppressed viral load (goal is at least 95%)	Percent	98	98.4	98.8	99.2	99.6	100	HMIS and Program Report
Incidence of tuberculosis (cases per 100,000 population)	Rate	69	50	40	35	35	30	HMIS and Program Report
Percentage of people with disabilities who use assistive devices and/or disability-related products	Rate	30	36	42	48	54	60	HMIS and Program Report
Probability of dying between age 30 and 70 from any of cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases	Percent	20%	18%	15%	13%	10%	8%	HMIS and Program Report

Indicator	Units	Baseline		Annual Targets				Data Sources
			2024/25	2025/26	2026/27	2027/28	2028/29	
Percentage of currently married women with unmet need of family planning	Percent	14%	13.80%	12.60%	11.40%	10.20%	8%	HMIS and Program Report
Teenage pregnancy rate (per 1,000 teens)	Rate	29.30	28.62	25.45	18.85	15.68	15.00	HMIS and Program Report
Population served by one ambulance	Ratio	53,000	46,400	39,800	33,200	26,600	20,000	Ambulance monitoring system
Ambulance response time in Kigali	Minutes	15	14	13	12	11	10	Ambulance monitoring system
Proportion of health facilities with available tracer health products among essential according to level of care	Percent	89%	90%	91%	92%	93%	95%	RMS report
International Health Regulation (IHR) index score	Percent	68%	70.4%	72.8%	75.2%	77.6%	80.0%	Annual Programmatic Report
Case fatality rate during outbreak	Rate	5.67	4.80	4.00	3.10	2.30	1.50	Health Facility Records
Proportion of research translated into policy and practices	Percent	N/A	10%	20%	30%	60%	80%	Programmatical Report
Proportion of health facilities using combined platforms to provide data for decision making	Percent	0	10%	20%	30%	40%	50%	Annual Performance Report
Proportion of health facilities (hospitals and health centers) with fully functioning Electronic Medical Record (EMR) system	Percent	12%	24%	35%	47%	58%	70%	Annual Sector Performance Report
% of human and veterinary medicines registered	Percent	20%	36%	52%	68%	84%	100%	FDA Report
% of food, feed, and food supplements registered	Percent	55%	64%	73%	82%	91%	100%	FDA Report

Indicator	Units	Baseline		Annual Targets				Data Sources
			2024/25	2025/26	2026/27	2027/28	2028/29	
Proportion of domestic contribution to the total health expenditure	Percent	61.3	61.90%	63.80%	66.20%	68.56%	70.80%	HRTT
Proportion of population that experience catastrophic health expenditure	Percent	1.15%	1.08%	1.05%	1.02%	0.97%	0.92%	Integrated Household Living Conditions Survey
Level of citizen satisfaction with service delivery in health sector	Percent	85%	87%	88%	89%	90%	92%	RGB Governance scorecard

8. Costing and Financing

8.1. Costing of NHSSP V

The One Health Tool is used for the costing of the HSSP V. The costing is estimated using two scenarios.

The first scenario prioritizes high-impact interventions and, in some multisector investments (e.g., WASH), the sector will only invest in policy and guidance, advocacy, and quality control activities and not in the fulfillment of materials and other equipment. The first scenario also assumes that some program management costs, such as those associated with leprosy, eye care, and oral health, will be integrated into their respective programs. The targets for NRL, FDA, and CHS are reduced.

The second scenario uses the assumption that Rwanda will fully realize SDG goals and other additional high-level outcomes. The major assumptions used in estimating the cost of HSSP V in the second scenario are driven by the targets set and investment on program management, such as trainings, supportive supervisions, and procurement of materials for WASH and other programs. Maternal, neonatal, and under-five mortality rates are targeted to decline respectively from 106, 11.5, and 39.4 per 100,000 in 2023 to about 65, 8.19, and 30 in 2029. The investment returns targeted to be realized for different programs, including maternal, child health, TB, malaria, and HIV, during the strategic plan period are estimated, and the details presented, in annex 2.

The total estimated HSSP V cost is RWF 5.9 trillion ($4.23 billion) under scenario 1 and RWF 6.9 trillion ($4.92 billion) under scenario 2 (table 3). The major cost driver is health infrastructure, for about 42.8% of the total cost (RWF 2.5 trillion) under scenario I and 36.8% of the total cost (RWF 2.5 trillion) under scenario 2. This is followed by quality health care through the PHC approach, with 29.5% (RWF 1.7 trillion) under scenario 1 and 32.6% (RWF 2.2 trillion) under scenario 2. Human resources is the third priority, with a 21.8% share (RWF 1.3 trillion) under scenario 1 and a 23.5% (RWF 1.6 trillion) share under scenario 2. The average estimated per capita, per year cost for HSSP V is RWF 80,486 ($58) under scenario 1 and RWF 94,363 ($68) under scenario 2.

