REPUBLIC OF RWANDA

EASTERN PROVINCE

KAYONZA DISTRICT

kayonzadistrict@kayonza.gov.rw

SECOND DISTRICT HEALTH STRATEGIC PLAN

2018/19 – 2023/24

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ACRONYMS AND ABBREVIATIONS:

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante Natal Care
ASRH&R	Adolescent Sexual and Reproductive Health and Rights
ARI	Acute Respiratory Infections
ART	Anti-Retroviral Treatment
BCC	Behavioral Communication and Change
BTC	BelgianTechnical Cooperation
CBHI	Community Based Health Insurance schemes (=Mutuelles)
CHUB	Butare University Hospital (teaching hospital)
CHUK	Kigali University Hospital (teaching hospital)
CHW	Community Health Worker
CPAF	Common Performance Assessment Framework (used for GBS and SBS donors)
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organizations
CSW	Commercial Sex Worker
CVD	Cardio Vascular Disease
DHIS	District Health Information System
DHS	Demographic and Health Survey
DHU	District Health Unit
DOTS	Directly Observed Treatment Scheme / Short Course
DPAF	Development Partner Assessment Framework
EAC	East African Community
EDPRS	Economic Development and Poverty Reduction Strategy
EMR	Electronic Medical Records
EMTCT	Elimination of Mother to Child Transmission
FBO	Faith Based Organization
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization

GBS	General Budget Support (=DBS)
GBV	Gender Based Violence
GFATM	Global Fund for AIDS, TB and Malaria (=GF)
GoR	Government of Rwanda
GP	General Practitioner
H&A	Harmonization and Alignment
HC	Health Centre
HF	Health Facilities
HF	Health Financing
HFU	Health Financing Unit
HH	Household
HIV	Human Immuno-Deficiency Virus
HMIS	Health Management Information System
HP	Health Post
HRH	Human Resources for Health
HSASB	Health Sector Annual Statistical Booklet
HSSP	Health Sector Strategic Plan
HSWG	Health Sector Working Group (new name for HSCG)
IEC	Information, Education and Communication
IMCI	Integrated Management of Child Illnesses (=PCIME)
IRS	Indoor Residual Spraying
JANS	Joint Assessment of National Strategies
KFH	King Faisal Hospital
LB	Life Births
LLIN	Long Lasting Impregnated (Bed) Nets
LMIS	Logistic Management Information System
MC	Male Circumcision
MDA	Mass Drug Administration
MDG	Millennium Development Goals
MH	Mental Health

MIGEPROF	Ministry of Gender and Family Promotion
MINALOC	Ministry of Local Administration, Community Development and Social Affairs
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education, Science, Technology and Research
MOH	Ministry of Health
MMR	Maternal Mortality Ratio (/100,000 births)
MTR	Mid Term Review
NA	Not Available
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NRH	National Reference / Referral Hospital
NTD	Neglected Tropical Diseases
UN	United Nations
NISR	National Institute of Statistics of Rwanda
OOP	Out of Pocket (expenditure)
PAC	Post Abortion Care
PBF	Performance Based Financing
PFM	Public Financial Management
PH	Provincial Hospital
PHAST	Participatory Hygiene and Sanitation Transformation
PHC	Primary Health Care
PHCS	Pre Hospital Care Services (ambulance etc) (= SAMU)
PHF	Private Health Facilities
PLWHA	People Living With HIV and AIDS (see PVVIH)
PMI	Presidential Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PNC	Post Natal Care
PPCP	Public Private Community Partnership

PPP	Public Private Partnership
PS	Private Sector
PW	Pregnant Women
PWD	People with Disabilities
QA	Quality Assurance
QC	Quality Control
RBC	Rwanda Biomedical Centre
RCHC	Rwanda Centre for Health Communication
RDHS	Rwanda Demographic and Health Survey (= DHS)
RDT	Rapid Diagnostic Tests (for Malaria)
RH	Reproductive Health
RMNCAH	Reproductive Maternal, Neonatal, Child and Adolescent Health
SSB	Rwanda Social Security Board
HRTT	Health Resource Tracking Tool
RWF	Rwanda Franc
SAMU	Service d'Aide Médicale d'Urgence / Pre-hospital care services (= PHCS)
SARA	Service Availability and Readiness Assessment
SBA	Skilled Birth Attendant
SBS	Sector Budget Support
SGBV	Sexual and Gender Based Violence
SMM	Senior Management Meeting
SOP	Standard Operating Procedures
SPIU	Single Project Implementation Unit
STH	Soil Transmitted Helminths
STI	Sexually Transmission Infections
SWAp	Sector Wide Approach
TB	Tuberculosis
TBD	To Be Decided
TCAM	Traditional, Complementary and Alternative Medicine

TWG	Technical Working Group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USD	US Dollars
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WISN	Workload Indicators for Staffing Needs

FOREWORD

The District Health Strategic Plan of Kayonza aims to improve preventive and curative management of major health problems by providing quality health care to the population served and ensuring efficient management. The existence of this strategic planning is to provide a clear picture of the District health sector from 2019 to 2024, thus making projections, taking into account the characteristics of the ecological and social environment, the economic capabilities of its inhabitants and the political reform.

Resulting from an extended consultation of all health stakeholders, this strategic plan is a tool for mobilizing funds and aligning development partners with local priorities and serving as a guide for future interventions. This strategic plan is the result of hard work done by a multidisciplinary and complementary team that includes District authorities, District Health Services (DHU, HFs) and a group of technical assistants from the Ministry of Health.

The success of implementation of this strategic plan will require the collaboration and involvement of all concerned: local leaders (from the village "umudugudu" to the District) who represent the population, authorities of cells, sectors and district, health partners, as well as the Ministry of Health. We hope that the components developed in this work in different aspects of health interventions in our District will allow national authorities and partners to have a good picture of our realities and challenges that impedes development based on the better health for all.

We highly appreciate the support to all those who have contributed much to the success of this strategic planning 2018-19 to 2024.

MURENZI Jean Claude

Mayor of Kayonza District

EXECUTIVE SUMMARY

Kayonza district health strategic plan has been inspired and guided by Vision 2020, which aim to make Rwanda a middle income county by 2020; National Strategy for Transformation (NST 2017 -2024); national publications (2010 ,2014,2015 DHS, 2013-2014 EICV, 2012 Population and Housing Census,) and Sustainable Development Goals. It is also in alignment with Health Sector Strategic Plan IV (HSSP IV) and Kayonza District Development Strategy. It will guide the district health sector and all stakeholders in this sector during the period of six years 2018-2024.

The process of developing this plan followed a broader approach of consulting all stakeholders in the health sector including: District Health Authorities, local authorities, health care providers, development partners including civil society as well as private sector. The development of this District Health Strategic Plan was based on the key identified health challenges during the implementation of the last DHSP.
This document is distributed in five main components with their sub components:

- District Health Sector Situation Analysis (Status and Achievements): Demographics, Healthcare services, Health System
- Strategic Directions: Essential Services Across the Life Course, Coverage of Essential Health Interventions
- Health Systems Strengthening: Health Workforce (HR), Service Delivery including health infrastructure, Health Products, Medicines and Commodities, Leadership & Governance; Health Information Systems (HIS) and Research; Financial risk protection, Quality of care
- Monitoring and Evaluation
- Costs and Financing

A costed plan and a monitoring and evaluation (M&E) plan have been developed and their implementations are the responsibility of all stakeholders in the health sector. Evaluation of the DHSP will be undertaken at mid-term (2021) and end-term (2024) evaluation will be conducted to assess attainment of set objectives and targets.

The achievement of targets will require resources. The budget of Kayonza district health strategic plan is estimated at **35,978,204,924Frw** for its implementation, monitoring and evaluation. The main sources of fund are government subsidiaries, donors and health facilities own revenue.

I. INTRODUCTION

1.1. Context and Background

Kayonza District is one of the seven districts constituting the Eastern Province of the Republic of Rwanda. It is located East of the Province and borders Gatsibo District in the North, Rwamagana District in the West, Ngoma District in the South-West, Kirehe District in the South-East and the Republic of Tanzania to the East. The District covers an average area of 1.954Km2. It is divided into 12 Administrative Sectors.

With regard to the health sector, KAYONZA District has two District Hospitals (Gahini and Rwinkwavu), each Sector has at least one health center , in total the District of KAYONZA has 15 Health Centers of which 12 are Public and 3 semi public , 16 public Health posts, 2 private health post , 5 Private Dispensaries, 2 private clinics and 1 District Pharmacy.

1.2. Purpose of District Health Strategic Plan (DHSP)

The District health Strategic Plan aims to provide a framework for participatory planning, centered on the population, patient and providers and directed towards strengthening the quality and performance of the District health system.

This strategic plan serves as a guiding document and decision-making tool for health. It also serves as an instrument for mobilizing funds and preparing annual operational plans, and least but not less, it guides the implementation of health sector programs and interventions while ensuring monitoring and evaluation through key performance indicators from 2018/19 to 2023/24, thus making projections, taking into account the characteristics of the ecological environment, the economic capabilities of its inhabitants and the political reform. And finally leads to improving the level of promotion, prevention, treatment, rehabilitation and control of diseases in order to ensure the good health and well-being of the population of KAYONZA District.

Therefore to achieve this goal, KAYONZA Strategic Health Plan will be implemented through the **15 Key Strategic Priorities**, namely: Maternal and Child Health, Expanded Program on Immunization, Sexual and Reproductive Health, Nutrition, Health promotion, Environment Health, family planning, gender-based violence, prevention of communicable diseases (HIV, TB, Malaria), non-communicable diseases, integrated surveillance of epidemics, surveillance of childhood diseases, mental health, neglected tropical diseases and traditional medicine.

1.3. Methodology used in developing DHSP

The elaboration of this health strategic plan required more than one methodological approach. The first approach consisted of community need assessment through representatives of community structure (public entities, private sectors, civil society, local NGOs, government authorities, religious organizations) involved in the community development and wellbeing.
Such a participatory approach facilitated the identification of priorities, objectives and implementation modalities. There was a strong consensus on significant challenges to improve health system in the District and leads the team to sent the possible interventions and activities to respond to the challenges.

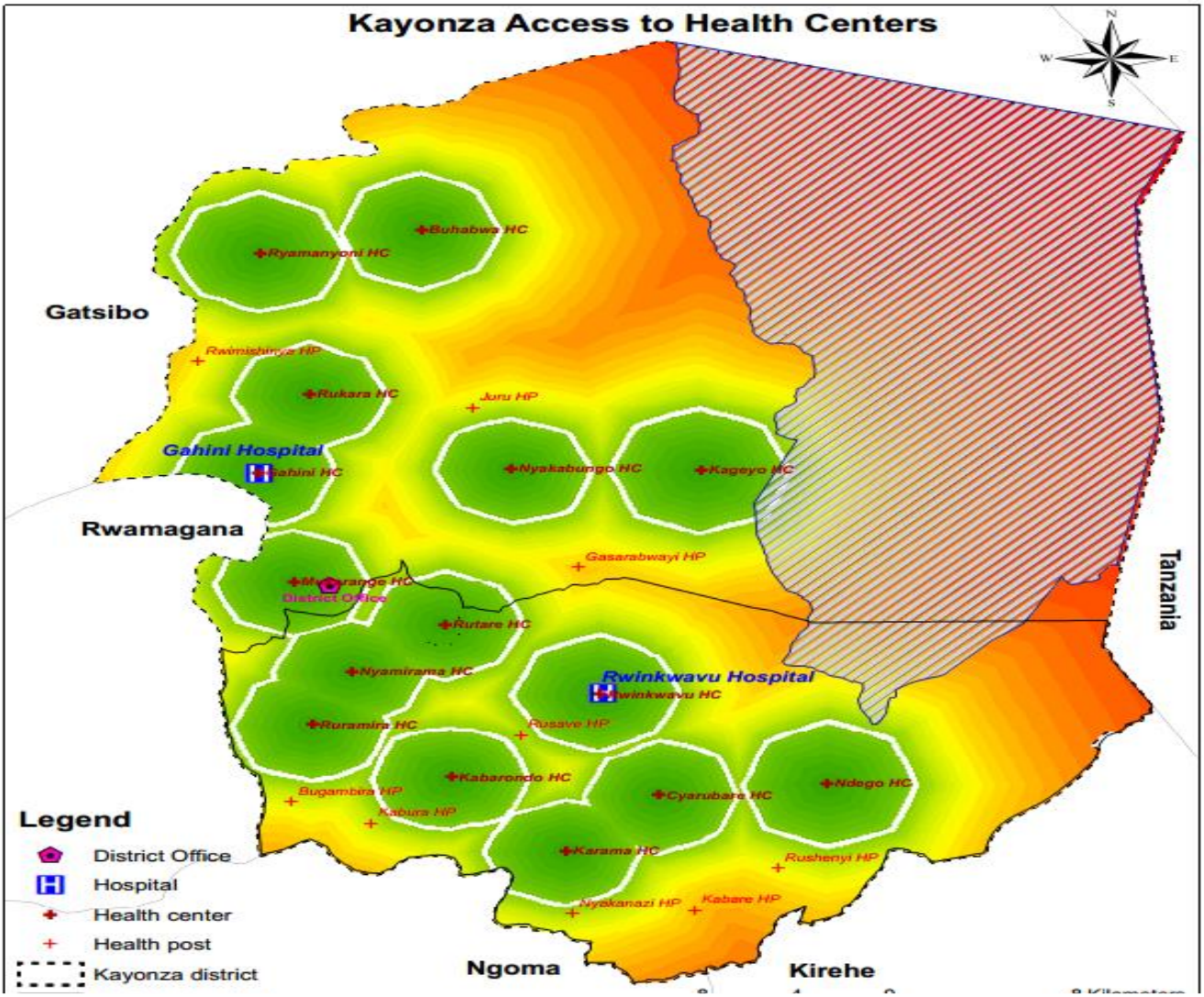
The second approach was literature review. First, material was gathered from several documents produced by institutions or facilities. That review made it possible to understand the situation today and the achievements thus far, and elucidated the necessary changes.
Lastly, data gathered from the different reports on health related issues and Rwanda Health Information System (HMIS) were analyzed and important priority programmes were identified.

All this was viewed within the context of District planning documents such as the DDS & DHSP I, which highlights health achievements, challenges and needs.
Briefly the development of DHSP II was done through three main steps:

- Consultative Meeting with District authorities and District health Partners (stakeholders in health).
- Situation Analysis with District Hospital, health Centers and Community level
- Internal Consultation with Technical Group at District Level.

II. DISTRICT HEALTH SECTOR SITUATION ANALYSIS

Figure1: Map of Health Facilities in Kayonza District



2.1. Demography status

The Kayonza District population is estimated at 427, 471 and distributed in the following demographic categories; 25,884 under 1year, 135,265 under 5year, 24,214 expected pregnancy women and 197,052 Women with reproductive Age.
Kayonza District has two District Hospitals (Rwinkwavu District Hospital and Gahini District Hospital), fifteen Health centers, sixteen health posts and four privates clinical.
Rwinkwavu District Hospital serves 220833 populations in their catchment area within eight Health centers while Gahini District Hospital serves 206,638 populations within seven health centers.

2.2. Infrastructure Needs

Kayonza District in terms of infrastructures has 25 Health facilities without running water, 15 with no grid line electricity, 22 without local area network and 8 health facilities which is in need of rehabilitation.

