

ANNEX A. Development Challenge

Reproductive Health and Family Planning

The bulk of reproductive health and family planning services (RH/FP) are provided by the public sector. Between 2005 and 2014, there was a significant increase in the uptake of modern methods of family planning among married women, from 10% to 48%. However, the rate of increase dramatically slowed over the last five years, increasing from 45% in 2010 to 48% in 2014-15. While progress has been made in uptake of family planning methods and reduction in the unmet need for family planning, 19% of married women continue to have an unmet need for FP. Additionally, by age nineteen, 21% of young women have already begun childbearing while 15-19 year olds are amongst the most underserved age group for RH/FP health services. Provider attitudes and lack of space for adequate privacy negatively impact access to reproductive health services for the youth at facility level.

The modern contraceptive prevalence rate (mCPR) among all women of reproductive age in Rwanda remains low, standing at 26%, which when factoring in the plateauing of modern FP methods, is a cause for concern, including to the GOR which has an mCPR target of 60% for married women by 2024. Consecutive Demographic and Health Surveys indicate that short-term contraceptive methods are more often used than long acting reversible contraceptive (LARC) methods, with permanent contraceptive methods having the lowest utilization rate. This may in part be due to client preferences, but could also be due to low provider skills in providing LARCs and administering permanent methods.

Additionally, a variety of factors may be inhibiting further progress in the uptake of family planning methods including cultural norms, religious beliefs, and misconceptions (barriers that are more pronounced among adolescents and young adults); and possibly the quality of family planning counselling and the capacity of providers to address potential side effects or problems associated with the method used.

Given that adolescents and young adults are least likely to utilize FP methods and comprise over 50% of the population, there is a clear need for innovative approaches to reach this age group. Health providers in Rwanda must be adequately prepared to address the reproductive health needs of youth to include misconceptions and rumors surrounding modern methods of family planning, side effects and problems associated with various methods.

Maternal Health

Rwanda is one of few Sub-Saharan nations to have already achieved the MDG for maternal mortality. Facility deliveries and skilled birth attendance increased between 2010 and 2015, achieving an impressive rate of 91% for both indicators. However, significant challenges remain in order to ensure safe delivery for mothers. The leading causes of maternal death in Rwanda, according to a 2015 maternal death audit review, are hemorrhage (38%), sepsis (23%) and eclampsia (11%). All of these causes are preventable, especially given the high facility delivery rate in Rwanda. Specific maternal health challenges include:

Antenatal Care (ANC): ANC provides the opportunity to screen for, and manage many health issues that impact maternal health and pregnancy outcomes like malaria, hypertension, diabetes, infections, malnutrition and anemia. Despite great improvements in the percentage of women who receive at least one ANC during pregnancy, there is limited follow up of pregnant women, and therefore, limited opportunities to identify and manage high risk pregnancies in a timely manner, possibly contributing to the high maternal and newborn mortality rates in Rwanda. Factors contributing to the low compliance with recommended ANC visits include a failure to appreciate the necessity for repeat ANC visits, long waiting hours, lack of spousal support, cultural beliefs, long distances to a health facility, and prohibitive transportation costs.

In addition to the low rate of pregnant women complying with the recommended four ANC visits, the GOR may adopt the 2016 World Health Organization (WHO) guidance recommending that expectant mothers attend 8 ANC visits during the course of one pregnancy. These new standards may need to be factored into approaches to encourage greater compliance by pregnant women to attend multiple ANC follow up visits, and to help health facilities better prepare for a higher volume of ANC visits.

Skilled Attendance at Birth: The majority of life threatening conditions for women following birth are preventable. However, many expecting mothers do not report to a health facility in time, and gaps in provider skills, emergency medicine, and essential obstetric equipment contribute to make these otherwise preventable conditions life threatening conditions.

The skill level of providers with the competency to provide quality basic emergency obstetric and newborn care (BEmONC) varies across facilities and is low at the health center level where the majority of deliveries occur. Additionally, comprehensive emergency obstetric and newborn care (CEmONC) skills also vary at district hospitals and higher levels where most complicated cases are typically referred. While USAID has supported health programs over the past decade to build these skills along with quality improvement initiatives, the high rate of attrition among healthcare providers has undermined these efforts especially in rural areas.

PNC: PNC provides an opportunity to follow up on issues identified in ANC and during labor and delivery that have the potential to impact the mother's and baby's health postpartum. According to RDHS 2014/15, only 43% of women receive a postnatal check-up in the first two days after birth, which is a significant increase from 18% in 2010. However, given that 91% of deliveries take place at a health facility, the rate of PNC could be expected to be higher. Similar social economic factors that negatively impact ANC also apply to PNC. Additionally, younger women also appear less likely to attend PNC.