Table 3: Estimated HSSP V Costing by Main Pillars, 2024/25–2028/29 (in million RWF)

Scenario 1: Achieving SDG goal through focus on priority high impact case								
		2025	2026	2027	2028	2029	Total	Share
Pillar 1	Health Workforce	211,806	221,484	271,491	286,334	296,368	1,287,483	21.8%
Pillar 2	Health Infrastructure Modernization	537,986	550,360	478,644	481,992	476,262	2,525,244	42.8%
Pillar 3	Quality of Care Through Primary Health Care	284,131	335,527	347,464	373,588	400,461	1,741,171	29.5%
Pillar 4	Health Security and Public Health Emergency Management	989	251	193	159	126	1,718	0.03%
Pillar 5	Research, Innovation, Biomanufacturing, Regulation, and Digitalization	29,360	49,462	66,252	84,439	103,704	333,217	5.6%

Enabler 1	Health Financing	1,138	1,442	1,516	1,365	909	6,370	0.1%
Enabler 2	Leadership and Governance	923	847	977	847	901	4,496	0.1%
Total	**Total in million RWF**	**1,066,333**	**1,159,374**	**1,166,537**	**1,228,724**	**1,278,731**	**5,899,699**	
	Total in million USD	**204**	**241**	**249**	**268**	**287**	**1,249**	

Scenario 2: Achieving SDG goal and including all priorities and interventions								
Pillar 1	Health Workforce	261,951	283,813	341,263	355,953	365,435	1,608,415	23.5%
Pillar 2	Health Infrastructure Modernization	537,986	550,360	478,644	481,992	476,262	2,525,244	36.8%
Pillar 3	Quality of Care Through Primary Health Care	333,412	413,479	445,130	496,297	546,896	2,235,214	32.59%
Pillar 4	Health Security and Public Health Emergency Management	989	251	193	159	126	1,718	0.03%
Pillar 5	Research, Innovation, Biomanufacturing, Regulation, and Digitalization	47,512	73,645	93,758	112,746	138,777	466,438	6.8%
Enabler 1	Health Financing	2,671	3,321	3,677	3,114	1,917	14,699	0.2%
Enabler 2	Leadership and Governance	1,342	1,062	1,282	1,267	1,327	6,280	0.1%
Total	**Total in million RWF**	**1,185,864**	**1,325,932**	**1,363,947**	**1,451,527**	**1,530,740**	**6,858,009**	**100.0%**
	Total in million USD	**851**	**951**	**979**	**1,042**	**1,098**	**4,921**	

The estimated cost per program varies by both program and costing scenario (table 4). In Scenario 1, NCDs incur the highest cost, accounting for 15.3% of total program expenses. This is followed by malaria control, maternal and child health, and WASH and environmental health, which account for 14.9%, 10.4%, and 10.3% of the total costs, respectively. In Scenario 2, WASH and environmental health occupy the largest share at 22.6% of the total costs, followed by NCDs, malaria control, and maternal and child health, accounting for 13.8%, 11.8%, and 8.2% of the overall program cost, respectively.

Table 4: HSSP V Major Service Delivery Programs' Cost Estimates (in million RWF)

	Type of program	Scenario 1		Scenario 2	
		Total Cost	Share in %	Total Cost	Share in %
1	Maternal and Newborn Health	128,637	10.4%	128,820	8.2%
2	Child Health	88,420	7.1%	108,329	6.9%
3	Immunization	89,131	7.2%	89,074	5.7%
4	Family Planning and RH	20,898	1.7%	20,898	1.3%
5	Adolescent and Youth Health	5,767	0.5%	5,767	0.4%
6	Nutrition and Food Safety	43,873	3.5%	43,873	2.8%
7	GBV	3,301	0.3%	3,301	0.2%
8	HIV Prevention and Control	41,221	3.3%	41,221	2.6%
9	Sexual Transmitted Infections	41,221	3.3%	41,221	2.6%
10	Malaria Prevention and Control	185,142	14.9%	185,142	11.8%
11	Neglected Tropical Diseases	11,353	0.9%	11,353	0.7%
12	TB Prevention and Control	65,603	5.3%	65,603	4.2%
13	Leprosy Prevention and Control	471	0.0%	471	0.0%
14	Non-Communicable Diseases	190,191	15.3%	217,633	13.8%
15	Mental Health	53,692	4.3%	53,692	3.4%
16	Eye Care	3,770	0.3%	5,945	0.4%
17	Oral Health	56,424	4.5%	81,459	5.2%
18	Clinical Services (IPD, OPD, Quality and Equity)	56,424	4.5%	81,459	5.2%
19	Medical Emergency & Trauma	12,980	1.0%	12,980	0.8%
20	Blood Transfusion	10,836	0.9%	14,236	0.9%
21	WASH and Environmental Health	127,265	10.3%	356,350	22.6%
22	Surveillance and Emergency Preparedness	1,718	0.1%	1,718	0.1%
23	Health Promotion/Communication	3,160	0.3%	3,160	0.2%
	Total million RWF	**1,241,498**		**1,573,704**	