2. 3. Socio-economic status of Population

In terms of time series of poverty, Kayonza District has registered a positive evolution. From 2010 to 2014 poverty decreased from 42.6% to 35.6%.

The District has a good network of rural roads, connecting its sectors and cells to the close Districts of Gatsibo, Rwamagana, Ngoma and Kirehe.

Mobile phone ownership is at 49%, the use of the electricity as main light source to only 4.3% and the access to clean water source at 70.6%.

Agriculture and livestock constitute the spinal column of the economy of Kayonza District where more than 90% of the population entirely depends on Agricultural sector.

63% of all households in the District own diverse type of livestock, this shows that Kayonza District is under the national average in terms of households raising livestock.

Around 81% have medical insurance, under five-year mortality rate is at 96 per 1000 born and infant mortality rate at 66 per 1000, assisted delivery in health facilities at 91.8%.
Family planning is at 47.1%, Stunting malnutrition is at 42.4%, morbidity rate of Diarrhea is 1.8%.

2.4. Disease Profile

2.4.1. Top diseases in OPD

Top diseases more frequently meet in OPD curative consultation in Kayonza District Health facilities are as follows: Malaria, Respiratory infections, Gastritis and duodenitis constitute over 80 %, others diseases represent 20%. (See annex 5)

2.4.2. Top causes of hospitalization;

Top five diseases more frequently meet in hospitalization in Kayonza District Health facilities are as follows: Malaria, Acute Respiratory infections, Abortions, Trauma and Diarrhea. (See annex 6)

2.5. Financial resource

Financial resources consist of funds donated by the government through salaries, projects, and funds from the population (sale of medicines, consultations, hospitalization, laboratory tests, other interventions and medical acts) especially through the mutual health insurance. Part of it comes from Central Government like MINICOFIN, MOH and donors like CDC-COAG and the GF project (Global Fund).

2.6. Human Resources for Health

District Hospitals have 23 General Practitioners, 26 Midwives, 320 Nurses, 46 Lab technicians and 2 Pharmacists. However, through different partners of District, have hired medical specialist: Gahini District Hospital has medical surgeon, orthopedic surgeon and anesthetist. Rwinkwavu District Hospital has two pediatric specialists and Gynecologist.

3. Summary of Strengths, Challenges, Opportunity and Threats

3.1. Strengths

Kayonza District has a potential of having all sectors covered by one health center or more (15HC in 12 sectors) supported by 2 District hospitals (Gahini and Rwinkwavu). In addition to all these existing infranstructure, 8 ambulances are connecting HC to hosptal for any needy patient service care, community health workers offer home based care services to different category of population (Under 5 childern, pregnant women and adults for malaria cases treatment)
District leadership is willing to support hygiene and sanitation through well and organized functional DHMT.

3.2. Challenges

Most challenges are related to climate and geographic accessibility as Kayonza District is among the most drought seasons districts in the Country with prolonged dry season which bring hanger with insufficient food security and all related health inconveniences. This also impact much to population of Kayonza to left their families for looking food especially Men and this contributes high prevalence of malnutrition in our district.
Even if each sector is covered by one health center or more, we still observe inequity in geographical distribution of health facilities and inadequate infrastructure with lack of proper waste management.

Insufficient fund to support all health activities and turnover of medical staff is still a challenge resulting to poor customer care and lower quality of health care services.

3.3. Opportunities

The district benefited a lot from the Central Government and donors program targeting HIV, TB, Malaria and MNCH.

3.4. Threats

Most of threats are related to financial barriers, dependence on external financial support, high rate of malnutrition (Stunting), under five mortality rate, taboo of talking about sex and reproductive health in community, staff overtime and turnover, high rate of teenage (15-19) pregnancy, presence of traditional healers.

4. District Health priorities

Kayonza District identified key health priorities which are the reflection of the greatest needs in the District where interventions will make a larger contribution in strengthening the District health sector.

The overall district priorities are as follows:

- Reducing under five mortality rate
- Reducing all forms of malnutrition in the community
- Avail sufficient source of clean water in community and health facilities as well as connection to electricity and ICT equipment & internet connectivity
- Staff recruitment and capacity development
- Strengthen community health service
- Improve hygiene and sanitation in community
- Ensure financial accessibility and quality of service delivery.
- Ensuring Effective Governance of health Facilities (DHMT, Health facilities : BoDs, Health Committee at health center, Public finance Management, Health steering committee, Coordination of District Partners)
- Extend and Construct Health post at each Cell

5. Innovations

The District contributing attainment of a middle-class status as envisaged in Vision 2050, the likely increase in the cost of providing care as a result of the epidemiological transition and increased life expectancy, together, will impact on the financing demands of the District's health system and subsequently on attainment of the DHSPII objectives. In this regard, innovative approaches to build a sustainable, equitable and efficient health financing system reliant on resources have been identified.

For each of the Strategic Objectives, some of these innovations have been summarized below:

In MCCH, District will implement early pregnancy detection (urine analysis by CHW), post-partum FP information; expand social marketing of modern contraceptives and condom availability.

In Health Systems, the SDG indicators are now part of the overall district performance table; low-dose high-frequency training will be conducted; some CHW will be allowed to enter formal training (if eligible) and the training of health providers in district level will be conducted in collaboration with the RBC/MOH, Local and Development partners.

In Service Delivery, the number of functioning Health Posts will be increased.

All these innovations will need more detail to effective implementation in the upcoming annual plans of the District.

II. DISTRICT STRATEGIC DIRECTIONS

2.1. Essential Services across the Life Course

The Life Course approach: In accordance with the recent WHO report (June 2016) 'Multi-sectoral action for a Life Course approach in healthy ageing", the DHSPII has adopted an approach whereby all services will be implemented against the life course of an individual. This implies that both past and present experiences of the person are shaped by his/her wider socio-economic and cultural context. Scientifically, this approach studies the physical and social hazards of life during gestation, childhood, adolescence, young adulthood and midlife, as these experiences affect disease risk and health outcomes in later (adult) life. The District through DHSPII is complying to show the importance of the underlying biological, behavioral and psychosocial processes that operate across the life span of all District and in general entire population.

According to WHO, Through RMNCAH the district interventions should be based on comprehensive quality health care throughout the life course of the individual from conception onwards with essential RMNCAH health promotion, prevention and treatment interventions integrated across continuum of care; and ensuring linkages, referral and counter referral between community and health facilities.

The overall goal of the RMNCAH Program is to eliminate preventable maternal, neonatal and child deaths and promote the well-being of women, male, children and adolescents using a multi-sectoral approach and ensure healthy ageing.

For operational reasons, DHSPII has divided the RMNCAH in three life cycles, each with its specific interventions, as highlighted below:

2.1.1. Priority area 1: Pregnancy, early life and children

2.1.1.1. Maternal & Neonatal and Child Health (MNCH)

By 2024, all persons in Kayonza will equitably receive quality Maternal, Neonatal and Child Health services, aligned to the economic development standards within the District.

Table 3. Baseline and targets for RMNCAH

OUTCOME/OUTPUT INDICATORS HSSP 4	**BASELINE 2017/2018**	**TARGETS 2020**	**TARGETS 2024**
Outcome indicators			
Prevalence of Stunting	42.4	23%	18
ANC coverage (4 standards visits)	45%	52%	62%
Percentage of births attended by skilled health professionals	91.80%	>95%	>95%

Percentage of new-borns with at least one PNC visit within the first two days of birth	32.7	61%	88%
Modern contraceptive prevalence rate	47.1	66	72
Neonatal mortality rate	35	***15***	***10***
Maternal mortality rate	210	126	126
Under five mortality rate	*37*	*25*	*20*
Percentage of Children 12-23 months fully immunized	93.4	>95%	>95%
Proportion of Exclusive Breastfeeding < 6 months	87%	>90%	>90%
Teenage pregnancy and motherhood rate (15-19 years)	9.9	6	5
Proportion of hospitals providing comprehensive GBV services	100	100	100
Unmet need for Family Planning	17.9	16	15

Source: RDHS &HMIS

Challenges:

- ✓ Ignorance on importance of PNC by Health Providers and Mothers Kayonza District
- ✓ There is existence of home deliveries that limited PNC
- ✓ Low coverage of 4th PNC

Strategies:

- Improve PNC coverage rate at health facility
- Improvement of coordination of maternal, neonatal and child health.
- Implement and monitor a harmonized, integrated and sustainable package of quality client and youth-friendly essential RMNCAH interventions (promotion, prevention and treatment), ensuring commodities and innovative technologies at hospital, health centre and community levels.

- Integrate RMNCAH package in health facility services and build capacity for health care providers at different levels of the health facilities (e.g. conducting up clinical mentorship on RMNCH in health facilities, expanding use of ICATT,)
- Conducting basic health systems research towards UHC of RMNCAH services to identify major obstacles towards access to care and the most (cost)-effective interventions.
- Intensify health promotion efforts to increase community knowledge and skills on RMNCAH interventions and promote health-seeking behavior.
- Strengthen governance and accountability for the integration of RMNCAH interventions in all services in District health facilities.
- Improve capacities for Neonatal service delivery in health facilities (including increase the ratio of Midwives/Doctors/Nurses to population).
- Improve health-seeking behavior and access among communities through public-private partnership (e.g. health posts, private HFs prioritizing remote and distant areas and strengthen male engagement in RMNCAH service delivery.
- Improvement of post natal consultation (PNC) coordination in health facilities.

Innovations/Interventions:

- Follow up implementation of early detection of pregnancy in the community (urine testing of pregnant women by CHW, ultrasound check at HCs, regular assessment/recommendations to improve quality of ANC at HFs,..)
- Sensitize health care providers and community members value of PNC.
- Remind health care providers to perform PNC and recording and sensitize mothers on importance of PNC.
- Expand and monitoring of both package and coverage for ECD services at the community level.
- Conducting focused group ANC approach.

2.1.1.2. Expanded program for Immunization

By the end of 2024, all children in Kayonza will be fully immunized all vaccines above 95%.

Challenges:

- ✓ There is still some number of children doesn't completing all vaccinations.
- ✓ Existence of drop outs.

Strategies:

- Advocacy for support from district health stakeholders during immunization campaign activities.
- Maintain high and effective coverage of immunization services.
- Strengthening collaboration with community and CHWs for effective coverage of EPI.
- Strengthening Integrate the EPI program further in the IMCI interventions

Key innovations:

- Integrate the EPI program further in the IMCI interventions

2.1.1.3. Nutrition

By the end of 2024, Kayonza district will decrease stunting from 42.4% to 18% and management of all forms malnutrition.

In Kayonza District nutrition of children has been tackled through different existing stakeholders since 2011. In 2012 the District adopted the District Plan to eliminate malnutrition (DPEM) that has been implemented by different stakeholders.

Kayonza district has developed a strategy to eliminate malnutrition called District plan to eliminate malnutrition

The Department attached to the social Cluster Ministries at District level composed of District Health Unit, Natural Resources and Agriculture, Gender and family promotion, Education and Youth in collaboration with the National Food and Nutrition Coordination Secretariat (NFNCS) Implement the nutrition activities through Different stakeholders at District and National Level.

Challenges.

- ✓ There is weakness in the coordination and joint operation to fight against malnutrition.
- ✓ Existence of a big number of malnourished children
- ✓ Low Mindset of some parents care and prepare balanced diet for their children
- ✓ Some of parents miss use the nutrition support given.
- ✓ Mindset of the population, Climate change, Family Conflict, Poor Hygiene at House Hold

Strategies:

- To improve the coordination of different stakeholders in the nutrition program in the district.

- To ensure the effective coverage of nutrition interventions (supplements/ commodities) and improve one-on-one nutrition cancelling to target groups (pregnant women, adolescents and under five children).
- To increase community awareness through sensitization on good nutrition practices and intensify health promotion / nutritional counseling for prevention of nutritional related conditions.
- Ensure food security and storage for emergency periods at sector level.
- Prevention of chronic malnutrition.
- Improving food and nutrition in schools

Key innovations/Intervention:

- Leverage on ECD program at community level to increase knowledge on good nutrition practices
- Expand the regular monitoring of overweight and obesity among children and adults
- To increase the local private sector engagement in the production of nutrition and food commodities.
- To organize DPEM coordination meeting with involving of all nutrition stakeholders in the District.
- To conduct supervision, Monitoring and Evaluation nutritional interventions at community level by DPEM committees.
- To reinforce nutritional and hygiene clubs at village levels.
- To reinforce home based care; ECD (early child development center)

2.2. Community Health

Kayonza district will improve the capacity of CHWs and ensure that they are well equipped, motivated and reporting on time to perform their duties and to strengthen their cooperatives.

Goal

By the end of 2024, we will increases the number of active CHWs, reporting on timely, completeness, in all data electronic information system their use.

In our district we have 1263 Community Health Workers (CHW) play an essential role in service delivery, particularly in expanding primary health care and ensuring UHC. The *Health Sector*

Policy (2015) and the evaluation of the Community Health Program (CHP) (2016) indicated that capacity building of CHWs be strengthened to improve health care services delivery at community level. It is proposed that a capacity building and an incentivization plan for CHWs be enhanced.

Challenges.

- ✓ There is high package or workload of CHWs.
- ✓ High turnover of Community health work hence leading to delay in service delivery in community due to new CHWs.
- ✓ There is poor management of CHWs cooperative

Strategies:

- To define service package and strengthen coordination with other community volunteers, (from different fields).
- Follow up of the supply chain to ensure good quality of service delivery.
- Follow up continuous capacity enhancement of CHWs on new knowledge and technologies.
- To strengthen the management of CHW cooperatives.

Key innovations/Interventions:

- Monitoring of functionality of social cluster coordination mechanism at the village level to ensure proper implementation of communities' activities including health ones.
- To provide capacity building CHWs to manage their cooperatives and conduct regular supervision and monitoring.
- To advocacy for incentives of CHWs.

2.1.2. Priority area 2: Adolescent Sexual and Reproductive Health (ASRH).

By the end of 2024, Kayonza District will be having integrated services of Adolescent Sexual and Reproductive Health in health facilities and improved awareness of community specifically the youth ASRH.

Challenges:

- ✓ Lack Knowledge on Reproductive Health
- ✓ Limited services on ASRH in health facilities
- ✓ Existence of early pregnancies or teenagers.

Strategies:

- Increase the demand for ASRH services in Adolescent and youth
- Expand the coverage of ASRH services (e.g increasing youth friendly centers and corners in appropriate settings)

Key innovations:

- Promote the use of technology messaging to youth and adolescents.
- Strengthen partnership with other public and private partners in the delivery of ASRH services.

2.1.2.1. Sexual and Gender Based Violence (SGBV)

By the end of 2024, Sexual and Gender Based Violence cases will be managed at all health center level.

Challenges:

- ✓ Low integration of SGBV services in all health centers
- ✓ Low skills of providers on SGBV case management
- ✓ There is existence family/domestic conflicts

Strategies:

- Expand the integrated SBGV services at the health centre level.
- Establish an effective monitoring mechanism for the follow up of SGBV victims (especially in social reintegration).
- Increasing Community awareness of gender related issues.
- Training the providers specifically health field on SGBV case management.

Innovations:

- Increasing awareness by the use of technology for timely SGBV case detection and reporting.

