

RWANDA



The President's Malaria Initiative (PMI)

Malaria prevention and control is a major U.S. foreign assistance objective, and PMI's strategy fully aligns with the U.S. Government's vision of ending preventable child and maternal deaths and ending extreme poverty. Under the PMI Strategy for 2015–2020, the U.S. Government's goal is to work with PMI-supported countries and partners to further reduce malaria deaths and substantially decrease malaria morbidity toward the long-term goal of elimination.

Country Context

Small and land-locked, Rwanda is the most densely populated country in continental Africa. The Rwanda health system is led by the Ministry of Health and has five tiers. Public health facilities represent 55 percent of the total number of health facilities in the country, and there exists an extensive network of public sector health centers.

The entire population of Rwanda is at risk for malaria. Malaria is mesoendemic in the plains and prone to be epidemic in the high plateaus and hills. In endemic zones, transmission occurs year-round with two seasonal peaks in May–June and November–December. Besides climate and altitude, other factors that influence transmission include high human concentration near vector habitat, population movement, irrigation schemes, and cross-border movement of people.

Rwanda has made remarkable progress in the fight against malaria. All major malaria indicators decreased significantly from 2005 to 2012. Rwanda's health management information system reported an 86 percent reduction in malaria incidence, an 87 percent reduction in malaria morbidity, a 74 percent reduction in malaria mortality, and a 71 percent reduction in malaria test positivity rate. Between 2011 and 2015, Rwanda saw an 11-fold increase in reported malaria cases. More analysis is needed to understand the causes of this increase; the Malaria and Other Parasitic Diseases Division attributes it to a number of factors including the increase of the total number of patients seeking healthcare in health facilities, increased rainfall and agricultural environmental modification, mosquito resistance to pyrethroid-based insecticide, and increased number of health facilities reporting into the system. Furthermore, with increasing malaria cases seen in the eastern African region, trans-border movement may be contributing to transmission. Nonetheless, the National Malaria Control Program has an ambitious vision to achieve malaria pre-elimination nationwide and near zero malaria deaths by 2018, which will contribute to the country's socio-economic development.

Progress to Date

The following table provides information on the major indicators used by PMI to measure progress in malaria prevention and treatment activities in Rwanda.

Rwanda Malaria Indicators	PMI Baseline (DHS 2005)	DHS 2008	DHS 2010	MIS 2013*	DHS 2014–2015
All-cause under-five mortality rate	152/1,000	103/1,000	76/1,000	–	50/1,000
Proportion of households with at least one ITN	15%	56%	82%	83%	81%
Proportion of children under five years old who slept under an ITN the previous night	13%	57%	70%	74%	68%
Proportion of pregnant women who slept under an ITN the previous night	17%	60%	72%	74%	73%
Proportion of women who received two or more doses of intermittent preventive treatment for pregnant women (IPTp) during their last pregnancy in the last 2 years		Not part of National Malaria Control Program strategy			

* MIS - Malaria Indicator Survey

AT A GLANCE

Population (2016):
12.9 million¹

Population at risk of malaria (2013): **100%²**

Malaria incidence/1,000 population at risk (2013): **121³**

Under-five mortality rate (2014):
50/1,000 live births⁴

1 U.S. Census Bureau, International Data Base 2015

2 World Health Organization (WHO), *World Malaria Report 2015*

3 WHO, *World Health Statistics 2016*

4 Demographic and Health Survey (DHS) 2014–2015

PMI Contributions Summary

Rwanda is currently in its tenth year as a PMI focus country. With support from PMI and its partners, malaria control interventions are being scaled up, and critical commodities are being distributed to vulnerable populations. The following table shows PMI contributions for fiscal year 2015 and cumulatively across the key intervention areas.

		PMI CONTRIBUTIONS ¹	FY 2015	CUMULATIVE
Insecticide-treated Nets		ITNs procured	375,000	4,647,900
		ITNs distributed	1,400,000	4,272,900
Indoor Residual Spraying		Houses sprayed	304,199	n/a ²
		Residents protected	1,248,678	n/a ²
Rapid Diagnostic Tests		RDTs procured	0	2,362,050
		RDTs distributed	489,810	1,689,030
Artemisinin-based Combination Therapy		ACTs procured	2,041,710	4,412,430
		ACTs distributed	1,876,001	3,159,821
		ACTs procured by other donors and distributed with PMI support	0	794,556
Health Workers		Health workers trained in malaria diagnosis	5,314	n/a ³

¹ The data reported in this table are up-to-date as of September 30, 2015. Please refer to Appendix 2 of the [2016 PMI Annual Report](#) for year-by-year breakouts of PMI contributions.

² A cumulative count of the number of houses sprayed and residents protected is not provided since many areas sprayed on more than one occasion.

³ A cumulative count of individual health workers trained is not provided since some health workers were trained on more than one occasion.

PMI Funding (in millions)



For details on FY 2016 PMI activities in Rwanda, please see the [Rwanda Malaria Operational Plan](#).