8.2. Fiscal Space and Resource Availability Projections

The assumptions used in projecting the available financing for the next five years are as follows: The Medium-Term Expenditure Framework projections provided by MINECOFIN to be allocated for health from 2024/25 to 2026/27 is used as projected, without adjustment, and the average growth rate of these three years are used to project available resources from domestic and on-budget support for the remaining two years (2027/28 and 2028/29). Given the decline in off-budget support and the current global environment, the assumption used to estimate off-budget support is that the aid will remain the same over the next five years and the amount used is the one estimated by the HRTT in 2021. The Rwanda Social Security Board projections of an annual increase of revenue from CBHI and Social Health Insurance of 5% and 15%, respectively, based on the 2024/25 estimated budget, is used. The expected RWF 21 billion increased funding from the government to the CBHI scheme, starting in 2024/25, is also included as part of these projections. The OOP paid as part of the facility internally generated revenue is estimated based on the recent HRTT report with a 6% annual growth rate.

With these assumptions, the total resource estimated to be mobilized will be RWF 4,675,580,689,289 ($3,355,037,808), with 47% expected to be generated from domestic and on-budget support, followed by health insurance with a 38% share and off-budget support, which will contribute about 14% of the projected resources. The contribution of OOP outside insurance is only 1%. The detailed projected resources and their share by source are shown in table 5.

Table 5: HSSP V Resource Projection by Sources of Funding, 2024/25–2028/29 (in RWF)

Year	Insurance	Income-Generating Activities	Government	Aid	Total
2024/2025	345,400,000,000	11,391,737,968	374,318,368,726	129,550,000,000	860,660,106,694
2025/2026	372,390,000,000	12,037,457,406	415,087,067,783	129,550,000,000	929,064,525,189
2026/2027	402,502,500,000	12,719,778,248	438,262,725,216	129,550,000,000	983,035,003,464
2027/2028	305,212,833,925	13,440,775,174	469,828,934,743	129,550,000,000	918,032,543,843
2026/2029	337,367,144,864	14,202,640,468	503,668,724,766	129,550,000,000	984,788,510,098
	1,762,872,478,789	**63,792,389,265**	**2,201,165,821,234**	**647,750,000,000**	**4,675,580,689,289**
	38%	**1%**	**47%**	**14%**	**100%**

8.3. Resource gap

With the two projected cost scenarios and fiscal space projections, HSSP V has a financing gap of RWF 1,224,118,753,280 ($878,386,017) and RWF 2,182,428,764,984 ($1,566,036,714) in scenarios 1 and 2, respectively, in the next five years (table 6). The estimated overall financing gap is 21% and 32%, respectively, under these scenarios. The average gap per year is RWF 244,823,750,656 ($175,677,203) under scenario 1 and RWF 436,485,752,997 ($313,207,343) under scenario 2. If private sector engagement and innovative financing mechanisms proposed in HSSP V are designed and implemented, these financing gaps are expected to be reduced.

Table 6: Estimated Financing Gap of HSSP V (in million RWF)

	2024/2025	2025/2026	2026/2027	2027/2028	2026/2029	TOTAL
Cost estimation						
Scenario 1 Cost estimation	1,066,333	1,159,374	1,166,537	1,228,724	1,278,731	5,899,699
Scenario 2 Cost estimation	1,185,864	1,325,932	1,363,947	1,451,527	1,530,740	6,858,009
Financial Projection						
Envelop All sources	860,660	929,065	983,035	918,033	984,789	4,675,581
Resource Gap						
GAP Scenario 1	205,673	230,310	183,502	310,692	293,942	1,224,119
	19%	20%	16%	25%	23%	21%
GAP Scenario 2	325,204	396,867	380,912	533,495	545,951	2,182,429
	27%	30%	28%	37%	36%	32%

Given their higher share of the total projected cost, the major areas that are going to be affected by the resource gaps are likely to be the health infrastructure, human resources, and quality of care pillars, which are the priorities of HSSP V. Since WASH and environmental health is one of the major cost drivers of programs, a multi-sectoral approach needs to be established to engage other sectors and partners to mobilize additional funding from both domestic and external resources through co-financing. At least 50% of the estimated cost needs to be mobilized from other sectors and partners. According to the latest HRTT report, infrastructure got only 2% of available funding in 2021/22 but its share of the total HSSP V cost is 42% and 38% under the two scenarios. The major driver of the above funding gap is likely to be infrastructure; hence, government and stakeholders should work together to mobilize the required funding from government, private sector, and external resources.

Annexes

Supplementary information pertaining to this document is included in separate annexes—annex 1: Impact analysis and the M&E framework; and annex 2: Priority interventions and costing.

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