2.1.2.2. Family Planning (FP)

By the end of 2024, to increase the percentage rate of women in reproductive age (15-49 years) using modern family planning method from 47.1% to 67.2% and decrease the rate of unmet need for family planning from 17% to 15%.

Challenges

- ✓ Low Mindset of the Population on value of Family Planning.
- ✓ Rumors on sides Effect Management.
- ✓ Lack of customer at Health Facilities to the clients

Strategies:

- To coordinate district health partners to participate in implementation of Family Planning program.
- Decentralizing of services to the community and health posts.
- Encourage male engagement in the use of FP services
- Increase the private sector engagement in the provision of FP services
- Strengthen the use of Post-Partum FP (PPFP) and effectively integrate this into ANC and maternity
- Scale up the use Medical Eligibility Criteria Wheel for contraceptive use to enhance acceptability and use of FP methods.

Key innovations:

- Establish system to document and track FP users for better adherence to the program.
- To improve service delivery/customer care to the clients seeking service regularly available/consistent.
- Campaigns, integrated health education in HFs and local outreach meetings.
- Introduce a community peer education system to promote the continuous use of long-acting and permanent methods of FP services and emergency contraceptives.

2.1.3. Priority area 3: Healthy Ageing and Palliative Care

The population of Kayonza District within coming seven years will be aware of health maintenance in good health status.

2.1.3.1. Health and ageing

The Life Course approach aims to maintain good health status and quality of life and to prevent diseases during adulthood and elderly life. All stages in the life course determine the health capital the person has acquired and thus contribute to his/her feeling of illness or well-being. As the life cycle is getting longer, people have the opportunity to be productive for a longer period of time than ever before, which will extend the period of wealth accumulation.

Strategic direction

By 2024, The District is aiming contribute in prevention, care, treatment and rehabilitation for NCDs are extended to all health facilities and the community; doctors, nurses and community health workers are equipped with capacity to provide appropriate care to the ageing population.

Challenges.

- ✓ Low knowledge of community members in prevention of NCDs risk factors
- ✓ Low integration of NCDs management and palliative care at health centers and community levels

Strategies:

- Implementation of the national NCD policy and strategy targeting the ageing group.
- Promote community education and awareness on practices to prevent NCD risk factors.
- Improve access to palliative care services to the community.

Key innovations:

- Initiate adequate access and appointment system intended to regulate patient streams.
- Ensure rigorous application of evidence-based treatment guidelines used by the health care providers
- To conduct regular check up
- Conduct campaign on positive life style on fighting against; drug abuse, sport promotion.

2.1.3.2 Palliative care

According to WHO, Palliative care aims to improve the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and treatment of pain or other physical, psychosocial and spiritual problems.

Strategic direction

By 2024, health care providers are skilled and equipped to appropriately manage terminally ill patients.

Challenges.

- ✓ Low knowledge of health care providers to deliver palliative care services
- ✓ Low integration of NCDs management and palliative care at health centers and community levels

Strategies:

- To improve capacities for health care providers to deliver palliative care services
- Establish capacity building plan on palliative care services to the targeted people (HCs and Community).

Key innovations/Intervention:

- Establish community group palliative care system for mutual psychosocial support.
- Establish home based palliative care practice program.
- To increase community awareness on how to give palliative care services.

2.2. Coverage of Essential Health Interventions

2.2.1. Priority area 1: Infectious diseases

2.2.1.1. HIV/AIDS, STIs and Viral Hepatitis

Strategic direction

By 2024, in Kayonza District the prevalence of HIV is maintained at 3.8% or lower, HIV incidence is reduced and the burden of viral hepatitis is reduced.

Table 4. Indicators HIV/AIDS & Hepatitis: Baseline and targets

OUTCOMES / OUTPUTS INDICATORS DHSP 2	BASELINE 2017/2018	TARGETS 2020	TARGETS 2024
Proportion of persons diagnosed with HIV infection receiving sustained ART	82.7	84.8%	90%
HIV prevalence among people aged 15-49	3.8	<3.8%	<3.8%

years			
HIV incidence/1000 population	3.7	3.7	3.7
Percentage of infants born to HIV + mothers free from HIV by 18 months	97%	>95%	>95%
Hepatitis B incidence per 100,000 population	TBD	TBD	TBD

Challenges.

- ✓ High Movement from neighbouring countries and other Districts,
- ✓ Delaying to start ART'
- ✓ There is existence of stigma and discrimination in HIV/AIDS patients

Strategies:

HIV/AIDS

- Strengthen the "test and treat all "strategy and expand access and promote utilization of HIV prevention and treatment services (VCT, Circumcision,..) to adolescents and population in general.
- To reduce the new HIV infections targeting key populations and hot spot areas.
- To reduce the mortality attributed to HIV/AIDS infection
- To reduce stigma and discrimination in HIV/AIDS patients
- Creation of FSW associations / corporative and initiate income generating income projects for job creation.
- Improve or reinforce OJT on use of finger prick to possible providers.

Viral Hepatitis

- Determine the burden of Viral Hepatitis (prevalence and incidence) in the Rwandan population particularly Kayonza District.
- Scale up prevention, testing and treatment of Viral Hepatitis and improve access
- Increase capacities of health facilities and care providers in testing and treatment of Viral Hepatitis
- Improve the surveillance and reporting system for Viral Hepatitis

Key innovations:

- To follow up and implement HIV self-testing and design innovative approaches to target adolescents.
- Engage local private partners for screening and vaccination against Viral Hepatitis within existing health care services.

2.2.1. 2 Tuberculosis, other respiratory communicable diseases and leprosy

Strategic direction

By 2024, The District is aiming to reduce TB Incidence per 100,000 population in Kayonza district by 40%.

Table 5. Baseline and targets for Tuberculosis

OUTCOMES/ OUTPUTS HSSP 2	BASELINE 2017/2018	TARGETS 2020	TARGETS 2024
TB incidence per 100,000 population	31.8	31.8	31.8
TB treatment coverage rate	75	86	88
Treatment success rate (TSR) for all forms of TB cases (DS & DR-TB cases)	84.9	87%	90

Source: HMIS, WHO TB Report

Challenges.

- ✓ Systematic TB Screening is not reinforced especially among contacts.
- ✓ Insufficient Follow-up of TB Patients

Strategies

- Improve the case finding and screening strategies
- Ensure universal access of drug sensitivity test for first and second line anti TB drugs
- Maintain high level of TB treatment success rate
- Ensure early detection and treatment of all identified TB+ cases.
- Strengthen TB/HIV collaboration activities at all levels

Key innovations

- Use of electronic individual recording system to report on TB and leprosy data
- Introduction of connectivity systems within the laboratory networks for the proper monitoring of laboratory result and ensure early initiation of TB treatment.

2.2.1.3 Malaria and other parasitic diseases

Strategic direction

By 2024, Malaria incidence has decreased from 215/1,000 to 122/1,000 population and the mortality due to malaria in health facilities is decreased by 56.8%.

Table 6. Baseline and Targets for Malaria

OUTCOMES/OUTPUTS INDICATORS/ HSSP 4	**BASELINE 2017/2018**	**TARGETS 2020**	**TARGETS 2024**
Proportion HH with at least one LLIN	81	84	85
Malaria incidence per 1,000 population	215	200	122
Malaria proportional mortality rate	3	3	3
Proportion of children under five years old who slept under a LLIN the previous night	81	84	85
Proportion of targeted population who received MDA	99%	99%	99%

Source: DHS, HMIS and MIS

Challenges.

- ✓ Low mindset population to sleep in LLIN and other measures to prevent malaria,
- ✓ Insufficient of LLIN In the Community,
- ✓ Miss use of LLIN
- ✓ High incidence of malaria,

Strategies

- Ensure sustained universal coverage with LLINs: UHC (1 net between 2 people)
- Improve vector control: through sensitizing community effective use of LLINs, clearing surrounding stagnant water and bushes and early treatment.

- Establish the mechanisms with the private sector and multi sectorial in malaria prevention and control interventions.
- Advocacy to central level to avail mosquito nets at local commercial agents for easy access to community.
- Mobilize the community to self purchase of mosquito nets from local private traders.

Key innovations:

- Strengthen collaboration with District stakeholders to implement existing programs of malaria interventions.
- Indoor residual spraying in framework of community works through "AMASIBO" to support logistics.

2.2.1.4 Neglected Tropical Diseases (NTD)

Strategic Direction

By 2024, NTDs are no longer a public health issue in Kayonza District.

Challenges.

- ✓ Low community awareness on NTDs
- ✓ Low reporting rate of NTDs and early detection of cases

Strategies

- Ensure community awareness, and proper diagnosis and management of NTDs in health facilities
- Strengthen NTDs case surveillance and reporting systems.
- Provisional of safe and sufficient water to community and proper waste disposal.
- Increase disease detection

Innovations

- Advocate for setting up surveillance systems for the prevalent NTDs in the District.
- Expand mass deworming

2.3. Priority area 5: Non-communicable diseases (NCDs) and injuries

2.3.1 Overall interventions for NCDs, Injuries and disabilities

Strategic direction

By 2024, In the District, the incidence of NCDs (cancer, cardio-vascular diseases, eye diseases, chronic lung diseases and diabetes) is reduced, and the mortality due to NCD and injuries is reduced.

Table 7. Baseline and targets for overall NCDs

OUTCOMES / OUTPUTS Indicators DHSP II	BASELINE 2017/2018	TARGETS 2020	TARGETS 2024
Percentage of NCD combined high risk factors in the population aged between 15-64 years	12	12	12
Percentage of premature mortality rate (under 40 years old) due to NCDs (cancer and diabetes)	TBD		
Percentage of premature mortality rate (under 40 years old) due to non-intentional injuries	TBD		
Teeth and gum diseases morbidity rate at health facility level	1.8%	1.5%	1.2%
Eye diseases problem morbidity rate at health facility level	<2	<2	<2

Source: DHS, HMIS & Step study

Challenges.

- ✓ Low knowledge of health care providers to deliver palliative care services
- ✓ Low integration of NCDs management and palliative care at health centers and community levels
- ✓ Low integration or engagement of district stakeholders in prevention mechanisms of NCDs.

Strategies

- Strengthen the NCD and injuries prevention, diagnostics and management
- Improve the stakeholders collaboration in NCD prevention and control
- Increase the awareness about NCDs risk factors and early detection in the community.
- Strengthen private and public sector partnerships in NCDs prevention and control
- Scale up of the Home Based Care Program through district.
- Scale up NCDs surveillance and reporting system for better monitoring and evaluation

Key innovations/Interventions:

- Initiate and conduct NCDs screening at the workplace
- Implement program NCDs self-screening test (Diabetes, High blood pressure…)
- Conduct massive diagnostics outreach for community NCDs screening
- Improve or reinforce private sector in local production of orthopedic materials and prostheses.
- To sensitize private and public sectors on NCDs prevention and control.
- To organize monthly massive sports for NCDs prevention and nutritional education.
- To provide knowledge to the CHWs and Community members.
- To provide capacity building of private sector on NCDs prevention and control.

2.3.2. Mental Health

Strategic direction

By 2024, mental health services are available at all health facilities level as per the defined service package at each level but no qualified mental health care providers.

Table 8. Baseline and targets for Mental Health

OUTCOME/OUTPUTS DHSP II	**BASELINE 2017/2018**	**TARGETS 2020**	**TARGETS 2024**
Proportion of new cases treated in health facilities (HC+DH) for mental disorders”	0.1	0.2	0.6

Challenges.

- ✓ Lack of mental Health Services at Health Center Level, unrecorded Data in Health Information Data base.
- ✓ Insufficient mental health qualified providers in health centers to cases.
- ✓ Community members are not aware with mental health patients and how to handle them.

Strategies:

- Set up mental health services interventions in all health centers and community units in line with expected service standards
- Implement mental health package in each health facility levels of service delivery
- Strengthen quality of mental health services at all district facility levels
- Scale up mental health case surveillance and reporting system for better patient's follow-up and management
- Expand services for prevention and management for drug addiction and harmful use of alcohol.

Key innovations:

- Establish community mental health services
- Establishment of standardized mental health units in DH, with mental health nurses and psychologists.
- Recruitment of qualified mental health care providers
- To organize campaigns of substances abuse.
- To provide knowledge to CHWs, traditional healers and entire community members.

2.4. Priority area 6: Health promotion, prevention and environmental health

2.4.1 Health Promotion and Prevention

By 2024, District communities are empowered with strategic information on healthy lifestyles and adopt evidence based public health measures to improve their lives.

Table 9. Baseline and targets for Health Promotion and Prevention

OUTPUTS / OUTCOMES HSSP 4	BASELINE 2017/2018	TARGETS 2020	TARGETS 2024
Percentage of Health centres without	12%	6%	0%

water			
Proportion of public Health Facilities (DH and HC) with effective waste management systems according to standards	1	1	2

Challenges.

- ✓ Lack of sufficient Budget for water Installation.
- ✓ Insufficient waste management system with health facilities

Strategies:

- Strengthen Community Action Cycle system/Community participation in Communicable and Non –communicable diseases, environmental health prevention programs and services
- Improve the coordination of health promotion stakeholder sat all levels to increase ownership and active participation
- Strengthen the M&E framework and reporting of health promotion and prevention programs at all levels;
- Advocate for health promotion budget through joint planning at district level.

Key innovations:

- Put in place a Community Action Cycle system from district to village level
- Introduce health promotion in pre-service training curriculum

2.4.2 Environmental Health

Strategic directions

By 2024, the prevalence of diarrhea diseases will be reduced to 9% and the nosocomial infections reduced by half.

Challenges.

- ✓ Inactive health committees at village level in health promotion activities.
- ✓ Insufficient skills of local authorities on environmental health issues.

Strategies:

- Implement the Community-Based Environmental Health Promotion Program
- Establish geographic information platform for sharing information within District.

- Strengthen capacity of environmental health entities from the District to the village level
- Implement the policy of water quality surveillance and water safety Plan, food safety, and health care waste management and injection safety, school hygiene, indoor air pollution, disaster management and preparedness, and occupational health;
- Strengthen the surveillance and reporting system for environmental health

Key innovations:

- Strengthen stakeholders coordination on environmental health related initiatives and geographic information sharing.
- Engagement of local Private sector in Health Care Waste Management
- Develop and scale innovative behavior change and social marketing strategies to increase hand washing and safely managed sanitation services

2.4.3 ASSURING HEALTH SECURITY

Strategic direction.

Prevent and control epidemic diseases and other public health threats in Kayonza through a sustainable, effective and efficient District epidemiological surveillance, response and recovery system.

Table 10. Baseline and targets for health security.

OUTCOME /OUTPUT INDICATORS DHSP 2	BASELINE 2017/2018	TARGETS 2020	TARGETS 2024
Proportion of outbreaks with a case fatality rate below recommended thresholds	80%	100%	100%

12.1 Outbreak and disaster prevention

Challenges.

- ✓ Low awareness of the community on health threats related issues.
- ✓ Existence of neighboring country that may cause a health threat.

Strategies:

- Implementation of legal and regulatory capacity for emerging and re-emerging public health threats.

- Ensure surveillance system for public health threats (AMR, epidemic-prone diseases, zoonotic, water-borne diseases and other public health concerns)
- Implement mechanisms for detection and management of cross boarder health threats in Kayonza district neighboring region.
- Strengthen community engagement in prevention, detection and response to public health threats

2.4.4 Outbreak and disaster detection

Challenges.