PAC: Abortion in Rwanda is illegal leading to many clandestine abortions, which are typically unsafe. An estimated 40% of clandestine abortions lead to complications requiring treatment in a health facility, and rural women are more at risk due to unsafe abortions. The incidence of abortion in Rwanda is estimated at 24.4 induced abortions per 1,000 women between the ages of 15 and 44, and almost 26,000 women sought post abortion care from public facilities in 2009.

Fistula Care: The lack of experienced providers is the largest challenge facing fistula repair in Rwanda. Weak obstetric care has not only led to mortality of mothers and their babies, but has

also continued to generate an unknown number of women living with obstetric fistula, whose quality of life and family structure has been significantly affected as a result of the condition. Between 2005 and 2017, about 2,791 women with fistula were surgically repaired. Given that fistula repair is irregular and not available in all hospitals because it requires special surgical skills and equipment, many women with fistula remain unserved. The GOR has established two centers for fistula treatment located at Kibongo and Ruhengeri Hospitals.

Newborn Care

Rwanda registered impressive achievements in child survival between 2005 and 2015 including meeting the MDG 5 ahead of schedule. Despite this achievement, there is room for improvement, particularly with neonatal mortality, which contributes to 40% of all under-five deaths in Rwanda. Newborn death surveillance and audits, introduced in Rwanda in 2010 show that the major causes of newborn mortality are asphyxia, complications of prematurity in health facilities, and newborn sepsis. Hypothermia was also a major finding at admission amongst the majority of babies who were admitted, and it is a growing challenge for providers to distinguish prematurity from growth restriction in utero, a unique and under researched challenge facing Rwanda that may be related to poor maternal nutrition, malaria and other causes. These health issues underscore the importance of PNC within the first two days of life, and between the first 48 hours to seven days of life.

The overwhelming majority of newborn deaths occur in health facilities (particularly district hospitals), and during the first week of life. Key contributors to newborn mortality at the district level include poor follow up by mothers in labor and delays in seeking care; delays in decision making at the facility level; and poor capacity of health facilities to resuscitate babies. Additionally, while the MOH has greatly scaled up Kangaroo Mother Care (KMC), space constraints continue to hamper admission rates and the quality of care given, and community-based KMC is not widely practiced. Lastly, a multi-country newborn care assessment conducted by USAID in 2016 identified water, sanitation and hygiene (WASH) as an area of opportunity to further address infection control at facility level.

Infant and child Survival

Neonatal deaths contribute to 40% of deaths for under-five children, followed by pneumonia (16%) and diarrhea (10%). Childhood immunization rates are high in Rwanda, with over 95% of children age 12-23 months fully vaccinated. But challenges remain; a recent unpublished survey on Integrated Management of Childhood Illnesses (IMCI) in health facilities conducted by the MOH revealed that a large number of nurses cannot correctly diagnose, and therefore manage, under-5 illnesses in children such as dehydration from diarrhea.

Malaria

Malaria is endemic in Rwanda and transmission occurs year-round with two peaks from May to June and from November to December following Rwanda's two rainy seasons. From 2005 to 2011, Rwanda achieved significant reductions in the burden of malaria through the successful implementation and scale-up of malaria control interventions. In a survey conducted in 2005, malaria was the number one etiology for morbidity of children under age five. In 2008, malaria dropped to the number three cause of morbidity, and by 2012 dropped further to number four for children under age five. According to data provided by the Rwanda HMIS, overall malaria incidence declined 86% between 2005 and 2011; outpatient malaria cases declined 87%; inpatient malaria deaths declined 74%; and the malaria test positivity rate declined 71%.

According to the 2010 Rwanda Demographic and Health Survey (DHS), malaria prevalence decreased from 2.6% in 2008 to 1.4% in 2010 in children under-five years of age. The decrease in malaria cases was in part due to the scale up of preventive measures.

Since 2012, however, malaria incidence increased every year in Rwanda from 48 per 1,000 in 2012 to 403 per 1,000 in 2016. Rwanda has seen more than an 8-fold increase in reported malaria cases, from 567,407 in 2012 to 4,794,778 in 2016. The DHS 2014–2015 revealed an increase of malaria prevalence among children under five years of age (from 1.4% in 2010 to 2.2%) and stable prevalence among women aged 15–49 years (from 0.7 % in 2010 to 0.6%). An increase in malaria-related deaths was also reported from 419 in 2013 to 715 in 2016, but the overall case fatality rate was reported to decrease from 1.8% to 1.5% during this same period. Based on an in-depth analysis of surveillance and other data to ascertain the potential causes of the increase in cases, among the different reasons that were identified were inconsistent vector control activities such as indoor residual spraying (IRS), an increase in the total number of patients seeking health care in health facilities, increased number of health facilities reporting into the system, improved availability of rapid diagnostic tests (RDTs) and artemisinin-based combination therapy (ACT) (encouraging patients to seek care at fully stocked health facilities), low universal ITN coverage (43% coverage of one ITN for every two people), mosquito resistance to pyrethroid insecticides, increased rainfall, and agricultural environmental modification among other causes.