- ✓ Insufficient skills of health providers at health facilities on IDSR detection and early reporting.

Strategies:

- Strengthen laboratory capacity for detection of epidemic prone-diseases and other public health threats
- Strengthen IDSR to improve timeliness, completeness and data quality
- Establish mechanisms for continuous risk mapping of public health threats

12.3. Outbreak and disaster response and recovery

Challenges.

- ✓ Insufficient skills of health providers at health facilities on IDSR detection and early reporting.

Strategies:

- Ensure adequate capacity for health emergency response through contingency plans and simulation exercises.
- Implementation of public health emergency response coordination mechanisms at different levels in District.
- Strengthen health emergency response team in the district.
- Develop sustainable plan for recovery following a public health event with in district.

Innovations:

- Introduce use of mentoring approaches and learning sessions in skills improvement.

- Encourage public and local partners to provide training on response to health threats

2.5 HEALTH SYSTEMS: OUTPUTS

The following outputs highlight the important interconnection and synergy between the traditional WHO building blocks that must be achieved to build a robust and cohesive health System Further description of each of the systems is detailed in Chapter 8. The specific achievements and challenges regarding each of these outputs are described earlier in Chapter 2 (Overview of the health sector).

2.5.1 System Resilience

It will be the combination of the various health systems together that will ensure the absorption of the shocks (caused by outbreaks, disaster or events, financial barriers that directly influence the health system ability to deliver services), whilst at the same time guaranteeing the continued provision of essential services.

2.5.1.1. Responsiveness

Responsiveness to the needs of the population will increase confidence and utilization of essential services.

2.5.1.2 Financial risk protection

The UHC target for financial risk protection is to eliminate the incidence of catastrophic health expenditure and of impoverishment due to out-of-pocket payments (OOP) for health services by having every people optimally financially protected through prepayment mechanisms such as CBHI and any other safety net mechanisms to mitigate the impact of direct and opportunity costs as financial barriers to accessing health services.

The main gap in Kayonza district is low coverage of community based health insurance below 85% which leads to delay of clients to come for health service at HFs and other side HFs fall in loss due to un paid services given to patient.

Strategies:

- Solidarity of social protection system
- Mobilize community resources to comply with medical insurances by adhere to CBHI.
- Mobilize the existing partners to intervene in support of vulnerable social group by give medical insurances

- Strengthening recovery system in health facilities.

Interventions/activities:

- To increase community awareness to give annual CBHI contribution fee.
- Advocacy to existing partners to support social vulnerable groups in the community.
- To increase capacity building of the staff (recovery team)
- T o strengthen recovery system to all services given to clients by HFs
- To introduce system of prepayment of services.

2.5.1.3. Equitable access

By the end of 2024, the population of Kayonza will have equal access to health services without any segregation.

Equitable access to essential services will reduce barriers that hinder people from accessing services, specifically for the vulnerable populations. The domains of equitable access to be addressed include: (i) improving the reach of the health system for people cut off by geographical barriers (ii) reducing financial barriers to improve financial risk protection particularly for the vulnerable populations and, (iii) reducing social and cultural barriers which particularly hinder women and children in some populations. This is critical in ensuring a better responsive health system.

Strategy:

- Ensure availability of essential medicine at HFs and community level.
- Ensure monitoring of functioning traditional healers.
- Improving collaboration and between traditional healers and modern health care.

Interventions:

- To ensure the purchase of essential medicine within HFs.
- To conduct regular supervision of traditional healers.
- To conducting regular meeting and capacity building with traditional healers.

2.5.1.4 Quality of care

Ensuring the highest possible quality during provision of essential health services and interventions will result in positive clients' experiences during the process of care, while

reducing the backload of referrals from DH to higher levels and reducing harm to the clients / patients. In general the aim is the provision of the most effective intervention that leads to the best possible health care outcome at the minimum cost.

Priority investments in this area will include the development and institutionalization of a Quality Improvement and Accreditation (Q&A) program; regular response to malpractice and a continuous accreditation process for public and private health facilities. Results from both the accreditation assessment, client satisfaction survey as well as findings from Citizen's Report card will be taken into consideration to improve quality of care.

2.5.1.6. Building community demand for health services

Building demand for essential interventions to ensure that individuals, households and communities are able to utilize available interventions will be a major focus for DHSPII. This will be through raising awareness at household, individual and community levels regarding available essential services, and ensuring that healthy behaviors and actions are practiced routinely.

Table 11. Baseline and targets for Quality of essential services

OUTPUT Indicators for DHSP 2	**BASELINE 2017/2018**	**TARGETS 2020**	**TARGETS 2024**
% Incident cases assessed and reported.	N/A	100%	100%
Number of DH that achieve level two of the national accreditation process	0	2	2
Percentage of HCs enrolled and pursuing level 1 of accreditation process	0%	23.5	82.4

2.6. HEALTH SYSTEMS: INPUTS & ACTIONS

2.6.1 Health Workforce (HR)

Strategic direction

By 2024, ensure availability of a qualified, competent and motivated workforce to deliver quality health services.

Table 12. Baseline and Targets for the Health Workforce

INPUT/PROCESS Indicators DHSP II	**BASELINE 2017/2018**	**TARGETS 2020 (mid-term)**	**TARGETS 2024**
Doctor/pop ratio (GP and Specialists as well)	1/28,380	1/20,187	1/11,993
Nurse/pop ratio	1/2,133	1/1,566	1/1,000
Midwife/pop ratio (women aged from 15-49)	1/24,597	1/20,799	1/17,000
Pharmacist /pop ratio	1/ 16,871	1/16,000	1/15,500
Lab Technicians /pop ratio	1/ 10,500	1/ 9,000	1/ 7,500

Source: IPPS & Surveys and Annual Health Statistical Booklet

Challenges:

- Insufficiency of staffs in health facilities,
- High turnover,
- Variable performance of staffs,
- Loop holes in the HR management laws

Strategies:

1. Improve the quality of the health workforce by strengthening a comprehensive, hands-on pre-service training, regulation of clinical practice and skills enhancement applying in-service mentorship.
2. Increase quantity and quality of health providers of the health workforce by recruiting qualified staff.
3. Strengthen HRH management at District health facilities for enhanced leadership skills, improve retention and reduce health workers turnover.
4. To ensure safety working in place health facilities.

Key Innovations/Intervention:

- Introduce a privileging system of GP to perform some interventions beyond the qualification based on experience.
- To establish capacity building plan of health providers.
- To providing protective equipments.
- Providing protecting measures to the staff (Vaccines.., QI, Fire extinguishers..,)

2.6.2 Service Delivery including health infrastructure

Strategic Direction

By 2024, ensure accessible, quality and efficient delivery of health services using technology, towards achieving Universal Health Coverage.

Table13. Baseline and Targets for Service Delivery including Health Infrastructure

OUTPUT Indicators DHSP II	**Baseline 2017/2018**	**Targets 2020**	**Targets 2024**
Number of sectors without a health centre	0	0	0
Number of health posts constructed/rehabilitated in a cell without any other health post or center	26	38	50
Number of super specialized health facility (to reduce the abroad referrals and promote medical tourism)	0	1	1

Surgical procedures per 100,000 population	971	1,500	3,000
Perioperative mortality rate (due to surgical procedure)	3.1	2	1.5
Ratio ground ambulance / population	1/50,505	1/50,000	<1/50,000
Average time to walk to a nearby HF (in minutes)	55	50	45
Number of hospitals with functional basic maintenance system (trained manpower, available tools and space for operations)	0	1	2
Percentage of health centers without electricity (not connected to a nearby grid)	17.2	0	0
Percentage of Health centers with functional internet and local area network connectivity.	36.5	50	60

Source: EICV, HMIS &Annual Health Statistical Booklet

Challenges:

- ✓ Insufficient and old health facilities infrastructures

14.3. Strategies

2.6.3. Service delivery:

- Review and rationalize the health service essential package by level of care (from Community to District Hospital) in view of the epidemiological transition and dual burden of communicable and non-communicable diseases.
- Strengthen the network of health providers, public as well as private, to ensure coverage of an integrated package of services for the population, explore possibilities of the capacity of the private sector to accept all public health insurance schemes, including CBHI.
- Re-enforce quality improvement (accreditation) mechanism/framework at all levels of care including mentorship programs, technical and managerial supervision
- Ensure safe surgery in health facilities.
- Regular update of clinical guidelines and building capacities of health care providers and interns through clinical practices.
- Reinforce medical research capabilities at all levels of health care provision.

2.6.4. Infrastructure: Strategy

- Construction, renovate and upgrade of HFs Infrastructures according standards (Renovation&Extension: (Buhabwa laboratory maternity VCT), (Nyakabungo laboratory maternity VCT), (Ruramira maternity, Ryamanyoni), (Gahini DH: Facing & Asbestos Archive pediatric Internal medicine,), Rutare, Rwinkwavu HC, Cyarubare maternity, (Rwinkwavu DH Fencing &Asbestos archive clients kitcken), Gahini HC Laboratory, Karama & Ndego Hc Toilets)

  (Construction:
- Improve water accessibility at health facilities.(Gahini DH & HC, Nyakabungo, Ruramira, Karama, Ndego, Kabura, Bugambira, Rushenyi, Juru, Kahi,)
- Purchase and maintain existing ambulances: (Cyarubare, Nyamirama, 2Rwinkwavu DH); (4Gahini DH:
- To purchase 4land cruisers for supervisions for both hospital (2Gahini & 2Rwinkwavu).
- To install electricity in health facilities: Kageyo, Karama, Ndego, Rushenyi,
- To purchases moto cycle of health facility: one moto cycle to each health center.
- Strengthen the maintenance of infrastructure in all public health facilities.

2.6.4. Medical Equipment

- Strengthen the maintenance of medical equipment in all public health facilities. :
  - ✓ 2Washing machine: 2 laundry machine: 2Ultrasound, 3CIPAP Machines for Gahini DH, 2Dental chairs for both hospital. 7radiate wormers for babies.

Transport

- Ensure safe transportation of patients to HPs and HC, especially on hard to reach areas
- Ensure availability and efficient use of ambulance services at health facility level
- Strengthen the maintenance and replacement of ambulances in all public health facilities

IT Hardware

- Synchronize all HIS systems together and link them with EMR to improve the patient management and data use for decision making

Key innovations

- Out sourcing the maintenance of biomedical equipment

2.6.5. Health Products, Medicines and Commodities

Strategic direction

By 2024 quality, affordable and efficacious medicines and medical products are available for all Kayonza District population.

Table 14. Baseline and Targets for Health Products

OUTPUT Indicators DHSP II	BASELINE 2017/2018	TARGETS 2020	TARGETS 2024
% of health products and health technologies readily available at the district Medical Warehouse	55	80	90
% HFs with < 5% of vital medical products stock-outs	87	>95	>95

Source: MOH Annual report and Annual Health Statistical Booklet

Challenges:

- Stock out of essential Medicine at Health Facilities

Strategies

- Ensure sustained availability of medical products and health technologies including essential medicines (vital and non-vital), blood and blood products, vaccines, laboratory commodities and medical devices.
- Strengthen capacity for medical products quality assurance,
- Build capacity, undertake/promote research on traditional, alternative/complementary medicines
- Ensure rational use of medicines and other medical products.
- Strengthen capacity in supply chain management systems (stores conditions, human resource, finance, supply systems, supply plans, supply regulations, etc.) and upgrade Information and technologies tools used.
- Strengthen diagnostics and medical technology capacities.
- Develop mechanisms to prevent and manage an antimicrobial resistance.

- Strengthen accreditation mechanisms and procedures for medical products and health technologies.

2.6.6. Leadership & Governance

Strategic direction

By 2024, effective leadership and governance (*oversight, coordination, organization, management, regulation and accountability*) of the health sector is ensured at all levels (public and private).

Table 15. Baseline and Targets for Leadership and Governance

OUTPUT/PROCESS Indicators DHSPII	BASELINE 2017/2018	TARGETS 2020	TARGETS 2024
Citizen level satisfaction rate with health services	77.4	80	>85

Source: MOH Annual Reports & RGB Governance Score Card

Challenges:

- Client complaints related to quality of service delivery
- Lack of health sector coordination at District Level

Strategies:

- Strengthen DHU capacity to ensure improved coordination and accountability, implementation and management of health activities within the catchment area.
- Improve the coordination of health sector stakeholders (public, private, NGO's, CSO, DPs and FBO's).
- Strengthen mechanisms to ensure vertical and horizontal accountability across all levels of health system.
- Strengthen Public Financial Management at health facility level.
- Implementation of legal frameworks, roles and responsibilities regarding decentralized health services and community health programs.

2.7. Health management information systems (HMIS) and research

Strategic direction

By 2024, ensure availability of interoperable, responsive and functional information systems providing high quality data in a timely manner to inform planning and decision-making;

Ensure availability of a strengthened research system providing policy relevant evidence.

Table 16 Baseline and targets for Health Information Systems (HIS)

OUTPUT/ Process Indicators DHSPII	**BASELINE 2017/2018**	**TARGETS 2020**	**TARGETS 2024**
Percentage of causes of deaths are reported according to ICD10	TBD	100%	100%
Percentage of births registered according to the CRVS	TBD	100	100
% of public health facilities (DH) using EMR full package system.	4%	43%	80%
Percentage of private facilities (dispensaries, clinics) regularly reporting through national data collection systems (DHIS-2 and e-IDSR)	33%	67%	100%

Source: District Hospital Annual report & Annual Health Statistical Booklet

2.7.1 Health Information Systems

Challenges:

- Low capacity of data users at health facilities for Decision Making
- Discrepancy in data collection, data entry and reporting system

Strategies

- Develop and enforce policies for personal data access and protection.
- Strengthen the use and scale up of different information systems including CRVS to improve data quality, timeliness and completeness.

- Strengthen and scale up of the verbal autopsies program to determine cause and report deaths (mothers, Neonatal and children) in the community.
- Synchronize all HIS systems together and link them with EMR to improve the patient management and data-use for decision making.
- Build capacity for population based surveys and health facility assessments

Innovations:

- E-IDSR with automated outbreak alerts built on the DHIS-2 platform
- Use of connected medical devices for monitoring NCDs
- Creation of interoperability profiles between resource systems

2.6.8. Research

Strategic Direction

By 2024, In Kayonza District research will guide new interventions, evidence-based policies and strategies by using existing data sources and improving the quality of research outputs.

Challenges:

- Low Capacity in Research for Health Providers

Strategies

- Strengthen health research regulations
- Build capacity for research in the health sector
- Promote the culture of research at different levels of the health system
- Strengthen collaboration with national research institutions

Innovations

- Establish a common basket fund for local operational research for health

2.6.9. Health Financing

Strategic direction

By 2024 District will ensure a sustainable, equitable and efficient health financing system through adequate resources mobilization.

Table 17. Baseline and targets of health financing

OUTCOMES /INPUT/PROCESS Indicators 4	BASELINE 2017/2018	TARGETS 2020	TARGETS 2024
Proportion of household expenditure on health as a share of total household income	TBD	<25	<10
Proportion of population covered by a health insurance	80.6%	>95%	>95%

Source: EICV, HRTT Report & Annual Statistical Booklet

The following health financing strategies and interventions will be implemented of DHSPII.

Challenges:

- ✓ There is still challenge in recovery system within the district health facilities.
- ✓ Low mindset of the population to release CBHI contributions leading to low coverage.

Strategies

- Ensure efficiency in the management of health facilities resources by improving cost recovery and cost saving plans for health products, including blood products;
- Establishment of revenue generating projects across the health system Promotion of Public Private and Community Partnerships (PPCP).
- Further consolidate the pre-payment and risk pooling arrangements
- Improve the efficiency of existing health services purchasing mechanisms

3. MONITORING AND EVALUATION DHSPII

Strategic direction

By 2024, there will be an efficient monitoring and evaluation (M&E) system that (i) provides timely and high quality evidence regarding the implementation of DHSPII and (ii) informs planning, allows continuous learning and knowledge management.

Assessing the progress and performance of the DHSPII will be undertaken through a District led Monitoring and Evaluation (M&E) platform with strengthened structures and coordination mechanisms; a selected set of key performance indicators with defined baselines and targets; strengthened information systems; strengthened capacity for data collection, management and analysis and; well-articulated mechanisms for review and action. A unified Data Observatory will guide accessibility to and compatibility with the different data sources as well as linkages with programs or systems that have different M&E systems.

The four main components of an M&E platform to be strengthened include:

4.1. The policy and institutional environment

- Overall coordination of M&E in the health sector is the responsibility of the DHU.
- All district stakeholders will be involved in M&E for the DHSPII
- An M&E plan addressing the objectives of the DHSPII will be used to monitor the implementation of DHSP2;
- The M&E logical framework and the performance table (Table 1) detail the selected key indicators to be monitored. These have been selected taking into consideration the SDG commitments, country and District priorities. Additional indicators to be monitored (at national and district levels) are shown in the log-frame. These mainly relate to input/process and outputs that can provide inferences regarding the attainment of targets at outcome and impact level. Programs will have additional indicators in their respective M&E plans to inform detailed program performance.
- Quantitative indicators will be supplemented by qualitative assessments to offer explanatory information regarding observed performance.

5. COSTS AND FINANCING

5.1. Costing methodology and assumptions

The DHSPII costs estimation was done using One Health tool, a unified costing tool that estimates the cost of health services and system inputs required to achieve desired health outcomes and impacts.

The scope of the costing exercise included:

- Estimating all costs related to delivering the package of health interventions identified in the DHSPII for the period 2018 to 2024; These included:
    - The costs of the *intervention services* prioritized in the strategic plan by each level of service delivery. This was costed using the *Delivery channel* in the health services module of the One Health tool.
    - The costs of the *health system inputs* including Human resources, infrastructure, information systems, financing systems etc. that will need to be strengthened in order to deliver the expanded range and coverage of services above. These were costed using the *health system module* of the One Health tool. The *program support* activities such as training, community mobilization etc. that are required to increase the uptake of services as well. The health programs / services costed include: Reproductive Health Maternal New-born and Child Health; Immunization; Malaria; TB; HIV/AIDS; Nutrition; Environmental Health and WASH; Non-communicable diseases; Health Promotion, Mental Health and Worker' Health. Costs related to health system investments include: Human Resource, Infrastructure, Governance, Health Information System, and Logistics.
- Estimation of the financial sustainability of the plan given the projected cost estimates and projected commitments by all sources of financing in Kayonza District.

The scope of the costing did NOT include:

- Scenario assessment in which different scale up plans can be costed to assess the most efficient option.
- Impact analysis to assess the effect of the planned interventions on the goals of UHC.

The DHSPII costing exercise is the result of a consultative and iterative process of data collection, targets setting and quality assurance to ensure alignment with Kayonza District strategy and accuracy of estimates. It was conducted in four phases:

(i) Calibration of the tool to specific needs of Rwanda: This included validating the population projections in *DemProj* and *Fam Plan* as well as entering health system baseline data specific to the District, such as the types and numbers of health workers and health infrastructure.

(ii) Meetings for data collection: Technical focal persons. They each provided the input for the activities that were costed as above;

(iii) It is also important to note that the DHSP2 cost-estimate was projected using the **2017** population of **427147** as baseline. Likewise baseline data on the Kayonza Health system was obtained from the HMIS, while coverage estimates for health service were obtained both from HMIS and opinions of District leaders.

(iv) The quantity of services required was estimated using the target populations, population in need and the coverage rate (baseline and targeted) for each intervention prioritized. They also include the input data for the costs for program support.

The products of the assessment include:

- The Projection files of the One Health Tool for the plan. These files contain the aggregate computation of the costs estimates (intervention services, health systems and program support).
- They have the input data of the interventions by service delivery level. These are defined as community level, health post level, health centre level, hospital level. In addition, a Microsoft Excel document is included. This is called "Intervention Coverage for the DHSPII. It is an extract from the One Health Tool of coverage rates and drugs and supply costs of the health interventions costed. It does not include the health system costs. It also has the program support costs that were aggregated for all the programs and units in the ministry of Health.

The policy direction informing the prioritization focussed on the need to address health system gaps such as the required investments in infrastructure and human resources identified during the development of the DHSPII as health services are scaled up. In addition, the plan focused on increasing efficiency and equity by emphasizing primary health care

Overall costs per capita for the DHSPII across the seven years

Intervention	Quantity	2016/2017	Quantity	2018/2019	Quantity	2019/2020	Quantity	2020/2021	Quantity	2021/2022	Quantity	2022/2023	Quantity	2023/2024	Total
Strategic Direction: Essential Services across the Life Course, Pregnancy, early life, children, adolescent and you programs															
Conduct mobilization meetings with community representatives (local outreach meetings)	1	4,210,000	1	4,420,500	1	4,641,525	1	4,873,601	1	5,117,281	1	5,373,145	1	5,641,803	34,277,856
Provide continuous mentorship of health facilities in MNCH	3	1,200,000	3	1,260,000	3	1,323,000	3	1,389,150	3	1,458,608	3	1,531,538	3	1,608,115	9,770,410
Organize campaigns for sensitization on PNC	2	12,000,000	2	12,600,000	2	13,230,000	2	13,891,500	2	14,586,075		15,315,379		16,081,148	97,704,101
provide health education session at health facilities of PNC	12	-	12	-	12	-	12	-	12	-	12	-	12	-	-
Organize staff in service trainings	1	11,930,200	1	12,526,710	1	13,153,046	1	13,810,698	1	14,501,233	1	15,226,294	1	15,987,609	97,135,789
Sensitization on delivery, Strengthening system of Rapid SMS	4	21,432,000	4	22,503,600	4	23,628,780	4	24,810,219	4	26,050,730	4	27,353,266	4	28,720,930	174,499,525
Organize sensitization campaigns and meetings	3	27,100,000	3	28,455,000	3	29,877,750	3	31,371,638	3	32,940,219	3	34,587,230	3	36,316,592	220,648,429
Improve service delivery at HFs		-		-		-		-		-		-		-	-
Provide staff training on FP methods including management of side effects		-		-		-		-		-		-		-	-
To decentralize services to Health posts		-		-		-		-		-		-		-	-
To strengthen collaboration with private sector for provision of family planning services in private health facilities		-		-		-		-		-		-		-	-
Organize Youth Mobilization campaigns On Reproductive Health	1	27,100,000	1	28,455,000	1	29,877,750	1	31,371,638	1	32,940,219	1	34,587,230	1	36,316,592	220,648,429
Community Sensitization on ANC, Organize outreach Strategy for ANC,involve CHWs	1	-	1	-	1	-	1	-	1	-	1	-	1	-	-
To increase the number of days of ANC at HFs		27,100,000	1	28,455,000	1	29,877,750	1	31,371,638	1	32,940,219	1	34,587,230	1	36,316,592	220,648,429

To organize ANC outreach	1	27,100,000	1	28,455,000	1	29,877,750	1	31,371,638	1	32,940,219	1	34,587,230	1	36,316,592	220,648,429
S TOTAL 1		**159,172,200**		**167,130,810**		**175,487,351**		**184,261,718**		**193,474,804**		**203,148,544**		**213,305,971**	**1,295,981,398**
															-
2.Expanded Program for Immunization (EPI)															-
To organize community mobilization	1	27,100,000	1	28,455,000	1	29,877,750	1	31,371,638	1	32,940,219	1	34,587,230	1	36,316,592	220,648,429
Conduct outreach on immunization	12	54,000,000	12	56,700,000	12	59,535,000	12	62,511,750	12	54,000,000	12	56,700,000	12	59,535,000	402,981,750
S TOTAL 2		**81,100,000**	**13**	**85,155,000**	**13**	**89,412,750**	**13**	**93,883,388**	**13**	**86,940,219**	**13**	**91,287,230**	**13**	**95,851,592**	623,630,179
3.Health Promotion, Prevention															-
To organize sensitization campaigns ,	2	27,100,000	2	28,455,000	2	29,877,750	2	31,371,638	2	32,940,219	2	34,587,230	3	36,316,592	220,648,429
health care providers training	2	11,930,200	2	12,526,710	2	13,153,046	2	13,810,698	2	14,501,233	2	15,226,294	2	15,987,609	97,135,789
mentorship and regular follow up	12	17,135,000	12	17,991,750	12	18,891,338	12	19,835,904	12	20,827,700	12	21,869,085	12	22,962,539	139,513,315
To organize mass sports on monthly basis	12	1,000,000	12	1,050,000	12	1,102,500	12	1,157,625	12	1,215,506	12	1,276,282	12	1,340,096	8,142,008
Elaborate plan of coordination and follow up of implementation, Education about risk factor reduction	4	11,000,000	4	11,550,000	4	12,127,500	4	12,733,875	4	13,370,569	4	14,039,097	4	14,741,052	89,562,093
Set up a system of reporting on health promotion	1	1,500,000	1	1,575,000	1	1,653,750	1	1,736,438	1	1,823,259	1	1,914,422	1	2,010,143	12,213,013
S TOTAL 2		**69,665,200**	**33**	**73,148,460**	**33**	**76,805,883**	**33**	**80,646,177**	**33**	**84,678,486**	**33**	**88,912,410**	**34**	**93,358,031**	**567,214,647**
4.Environmental Health															-
To conduct community meetings	1	1,500,000	1	1,575,000	1	1,653,750	1	1,736,438	1	1,823,259	1	1,914,422	1	2,010,143	12,213,013
To strengthen village based health clubs	1	1,500,000	1	1,575,000	1	1,653,750	1	1,736,438	1	1,823,259	1	1,914,422	1	2,010,143	12,213,013
To conduct regular community environmental inspections	1	1,500,000	1	1,575,000	1	1,653,750	1	1,736,438	1	1,823,259	1	1,914,422	1	2,010,143	12,213,013
To expand coverage of safe water pipelines	1	120,000,000	1	126,000,000	1	132,300,000	1	138,915,000	1	145,860,750	1	153,153,788	1	160,811,477	977,041,014

To collaborate with private sector to supply water treatment chemicals to the community	1	35,000,000	1	36,750,000	1	38,587,500	1	40,516,875	1	42,542,719	1	44,669,855	1	46,903,347	284,970,296
To provide treatment plant for used water in the hospitals	1	64,000,000	1	64,000,000	1	67,200,000	1	70,560,000	1	74,088,000	1	77,792,400	1	81,682,020	499,322,420
S TOTAL 2		**223,500,000**		**231,475,000**		**243,048,750**		**255,201,188**		**267,961,247**		**281,359,309**		**295,427,275**	**1,797,972,768**
5. SGBV															-
Increase YFC, establish youth corner at HCs	1	10,000,000	1	10,500,000	1	11,025,000	1	11,576,250	1	12,155,063	1	12,762,816	1	13,400,956	81,420,085
Reinforce school based reproductive health clubs,	1	500,000	1	525,000	1	551,250	1	578,813	1	607,753	1	638,141	1	670,048	4,071,004
To organize regular meetings with churches and other faith based organizations for mobilizing youth for safe sexual behavior	4	500,000	4	525,000	4	551,250	4	578,813	4	607,753	4	638,141	4	670,048	4,071,004
To sensitize youth on reproductive health through various channels : radio, competitions, campaigns	1	27,100,000	1	28,455,000	1	29,877,750	1	31,371,638	1	32,940,219	1	34,587,230	1	36,316,592	220,648,429
Establish counseling services within the PPP model and organizing study tour to model sites	1	23,000,000	1	24,150,000	1	25,357,500	1	26,625,375	1	27,956,644	1	29,354,476	1	30,822,200	187,266,194
Discourage substance abuse	4	500,000	4	525,000	4	551,250	4	578,813	4	607,753	4	638,141	4	670,048	4,071,004
S TOTAL 2		**61,600,000**	**12**	**64,680,000**	**12**	**67,914,000**	**12**	**71,309,700**	**12**	**74,875,185**	**12**	**78,618,944**	**12**	**82,549,891**	501,547,721
6. FAMILY PLANNING															-
Avail FP medicines to those in need & training to the CHWs on FP, To provide FP during community outreach meetings	1	5,000,000	1	5,250,000	1	5,512,500	1	5,788,125	1	6,077,531	1	6,381,408	1	6,700,478	40,710,042
Campaigns, integrated health education in HFs in all services including ANC and community outreach meetings	1	27,100,000	1	28,455,000	1	29,877,750	1	31,371,638	1	32,940,219	1	34,587,230	1	36,316,592	220,648,429
Involving churches in FP	1	1,000,000	1	1,050,000	1	1,102,500	1	1,157,625	1	1,215,506	1	1,276,282	1	1,340,096	8,142,008
Identity peers for community education	1	1,000,000	1	1,050,000	1	1,102,500	1	1,157,625	1	1,215,506	1	1,276,282	1	1,340,096	8,142,008

Strengthen provision of FP services in post partum, Improve service delivery in health facilities	12	12,000,000	12	12,600,000	12	13,230,000	12	13,891,500	12	14,586,075	12	15,315,379	12	16,081,148	97,704,101
S TOTAL 2		**46,100,000**	**16**	**48,405,000**	**16**	**50,825,250**	**16**	**53,366,513**	**16**	**56,034,838**	**16**	**58,836,580**	**16**	**61,778,409**	375,346,590
7. HIV/AIDS,STI & viral Hepatitis															-
To provide community education at health facilities on danger of stigma to PLHIV, and the benefits of HIV, TB and hepatitis testing	1	27,100,000	1	28,455,000	1	29,877,750	1	31,371,638	1	32,940,219	1	34,587,230	1	36,316,592	220,648,429
To provide counseling for self disclosure of HIV status	1	1,000,000	1	1,050,000	1	1,102,500	1	1,157,625	1	1,215,506	1	1,276,282	1	1,340,096	8,142,008
To avail adequate building fulfilling privacy norms for HIV /ART departments at hospitals	1	90,000,000	1	94,500,000	1	99,225,000	1	104,186,250	1	109,395,563	1	114,865,341	1	120,608,608	732,780,761
Identify high risk groups eg: sex workers , testing campaigns, truck drivers and provide education and condom distribution campaigns	1	27,100,000	1	28,455,000	1	29,877,750	1	31,371,638	1	32,940,219	1	34,587,230	1	36,316,592	220,648,429
To conduct male circumcision campaigns	4	11,000,000	4	11,550,000	4	12,127,500	4	12,733,875	4	13,370,569	4	14,039,097	4	14,741,052	89,562,093
To increase staff numbers according to the package of services required and national HRH staffing norms	1	1,000,000	1	1,050,000	1	1,102,500	1	1,157,625	1	1,215,506	1	1,276,282	1	1,340,096	8,142,008
Improve HRH motivation	12	1,080,000,000	12	1,134,000,000	12	1,190,700,000	12	1,250,235,000	12	1,312,746,750	12	1,378,384,088	12	1,447,303,292	8,793,369,129
To provide staff training for detection and management of HIV, TB and hepatitis cases	1	169,620,000	1	178,101,000	1	187,006,050	1	196,356,353	1	206,174,170	1	216,482,879	1	227,307,023	1,381,047,474
S TOTAL 2		**1,406,820,000**	**22**	**1,477,161,000**	**22**	**1,551,019,050**	**22**	**1,628,570,003**	**22**	**1,709,998,503**	**22**	**1,795,498,428**	**22**	**1,885,273,349**	11,454,340,332
8. TB AND OTHER RESPIRATORY INFECTIONS															-
To conduct screening campaigns in high risk populations such as transit centers and schools	4	11,000,000	4	11,550,000	4	12,127,500	4	12,733,875	4	13,370,569	4	14,039,097	4	14,741,052	89,562,093
Reset patients flow, triage of patients with cough , isolation precautions in health facilities	1	8,000,000	1	8,400,000	1	8,820,000	1	9,261,000	1	9,724,050	1	10,210,253	1	10,720,765	65,136,068

To provide staff training for detection and management of TB cases	1	169,620,000	1	178,101,000	1	187,006,050	1	196,356,353	1	206,174,170	1	216,482,879	1	227,307,023	1,381,047,474
S TOTAL 2		**188,620,000**	**6**	**198,051,000**	**6**	**207,953,550**	**6**	**218,351,228**	**6**	**229,268,789**	**6**	**240,732,228**	**6**	**252,768,840**	1,535,745,634
9. MALARIA AND OTHER PARASITIC DISEASES															-
Indoor residual spraying	-	-													-
Collaborate with the agriculture sector and mining companies, involve private sector for availing mosquito nets sold to the community	4	450,000	4	472,500	4	496,125	4	520,931	4	546,978	4	574,327	4	603,043	3,663,904
Community mobilization for the use of LLIN and home hygiene	4	11,000,000	4	11,550,000	4	12,127,500	4	12,733,875	4	13,370,569	4	14,039,097	4	14,741,052	89,562,093
Early identification of the high risk population and provision of mosquito nets	-	-													-
S TOTAL 2		**11,450,000**	**8**	**12,022,500**	**8**	**12,623,625**	**8**	**13,254,806**	**8**	**13,917,547**	**8**	**14,613,424**	**8**	**15,344,095**	93,225,997
10. NEGLECTED TROPICAL DISEASES															-
Provide antihelminthics to the adult population as well Promotion water treatment plants, provision of water treatment chemicals, disease screening	1	2,000,000	1	2,100,000	1	2,205,000	1	2,315,250	1	2,431,013	1	2,552,563	1	2,680,191	16,284,017
To encourage Disease screening at health posts	1	2,300,000	1	2,415,000	1	2,535,750	1	2,662,538	1	2,795,664	1	2,935,448	1	3,082,220	18,726,619
Sensitise the community for construction of sufficient proper latrines,	4	11,000,000	4	11,550,000	4	12,127,500	4	12,733,875	4	13,370,569	4	14,039,097	4	14,741,052	89,562,093
S TOTAL 2		**15,300,000**	**6**	**16,065,000**	**6**	**16,868,250**	**6**	**17,711,663**	**6**	**18,597,246**	**6**	**19,527,108**	**6**	**20,503,463**	124,572,729
11. NUTRITION															-
To organize regular meetings of stakeholders	4	2,400,000	4	2,520,000	4	2,646,000	4	2,778,300	4	2,917,215	4	3,063,076	4	3,216,230	19,540,820
Conduct recruitments	1			-	-	-	-	-	-	-	-	-	-	-	-

To advocate for provision of FBF to under five years children, pregnancy and lactating women of vulnerable families of ubudehe 2 (receiving food support)	-	-		-	-	-	-	-	-	-	-	-	-	-	-
Provide food to vulnerable people or families through public works	12	25,000,000	12	26,250,000	12	27,562,500	12	28,940,625	12	30,387,656	12	31,907,039	12	33,502,391	203,550,211
To provide tools to CHWs for growth monitoring	1	1,500,000	1	1,575,000	1	1,653,750	1	1,736,438	1	1,823,259	1	1,914,422	1	2,010,143	12,213,013
To reinforce nutrition screening in IMCI and routine immunization at health facilities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
To provide training to the DPEM committees members	1	15,400,000	4	16,170,000	4	16,978,500	4	17,827,425	4	18,718,796	4	19,654,736	4	20,637,473	125,386,930
To provide mission and transport allowances to the committees members attending meetings	1	15,400,000	4	16,170,000	4	16,978,500	4	17,827,425	4	18,718,796	4	19,654,736	4	20,637,473	125,386,930
To provide health education on nutrition during community outreach meetings and at the HFs	4	4,100,000	4	4,305,000	4	4,520,250	4	4,746,263	4	4,983,576	4	5,232,754	4	5,494,392	33,382,235
To organize high coverage nutrition education through media	1	7,280,000	1	7,644,000	1	8,026,200	1	8,427,510	1	8,848,886	1	9,291,330	1	9,755,896	59,273,822
To provide training to the nutrition and hygiene clubs members	1	1,500,000	1	1,575,000	1	1,653,750	1	1,736,438	1	1,823,259	1	1,914,422	1	2,010,143	12,213,013
To set up a monthly reporting system for village based nutrition and hygiene clubs	1	1,500,000	1	1,575,000	1	1,653,750	1	1,736,438	1	1,823,259	1	1,914,422	1	2,010,143	12,213,013
S TOTAL 2		**74,080,000**		**77,784,000**		**81,673,200**		**85,756,860**		**90,044,703**		**94,546,938**		**99,274,285**	**603,159,986**
12. COMMUNITY HEALTH (COORDINATION OF CHWs)															-
To provide training to the new community	1	1,269,000	1	1,332,450	1	1,399,073	1	1,469,026	1	1,542,477	1	1,619,601	1	1,700,581	10,332,209
To provide refresher training to the existing CHWs	1	3,795,000	1	3,984,750	1	4,183,988	1	4,393,187	1	4,612,846	1	4,843,489	1	5,085,663	30,898,922
To provide necessary equipment to carry out their responsibilities	-	-		-	-	-	-	-	-	-	-	-	-	-	-

To facilitate them to get drugs at the nearest site for easy collection	-	-		-	-	-	-	-	-	-	-	-	-	-	-
To organize quarterly assessment for replacement as needed	4	1,020,000	4	1,071,000	4	1,124,550	4	1,180,778	4	1,239,816	4	1,301,807	4	1,366,898	8,304,849
To provide financial management training to the cooperatives' leaders	1	375,000	1	393,750	1	413,438	1	434,109	1	455,815	1	478,606	1	502,536	3,053,253
To provide project management training to the cooperatives' leaders	2	375,000	1	393,750	1	413,438	1	434,109	1	455,815	1	478,606	1	502,536	3,053,253
To advice and supervise for better management	4	1,020,000	4	1,071,000	4	1,124,550	4	1,180,778	4	1,239,816	4	1,301,807	4	1,366,898	8,304,849
S TOTAL 2		**7,854,000**		**8,246,700**		**8,659,035**		**9,091,987**		**9,546,586**		**10,023,915**		**10,525,111**	**63,947,334**
13. OVERALL INTERVENTIONS FOR NCDs , INJURIES AND DISABILITIES															**-**
To collaborate with Police for organizing campaigns on prevention of road traffic accidents	4	450,000	4	472,500	4	496,125	4	520,931	4	546,978	4	574,327	4	603,043	3,663,904
To provide health education on healthy nutrition and NCDs prevention through social media approach and at the HFs	1	7,280,000	1	7,644,000	1	8,026,200	1	8,427,510	1	8,848,886	1	9,291,330	1	9,755,896	59,273,822
To organize mass sport activities on monhly basis	12	200,000	12	210,000	12	220,500	12	231,525	12	243,101	12	255,256	12	268,019	1,628,402
To provide first aid training to villaage based red cross members and school teachers	1	3,600,000	1	3,780,000	1	3,969,000	1	4,167,450	1	4,375,823	1	4,594,614	1	4,824,344	29,311,230
To conduct research of rik factors to NCDs	12	1,020,000	12	1,071,000	13	1,124,550	13	1,180,778	14	1,239,816	15	1,301,807	15	1,366,898	8,304,849
To organise screening campaigns in the community	2	2,400,000	2	2,520,000	2	2,646,000	2	2,778,300	2	2,917,215	2	3,063,076	3	3,216,230	19,540,820
To organize training on clinical management of cardiovascular diseases	1	5,000,000	1	5,250,000	1	5,512,500	1	5,788,125	1	6,077,531	1	6,381,408	1	6,700,478	40,710,042
To invite private sector representatives in meetings and trainings for prevention , control and treatment of NCDs activities	1	500,000	1	525,000	1	551,250	1	578,813	1	607,753	1	638,141	1	670,048	4,071,004
S TOTAL 2		**20,450,000**	**34**	**21,472,500**	**35**	**22,546,125**	**36**	**23,673,431**	**37**	**24,857,103**	**38**	**26,099,958**	**39**	**27,404,956**	**166,504,073**

14. MENTAL HEALTH															-
To recruitment mental health care provide in Health centers	1	4,912,875	1	5,158,519	1	5,416,445	1	5,687,267	1	5,971,630	1	6,270,212	1	6,583,722	40,000,670
To provide staff training /OJT on mental health management	1	-	1	-	1	-	1	-	1	-	1	-	1	-	-
To avail essential medicines for mental health cares	12	11,000,000	12	11,550,000	12	11,000,000	12	11,000,000	12	11,000,000	12	11,000,000	12	11,550,000	78,100,000
To create mental health department in all health centers and hospitals	16	360,000,000	16	378,000,000	16	360,000,000	16	360,000,000	16	360,000,000	16	360,000,000	16	378,000,000	2,556,000,000
To integrate mental health services in health facilities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
To organize campaigns against substance abuse	2	3,600,000	2	3,780,000	2	3,600,000	2	3,600,000	2	3,600,000	2	3,600,000	2	3,780,000	25,560,000
S TOTAL 2		**379,512,875**	**32**	**398,488,519**	**32**	**380,016,445**	**32**	**380,287,267**	**32**	**380,571,630**	**32**	**380,870,212**	**32**	**399,913,722**	**2,699,660,670**
15. HEALTH WORKFORCE (HRH)															-
To maximize the package of services provided at the health facilities	1	-	1	-	1	-	1	-	1	-	1	-	1	-	-
To improve service delivery	1	-	1	-	1	-	1	-	1	-	1	-	1	-	-
To develop staffing plans based on workloads	1	-	1	-	1	-	1	-	1	-	1	-	1	-	-
To develop staff retention plans	1	-	1	-	1	-	1	-	1	-	1	-	1	-	-
To strengthen revoery systems of health facilities	17	18,700,000	17	18,700,000	17	18,700,000	17	18,700,000	17	18,700,000	17	18,700,000	17	19,635,000	131,835,000
To provide on job security protection	17	3,400,000	17	3,400,000	17	3,400,000	17	3,400,000	17	3,400,000	17	3,400,000	17	3,570,000	23,970,000
To pay salaries, PBF and other incentives on time	1	1,030,000,000	1	1,133,000,000	1	1,246,300,000	1	1,370,930,000	1	1,508,023,000	1	1,658,825,300	1	1,741,766,565	9,688,844,865
To construct new buildings for shelters to medical personnel at hospitals	17	595,000,000	17	595,000,000	17	595,000,000	17	595,000,000	17	595,000,000	17	595,000,000	17	624,750,000	4,194,750,000
To provide specific staff protection measures according to the nature of work (vaccines, screening, PPEs etc)	1	-	1	-	1	-	1	-	1	-	1	-	1	-	-

To conduct quarterly and annual performance evaluation to the staff	4	-	4	-	4	-	4	-	4	-	4	-	4	-	-
To provide staff horizontal promotion according to their performance	12		12		12		12		12		12		12	-	-
To provide in service training to staffs	12	-	12	-	12	-	12	-	12	-	12	-	12	-	-
To provide training on HR management and essential leadership skills	1	2,550,000	1	2,550,000	1	2,550,000	1	2,550,000	1	2,550,000	1	2,550,000	1	2,677,500	17,977,500
To develop policies and internal regulations for proper management of HRH	2	2,550,000	2	2,550,000	2	2,550,000	2	2,550,000	2	2,550,000	2	2,550,000	2	2,677,500	17,977,500
S TOTAL 2		**1,652,200,000**	**88**	**1,755,200,000**	**88**	**1,868,500,000**	**88**	**1,993,130,000**	**88**	**2,130,223,000**	**89**	**2,281,025,300**	**88**	**2,395,076,565**	**14,075,354,865**
16. SERVICE DELIVERY INCLUDING HEALTH INFRASTRUCTURE															
To build new VCTs at Buhabwa and Nyakabungo Health centers	1	-	1	110,000,000	1	121,000,000	1	133,100,000	1	146,410,000	1	161,051,000	1	177,156,100	848,717,100
To remove asbestos roofing and construct new fence, archive , pediatrics and internal medicine buildings at Gahini DH	1	30,000,000	1	30,000,000	1	33,000,000	1	36,300,000	1	39,930,000	1	43,923,000	1	48,315,300	261,468,300
To remove asbestos ceiling and construct new fence, reception & archive ,and clients' kitchen at Rwinkwavu DH	1	30,000,000	1	30,000,000	1	33,000,000	1	36,300,000	1	39,930,000	1	43,923,000	1	48,315,300	261,468,300
To build new maternities at Ruramira, Cyarubare, Ryamanyoni, Buhabwa, Nyakabungo and Rutare Health Centers	1	120,000,000	1	120,000,000	1	132,000,000	1	145,200,000	1	159,720,000	1	175,692,000	1	193,261,200	1,045,873,200
To build a new laboratory at Gahini, Nyakabungo, Buhabwa HCs	1	80,000,000	1	80,000,000	1	88,000,000	1	96,800,000	1	106,480,000	1	117,128,000	1	128,840,800	697,248,800
To build patients' toilets at Karama HC	1	16,000,000	1	16,000,000	1	17,600,000	1	19,360,000	1	21,296,000	1	23,425,600	1	25,768,160	139,449,760
To provide safe water pipelines to Gahini DH, and Nyakabungo,Ruramira, Karama, Ndego, Kabura, Bugambira, Rushenyi, Juru, Kahi HCs	1	64,000,000	1	64,000,000	1	70,400,000	1	77,440,000	1	85,184,000	1	93,702,400	1	103,072,640	557,799,040

To purchase 2 new ambulances for Rwinkwavu and 4 for Gahini DHs	1	50,000,000	1	50,000,000	1	55,000,000	1	60,500,000	1	66,550,000	1	73,205,000	1	80,525,500	435,780,500
To provide corrective maintenance for 8 ambulances: 1 for Cyarubare, Nyamirama , 2 for Rwinkwavu DH and 4 for Gahini DH	1	20,000,000	1	20,000,000	1	22,000,000	1	24,200,000	1	26,620,000	1	29,282,000	1	32,210,200	174,312,200
To build 35 health posts, 1 for each cells without a health facility	1	1,225,000,000	1	1,225,000,000	1	1,347,500,000	1	1,482,250,000	1	1,630,475,000	1	1,793,522,500	1	1,972,874,750	10,676,622,250
To Provide training to health facilities staffs on quality improvement and accreditation	1	10,000,000	1	10,000,000	1	11,000,000	1	12,100,000	1	13,310,000	1	14,641,000	1	16,105,100	87,156,100
To provide training on medical stocks management to the health facilities staffs	1	3,200,000	1	3,200,000	1	3,520,000	1	3,872,000	1	4,259,200	1	4,685,120	1	5,153,632	27,889,952
To purchase medical equipment and supplies for health facilities	1	250,800,000	1	250,800,000	1	275,880,000	1	303,468,000	1	333,814,800	1	367,196,280	1	403,915,908	2,185,874,988
S TOTAL 2		**1,899,000,000**		**2,009,000,000**		**2,209,900,000**		**2,430,890,000**		**2,673,979,000**		**2,941,376,900**		**3,235,514,590**	**17,399,660,490**
GRAND TOTAL		**4,397,424,275**		**4,634,485,489**		**4,853,353,263**		**5,108,495,926**		**5,370,989,885**		**5,665,100,529**		**5,948,355,556**	**35,978,204,924**

11. ANNEXES

11.1. DHSP II Priorities 2018-2024.

11.2. DHSP II Indicators.

11.3. DHSP II Budget.

11.4. List of Health Facilities in Kayonza District.

11.5. Top diseases OPD in District.

11.6. Top causes of hospitalization in District.

Strategic Direction	Priority Area	GAPS/ Situation analysis	Strategies	Innovation	Intervention/ Activities
Essential Services across the Life Course	**1. Maternal & Neonatal and Child Health (MNCH)**				
		Newborn, infant and child mortality rates are still higher than the national targets	Obtaining the focal persons for coordination of MNCH program	Expand the capacity for early detection of pregnancy in the community (urine testing of pregnant women by CHW, ultrasound check at HCs)	To conduct staff Recruitment
			Capacity building		To provide in service staff training
					To conduct mobilization meetings with community representatives (local outreach meetings)
					To provide continuous mentorship of health facilities in MNCH
		Low coverage of post natal care in HFs	Sensitization of the community		To organize campaigns for sensitization on PNC
					To provide health education session at health facilities of PNC
			Capacity building of HRH		To organize staff in service trainings

		Resistance to change of some group of Population on giving birth at HFs	Behavior Change Communication		Sensitization on delivery, Strengthening system of Rapid SMS
		Insufficient awareness of the importance of PNC by Health Providers and Mothers	Behavior Change Communication		To organize staff training
					To organize sensitization campaigns and meetings
		Misconceptions of the Population on Family Planning , limited customer care at HFs	Improve community acceptability of the modern family planning methods		To organize meetings and sensitization campaigns
					To improve service delivery at HFs
					To Provide staff training on FP methods including management of side effects
		Insufficient Knowledge and inaccessibility of Reproductive Health services,	Improve accessibility of FP		To decentralize services to Health posts To strengthen collaboration with private sector for provision of family planning services in private health facilities
			Raising community awareness		Organize Youth Mobilization campaigns On Reproductive Health

		Low ANC Coverage	To improve community knowledge on ANC ,		Community Sensitization on ANC, Organize outreach Strategy for ANC,involve CHWs
			To improve service delivery at HFs		To increase the number of days of ANC at HFs
			To decentralize ANC services to the population		To organize ANC outreach
	2.Expanded Program for Immunization (EPI)				
		Child immunization drop out	Maintain high and effective coverage of immunization services;		To organize community mobilization outreach on immunization
	3.Health Promotion, Prevention				
		Insufficient knowledge, attitude and behaviour of the community on health maintenance	Raising community awareness		To organize sensitization campaigns , health care providers training,mentorship and regular follow up
			Improving community lifestyle towards health maintenance		To organize mass sports on monthly basis
		Insufficient coordination of health promotion activities	Improve the coordination of health promotion stakeholder		Elaborate plan of coordination and follow up of implementation, Education about risk factor reduction

		Unavailability of data on health promotion inputs	Strengthen the M&E framework		Set up a system of reporting on health promotion
	4.Environmental Health				
		Some households without waste management disposal facilities	Behavior Change Communication		To conduct community meetings
					To strengthen village based health clubs
					To conduct regular community environmental inspections
		Limited availability of safe water to the population	Increasing safe water supply		To expand coverage of safe water pipelines
			Availing water treatment facilities		To collaborate with private sector to supply water treatment chemicals to the community
					To provide treatment plant for used water in the hospitals
	5. SGBV				
	Teenage pregnancies	Limited knowledge on reproductive health, School drop out and Inaccessibility to reproductive health services	Raising awareness on the adolescents ‘reproductive health issues	Umugoroba w'ingimbi n'abangavu (at village level, holidays)	Increase YFC, establish youth corner at HCs

				Identity and train peers for education and provision of reproductive health services in the community	Reinforce school based reproductive health clubs,
			Collaborative program between the legal government and churches on reproductive health	Local program for fighting against adolescents pregnancies "Mwari w'u Rwanda "	To organize regular meetings with churches and other faith based organizations for mobilizing youth for safe sexual behavior
			Sensitizing the youth on cultural values regarding sexuality		To sensitize youth on reproductive health through various channels : radio, competitions, campaigns
	Domestic sexual violence	Substance abuse, poverty, illegal relationships (engagement), lack of forum for discussing family conflicts	Strengthening communication between couples	Inspire family counseling hubs	Establish counseling services within the PPP model and organizing study tour to model sites
			Reduce substance abuse		Discourage substance abuse
	6. FAMILY PLANNING				

		Churches interference, inaccessibility of services, limited knowledge on FP, unacceptability of some methods, low male involvement, cultural beliefs	Decentralizing PF services to the community, health posts and private facilities	Community reproductive health agent (for youth)	Avail FP medicines to those in need & training to the CHWs on FP, To provide FP during community outreach meetings
			Mobilization	Peer education on FP	Campaigns, integrated health education in HFs in all services including ANC and community outreach meetings Involving churches in FP Identity peers for community education
			To increase coverage of FP		Strengthen provision of FP services in post partum, Improve service delivery in health facilities
	7. HIV/AIDS,STI & viral Hepatitis				
		Low staffing in facilities, lack of testing equipment , social stigma, reduction of external funding	Reducing stigma to PLHIV in the community		To provide community education at health facilities on danger of stigma to PLHIV, and the benefits of HIV, TB and hepatitis testing

					To provide counseling for self disclosure of HIV status
			Infrastructure and equipment development		To avail adequate building fulfilling privacy norms for HIV /ART departments at hospitals
					Identify high risk groups eg: sex workers , testing campaigns, truck drivers and provide education and condom distribution campaigns
			Reducing new HIV cases		To conduct male circumcision campaigns
			Increase staffing levels		To increase staff numbers according to the package of services required and national HRH staffing norms
			Staff retention		Improve HRH motivation
			Capacity building		To provide staff training for detection and management of HIV, TB and hepatitis cases
	8. TB AND OTHER RESPIRATORY INFECTIONS				

		Low detection and treatment success , inadequate triage and isolation of suspects and confirmed cases in HFs	Increase detection of TB cases		To conduct screening campaigns in high risk populations such as transit centers and schools
			Strengthen TB infection control measures in HFs		Reset patients flow, triage of patients with cough , isolation precautions in health facilities
			Capacity building for case management		To provide staff training for detection and management of TB cases
	9. MALARIA AND OTHER PARASITIC DISEASES				
		Increase of malaria cases since 2014, environmental factors , irrigation agriculture, mining activities	Vector control measures	IRS within the framework of community work - Amasibo to support logistics	Indoor residual spraying
			Multidisciplinary collaboration in fighting against malaria		Collaborate with the agriculture sector and mining companies, involve private sector for availing mosquito nets sold to the community

			Behaviour change communication		Community mobilization for the use of LLIN and home hygiene
		High malaria case fatality rates for incoming habitants from low endemicity regions	Special protection measures		Early identification of the high risk population and provision of mosquito nets
	10. NEGLECTED TROPICAL DISEASES				
		The zone is potentially at risk because of water scarcity , existence of swamps & Akagera National park bordering the district	Provision of safe & sufficient water to communities,	Expand mass deworming target	Provide antihelminthics to the adult population as well Promotion water treatment plants, provision of water treatment chemicals, disease screening
			Increasing disease case detection		To encourage Disease screening at health posts
			Proper waste disposal		Sensitise the community for construction of sufficient proper latrines,
	11. NUTRITION				

	Nutrition	There is no platform for collaboration of implementers / stakeholders are not well coordinated	To improve the coordination of different stakeholders in the nutrition program in the district		To organize regular meetings of stakeholders
		Lack of nutritionist in the health centers	Refilling the posts		Conduct recruitments
		Lack of food sustainability due to drought	Ensure food security and storage for emergency periods at sector levels		To advocate for provision of FBF to under five years children, pregnancy and lactating women of vulnerable families of ubudehe 2 (receiving food support)
					Provide food to vulnerable people or families through public works
		Insufficient screening of malnutrition by CHWs and HFs	Systematic screening of under five children		To provide tools to CHWs for growth monitoring
					To reinforce nutrition screening in IMCI and routine immunization at health facilities

		DPEM committees are not active	Capacity building		To provide training to the DPEM committees members
			Financial support to the DPEM		To provide mission and transport allowances to the committees members attending meetings
		Lack of basic knowledge on healthy nutrition for the community members	Raising awareness		To provide health education on nutrition during community outreach meetings and at the HFs
					To organize high coverage nutrition education through media
			To reinforce clubs on nutrition and hygiene at village level, mostly amasibo.		To provide training to the nutrition and hygiene clubs members To set up a monthly reporting system for village based nutrition and hygiene clubs
	12. COMMUNITY HEALTH (COORDINATION OF CHWs)				
		High turnover, Reduced CHWs's cooperatives performance indicators	Capacity building		To provide training to the new community
					To provide refresher training to the existing CHWs
			Motivation of CHWs for reducing the		To provide necessary equipment to carry out their responsibilities

			turnover		To facilitate them to get drugs at the nearest site for easy collection
			Early replacement of CHWs who departed		To organize quarterly assessment for replacement as needed
		Many projects of income generation for CHWs cooperatives are ansuccessful	To strengthen the management of CHWs cooperatives		To provide financial management training to the cooperatives' leaders
					To provide project management training to the cooperatives' leaders
					To advice and supervise for better management
	13. OVERALL INTERVENTIONS FOR NCDs , INJURIES AND DISABILITIES				
		Risky behavior of the community towards NCDs, injuries and disabilities	Behavior change communication		To collaborate with Police for organizing campaigns on prevention of road traffic accidents
					To provide health education on healthy nutrition and NCDs prevention through social media approach and at the HFs
					To organize mass sport activities on monhly basis

			Capacity building		To provide first aid training to villaage based red cross members and school teachers
			Promoting evidence based interventions against NCDs		To conduct research of rik factors to NCDs
			Promoting early detection and treatment of NCD cases		To organise screening campaigns in the community
					To organize training on clinical management of cardiovascular diseases
		Insufficiet contribution of the prvate sector in NCDs prevention and control, treatment	To strengthen the private and public sector partnerships in NCDs prevention and control		To invite private sector representatives in meetings and trainings for prevention , control and treatment of NCDs activities
	14. MENTAL HEALTH				
		Lack of enough ,qualified mental health care provider in health centers, mental health services not included in the package of services provided by most of health facilities	Establish mental health services in all health centres		To recruitment mental health care provide in Health centers

			Capacity building		To provide staff training on mental health management
			System strengthening		To avail essential medicines for mental health cares
					To create mental health department in all health centers and hospitals
					To integrate mental health services in health facilities
			Raising community awareness		To organize campaigns against substance abuse
	15. HEALTH WORKFORCE (HRH)				
		Insufficiency of staffs in health facilities, High turnover, variable performance of staffs, loop holes in the HR management laws	Enhancing the capacity of HFs to obtain and retain staffs		To maximize the package of services provided at the health facilities
					To improve service delivery
					To develop staffing plans based on workloads
					To develop staff retention plans

				To strengthen revoery systems of health facilities
		Improving working conditions for the health sector staffs		To provide on job security protection
				To pay salaries, PBF and other incentives on time
				To construct new buildings for shelters to medical personnel at hospitals
				To provide specific staff protection measures according to the nature of work (vaccines, screening, PPEs etc)
		Staff performance management		To conduct quarterly and annual performance evaluation to the staff
				To provide staff horizontal promotion according to their performance
		Capacity building		To provide in service training to staffs
		Improving human resource management skills to the health facilities leaders and managers		To provide training on HR management and essential leadership skills

			Establishing local procedures for HR management not conflicting with national laws and regularions if existing		To develop policies and internal regulations for proper management of HRH
	16. SERVICE DELIVERY INCLUDING HEALTH INFRASTRUCTURE				
		Insufficient and old health facilities infrastructure	To renovate, upgrade and build health facility infrastructure		To build new maternities, laboratories and VCTs at Buhabwa and Nyakabungo Health centers
					To new build maternity at Ruramira and Ryamanyoni
					To remove asbestos roofing and construct new fence, archive , pediatrics and internal medicine buildings at Gahini DH
					To remove asbestos ceiling and construct new fence, reception & archive ,and clients' kitchen at Rwinkwavu DH
					To build new maternities at Ruramira, Cyarubare and Rutare Health Centers

					To build a new laboratory at Gahini HC
					To build patients' toilets at Karama HC
					To provide safe water pipelines to Gahini DH, and Nyakabungo,Ruramira, Karama, Ndego, Kabura, Bugambira, Rushenyi, Juru, Kahi HCs
					To purchase 2 new ambulances for Rwinkwavu and 4 for Gahini DHs
					To provide corrective maintenance for 8 ambulances: 1 for Cyarubare, Nyamirama , 2 for Rwinkwavu DH and 4 for Gahini DH
					To build 35 health posts, 1 for each cells without a health facility
		Clients complaints related to quality of service delivery	Continuous quality improvement and accreditation of health facilities		To Provide training to health facilities staffs on quality improvement and accreditation

			Improving availability of medical commodities and supplies in health facilities		To provide training on medical stocks management to the health facilities staffs
					To purchase medical equipment and supplies for health facilities

DISTRICT HEALTH INDICATORS.

Indicator	Baseline 2016/2017	MTR Target 2020/21	End Target 2024	Frequency of reporting	Source of data	Challenges	Main Priorities/Interventions
Impact indicator							
Population of KAYONZA	427,471	473,084	579,430	Annual	NISR/HMIS	Low mindset to adhere on birth spacing and control programs like Family Planning	Continuous mobilization of community for mind change.
Fertility Rate	***4.50%***	***3.50%***	***2.50%***	Annual	DHS	Resistance of the Population on Family Planning Utilization	Community Mobilization on Utilization of Family Planning
Neonatal Mortality Rate/1000 LB	35	***15***	***10***	Annual	HSSP 4, HMIS	Low attendance of Pregnant women For 4ANC, Delay to reach HFs for Delivery.	Community Mobilization On ANC & Delivery at HF
Under five mortality rate	***37***	***25***	***20***	Annual	HSSP 4, HMIS	Mindset of the population to reach HF on Time for Consultation/Treatment, (Beliefs in Traditional Healers) Lack of Health Insurance,	Mobilization of the population, Reinforce community health Program (IMCI)
Infant Mortality Rate/1000 LB	***61***	***19***	***14***	Annual	HMIS	Delay of the population to reach HF on Time for Consultation/Treatm	Mobilization of the population, Reinforce community

						ent, Lack of Health Insurance,	health Program (IMCI)
Outcomes/Output Essential Services across the Life Course: pregnancy, early life, children, adolescents and youth programs							
Prevalence of Stunting	42.4	28%	18%	Annual	DHS, HMIS	Mindset of the population, Climate change, Family Conflict, Poor Hygiene at HH	Mobilization On Balanced Diet, Promote Irrigation Scheme, Promote Family Planning Method, Improve hygiene and Sanitation, Integration of nutrition Screening into Minimization, Advocacy to give FBF to other legible groups (pregnant women)
ANC coverage (4 standards visits)	45%	52%	62%	Monthly	HMIS	Mindset of the Population, Long Distance	Community Sensitization on ANC targeting , Organize

							outreach Strategy for ANC
Percentage of births attended by skilled health professionals	91.80%	>95%	>95%	Annual	DHS, HMIS	Few Population still have low Mindset based on traditional briefs leading deliveries at Homes	Sensitization on delivery, Strengthening system of Rapid SMS
Percentage of new-borns with at least one PNC visit within the first two days of birth	32.7	61%	88%	Monthly, Quarterly, Annually	HMIS	Ignorance on importance of PNC by Health Providers and Mothers	Build capacity of Health Providers on PNC, Sensitize mothers on importance of PNC
Modern contraceptive prevalence rate	47.1%	64.2	67.2%	Monthly, Quarterly, Annually	HMIS	Low Mindset of the Population on value of Family Planning (Rumors) sides Effect Management. Lack of customer at HFs to the clients	Community Mobilization, BCC, Train Health Providers on Family Planning Methods and sides Effect Management. To improve customer of providers to clients.
Percentage of Children 12-23 months fully immunized	93.4	>95%	>95%	Monthly, Quarterly, Annually	HMIS	no challenges	Maintain

Exclusive Breastfeeding < 6 months	5,4%	19%	30%	Monthly, Quarterly, Annually	DHS	Mindset	BCC on Exclusive Breastfeeding
Teenage pregnancy and motherhood rate (15-19 years)	9.9	6	5	Monthly, Quarterly, Annually	HMIS	Lack Knowledge on Reproductive Health	Organize Youth Mobilization On Reproductive Health and Family Planning
Unmet need for Family Planning	17.9	16	15	Monthly, Quarterly, Annually	DHS	accessibility of Family Planning Methods especially for Youth	establish youth corner at Health centre, Avail Family Planning Methods at villages centers
Coverage of Essential Health Interventions: communicable and non-communicable diseases							
Proportion of persons diagnosed with HIV infection receiving sustained ART	98	>95%	>95	Monthly, Quarterly, Annually	HMIS	Delaying to start ART	Sensitization of people HIV +ve to start ART After HIV Infection. Re-enforce test and treat
HIV prevalence among people aged 15-49 years	3.8	<3.8%	<3.8%	Monthly, Quarterly, Annually	DHS	High Movement from neighboring countries and other District,	Community mobilization on HIV Prevention and Focus on High Risk Group

Percentage of infants born to HIV + mothers free from HIV by 18 months	97	>98	>98	Monthly, Quarterly, Annually	HMIS	There is existence of stigma and discrimination in HIV/AIDS patients	Reinforce Follow up for infant Born to Mother HIV +
TB treatment coverage rate	75	86	88	Monthly, Quarterly, Annually	HMIS	insufficient Follow-up of TB Patients	Improve Follow-up
TB Treatment success rate	84.9	87%	90	Monthly, Quarterly, Annually	HMIS	insufficient Follow-up of TB Patients,	Improve Follow-up & DOT
Proportion HH with at least one LLIN	97.3	97.3	98	Annually	DHS	availability of LLIN at household level	avail LLIN at HH Level
Malaria incidence per 1,000 population	215	200	122	Monthly, Quarterly, Annually	HMIS	High incidence of malaria , Mindset of the population on malaria Prevention	Community awareness on Malaria Prevention,
Malaria proportional mortality rate	9	4.5	3	Monthly, Quarterly, Annually	HMIS	Delay of the population to consult HF and CHWs,	Community Mobilization , Reinforce HBM
Proportion of children under five years old who slept under a LLIN the previous night	81	84	85	Monthly, Quarterly, Annually	DHS 2010, 2015	Mindset to sleep in LLIN, Insufficient of LLIN In the Community, useless of LLIN	Community mobilization, avail LLIN In community
Proportion of targeted population	99	99	99	Semester	MCH Report	None	Organize MCH week 2/ year

who received MDA (Massive drug Administration)							
Teeth and gum diseases morbidity rate at health facility level	1.8%	1.5%	1.2%	Monthly, Quarterly, Annually	HMIS	Mindset on Teeth Hygiene by the Community	Organize community Campaign
Cataract Surgical Rate (number of cataract surgeries per 1000 population per year)	60	240	480	Monthly, Quarterly, Annually	New indicator	Lack of specialized staff at District Hospital Level	avail specialized staff at District hospital
Eye diseases problem morbidity rate at health facility level	2.9%	<2	<2	Monthly, Quarterly, Annually	HMIS	Lack of specialized staff at District Hospital Level	avail specialized staff at District hospital
Proportion of new cases treated in health facilities (HC+DH) for mental disorders	0.1	0.2	0.6	Monthly, Quarterly, Annually	HMIS	Lack of mental Health Services at HF Level, unrecorded Data to HMIS	Conduct baseline survey of mental disorders. Establish Mental Health Services at Health Facilities Level

Percentage of Health centres without water	12%	6%	0%	Monthly, Annually	District Report	Lack of sufficient Budget for water Installation	advocacy for budget allocation
Number of Hospitals with water treatment plants according to standards	0	1	2	Annual	District Report	Lack budget allocated to Water treatment Plant	advocacy for budget allocation
Number of DH with effective waste management systems according to standards	1	1	2	Annual	District report	Lack of Budget	advocacy for budget allocation
HEALTH SYSTEMS SUPPORTING DELIVERY OF HEALTH PROGRAMS							
% Incident cases assessed and reported.	N/A	100%	100%	Monthly, Quarterly, Annually	Report	Lack of baseline data,	Reinforce Follow up malpractices cases identified
Specialists /Pop)	0	1/13845	8/72429				
Doctor/pop ratio (GP and Specialists as well)	1/21, 290	1/ 15000	1/7,000	Annual	Health Human Resources report	Lack of Budget,	Advocacy for budget
Nurse/pop ratio	1/133 1	1/ 800	1/800	Annual	Health Human Resources report	Lack of Budget	Advocacy for budget

Midwife/pop ratio (women aged from 15-49)	1/16441	1/ 12000	1/10347	Annual	Health Human Resources report	Lack of Budget	Advocacy for budget
Pharmacist /pop ratio	4	1/144858	1/144858	Annual	Health Human Resources report	Lack of Budget	Advocacy for budget
Lab Technicians /pop ratio	1/9,257	1/7,50	1/ 7,500	Annual	Health Human Resources report	Lack of Budget	Advocacy for budget
Number of Cells with health facility	31	40	50	Annually	District and Partners	Limited budget	Advocacy for budget
Ambulance ration per Population of KAYONZA	4	10	12	Bi-annually	Health Report	Lack of Budget	Advocacy for budget
Number of health centers with at least 2 functional moto cycles	60%	80%	100%	Annually	Facility reports	Lack of budgets, old motos	Advocate for budget
Average time to walk to a nearby HF (in minutes)	57	50	45	Annual	Health Report	inaccessibility of Primary health Care	Advocacy for budget for Construction of Health post at Cell level from both central level and Partners.

Number of hospitals with functional basic maintenance system (trained manpower, available tools and space for operations)	2	2	2	Annual	Report	No advanced skills in maintenance for both hospitals	Advocacy for budget (Construction , spare Parts, Capacity Building for Health Providers)
Percentage of health centres without electricity (not connected to a nearby grid)	20%	6%	0%	Annual	Report	Lack of Budget, Geographical Accessibility	Advocacy for Budget
Percentage of Health centres with functional internet and local area network connectivity	20%	40%	60%	Annual	Report	Networking accessibility, Budget constraint	Advocacy for Budget,
% HFs with < 5% of vital medical products stock-outs	89	>95	>95	Monthly, Quarterly, Annually	Report	stock out at National Level	Advocacy to minimize any vital medical products stock out.
% of public health facilities (HC and DH) using EMR full package	5%	95%	100%	Monthly, Quarterly	report	Lack of staff Trained Staff, insufficient Computers	Advocacy and train health providers on use of EMR system in HFs

system							
% of private facilities regularly reporting through national data collection systems (DHIS-2 and e-IDSR)	60%	100%	100%	Monthly, Quarterly	Report	Private health Facilities are not Trained on HMIS	Advocacy and train private health facilities staff on use of e-data base (HMIS..,)
% of DHMT meeting conducted	50%	100%	100%	Quarterly	report	No budget allocation for functional of DHMT	Advocacy to avail fund for operational
Number of DHMT supervisions done	2%	6	12	Semester	report	No budget allocation for functional of DHMT	Advocacy to avail fund for operational
% of Institutions with occupational health and safety programs	0%	>95%	>95%	Annually	report	Mind set of institutions to implement program.	Mobilization of institution to establish the system.

% of schools with primary health care system	17.6 %	50%	100%	Annually	report	Mind set of schools to implement program. Limited budget to qualified staff.	To Mobilization of schools to initiate program, advocacy to plan for recruitment of qualified staff
% of health facilities that comply to Accreditation level 1 for HCs and Level 2 for DHs	0%	23.5	82.4	Annually	report	Infrastructure limitation, Limited number of staff and high turnover.	Advocacy to avail budget for construction, Capacity building of human resource/staff
Number of clinical, Operational and Evaluative studies conducted in DHs	0	2 per year(8) publications	16 Publications	Annually	Research Reports	Lack of focal person/staff on research areas	To avail staff to facilitate the activity, Advocate for financial means
% of public and private institutions comply with hygiene and sanitation standards.	20%	>95%	>95%	Annually	Inspection reports	Hygiene and sanitation standards not yet available to all institutions	To conduct monthly hygiene inspection to the community including hotels and restaurants

Annex 5: Top ten diseases OPD

No	Indicators	Number of cases	**%**
1	Malaria	47378	44.1
2	Respiratory infections	29427	27.4
3	Cough	6526	6.1
4	Gastritis and duodenitis	5298	4.9
5	Skin Infections	4419	4.1
6	Urinary Tract Infections	4354	4.1
7	Entamoeba	3763	3.5
8	Diarrhea	2442	2.3
9	Pneumonia	2340	2.2
10	Ear Infections	1507	1.4
	Total	107454	100.0

Source: HMIS 2017

Annex 6: Top ten causes of hospitalization;

No	Indicators

1	Malaria
2	Acute Respiratory infections
3	Abortions
4	Trauma cases
5	Diarrhea
6	Gastritis
7	Asphyxia Neonatal
8	Urinary Tract Infections
9	Anemia severe
10	Food poisoning

Source : HMIS 2017

LIST OF HEALTH POST IN KAYONZA DISTRICT

No	NAMES	SECTOR	CELL
1	ISANGANO	NDEGO	ISANGANO
2	UMUYENZI	KABARE	CYARUBARE
3	RUSHENYI	KABARE	RUBIMBA

4	KABARE	KABARE	RUBUMBA
5	NYAKANAZI	MURAMA	NYAKANAZI
6	RUSAVE	MURAMA	RUSAVE
7	KABURA	KABARONDO	KABURA
8	BUGAMBIRA	RURAMIRA	BUGAMBIRA
9	GASARABWAYI	MWILI	NYAMUGALI
10	RUGEYO	MWILI	KAGEYO
11	JURU	GAHINI	JURU
12	TSIMA	GAHINI	KAHI
13	GAKOMA	MURUNDI	BUHABWA
14	KIGOBE	MURUNDI	RYAMANYONI
15	RWIMISHINYA	RUKARA	RWIMISHINYA
16	KAWANGIRE	RUKARA	KAWANGIRE
17	KIYENZI	GAHINI	KIYENZI

LIST OF PRIVATE CLINIC/ DISPANSARY IN KAYONZA DISTRICT

No	NAMES	SECTOR	CELL
1	KAYONZA DISPENSARY	MUKARANGE	NYAGATOVU

2	SAVER DISPANSARY	MUKARANGE	NYAGATOVU
3	NARADA CLINIC	MUKARANGE	KAYONZA
4	NIWAWE DISPANSARY	KABARONDO	CYABAJWE
5	LA CLINIQUE GRACE	KABARONDO	CYABAJWA
6	GIRUBUZIMA DISPANSARY	GAHINI	RYAKIYENZI

LIST OF PRIVATE PHARMACY IN KAYONZA DISTRICT.

No	NAMES	SECTOR	CELL
1	PHARMACY SAINTE THERESE	KABARONDO	CYABAJWA
	PHARMACY MEDSAFE	KABARONDO	CYABAJWA
2	PHARMACY CELLIA	KABARONDO	CYABAJWA
3	PHARMACY GRATIS	MUKARANGE	KAYONZA
4	PHARMACY ESPERANTO	MUKARANGE	BWIZA

District Performance.

selected indicators

No	Health Indicators to be monitored regularly	2016	2017
1	Facility deliveries coverage	85.4	87.8
2	% of deliveries with at least 1 postnatal check up for mothers within 10 days	32.7	37
3	FP coverage rate - facilities married women	65.6	72.1
4	Modern Contraceptive method utilization rate	47.1	52.2
5	FP Permanent or Long method utilization rate	15.5	15.2
6	# of women who die while pregnant, delivering or in less than a week after delivering	7	13
7	ANC 4	45.2	42.9
8	# of home deliveries	319	309
9	**II.CHILD HEALTH**		
10	ARI proportional morbidity under 5 years	42.4	54.4
11	Malaria proportional morbidity < 5 years	33.7	28.3
12	Proportion of U5 visits seeking treatment for diarrhea	1.2	0.9
13	% children immunized for measles <1(M&R vaccination coverage rate)	93.4	94
14	% of Neonatal death	12.6	9.6

15	#<5 years death from weekly mortality report	183/00	84/00
16	# of infant death from weekly mortality report	154	73
17	# of children in nutrition rehabilitation program	296	338
18	ANC HIV positive test rate	1.4	1.2
19	% of patients who need ART and receive it	93	98
20	% of drop out for patients on ARV	0	0
21	TB treatment success rate	84.9	89.3
22	Malaria proportional morbidity	37.6	28.5
23	Malaria slide positivity rate	57	48.1
24	OPD cases per capita	1.4	1.3
	V.PHARMACY		
25	% of HC & DH with at least 2 days of stock out for tracer drugs	0	0
	VI.MUTUELLE		
26	% CBHI coverage	78%	81%
	VII.GOVERNANCE		
27	# of DHMT quarterly meetings conducted	2	4