

## 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

Rwanda is a small country with an estimated population of approximately 12 million, making it the most densely populated country in continental Africa. The Rwanda health system is led by the Ministry of Health with the Malaria and Other Parasitic Disease Division housed within the Rwanda Biomedical Center. Rwanda has an extensive network of public sector health centers and community health workers.

The entire population of Rwanda is at risk of malaria. Transmission is mesoendemic in the plains and prone to epidemics in the high plateaus and hills. In endemic zones, malaria transmission occurs year round with seasonal peaks in May–June and November–December.

Rwanda made remarkable progress in the fight against malaria from 2005 to 2012, during which time there was an 86 percent reduction in malaria incidence and 74 percent reduction in malaria mortality. However, between 2012 and 2016, Rwanda saw just over an 8-fold increase in reported malaria cases. The increase was observed countrywide but largest in the Eastern and Southern provinces. Although malaria cases increased dramatically, only small increases were noted in severe cases and deaths, with substantial reductions in case fatality rates indicating strong malaria case management.

Although more analysis is needed to understand the complex interplay of factors, the Malaria and Other Parasitic Diseases Division attributes the increase in malaria cases in part to expanded access to healthcare, inadequate coverage with effective bednets, agricultural environmental modifications, mosquito resistance to pyrethroid insecticides, and change in mosquito behavior towards outdoor biting. With increasing malaria cases seen throughout the region, trans-border movement of people might also contribute to transmission. Nonetheless, the goal of the national malaria control program is to reduce malaria mortality by 30 percent of the 2015–2016 level by 2020 as a main step toward achieving the vision to reduce malaria burden as a way to contribute to Rwanda's socioeconomic 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 (2017):  
**12.2 million<sup>1</sup>**

Population at risk of malaria (2016): **100%<sup>2</sup>**

Malaria incidence/1,000 population at risk (2015):  
**301.3<sup>3</sup>**

Under-five mortality rate (2014):  
**50/1,000 live births<sup>4</sup>**

1 World Bank, Population Estimates & Projections 2017

2 World Health Organization (WHO), *World Malaria Report 2017*

3 WHO, *World Health Statistics 2017*

4 Demographic and Health Survey (DHS) 2014/2015

## PMI Contributions Summary

Rwanda is currently in its twelfth 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 2017 and cumulatively across the key intervention areas.

		PMI CONTRIBUTIONS <sup>1</sup>	FY 2017	CUMULATIVE
Insecticide-treated Nets		ITNs procured	0	5,647,900
		ITNs distributed	948,676	5,596,576
Indoor Residual Spraying		Houses sprayed	231,258	n/a <sup>2</sup>
		Residents protected	919,735	n/a <sup>2</sup>
Rapid Diagnostic Tests		RDTs procured	0	2,362,050
		RDTs distributed	0	2,361,220
Artemisinin-based Combination Therapy		ACTs procured	2,992,140	8,026,740
		ACTs distributed	1,124,591	4,906,582
		ACTs procured by other donors and distributed with PMI support	0	794,556
Health Workers		Health workers trained in treatment with ACTs	2,453	n/a <sup>5</sup>
		Health workers trained in malaria diagnosis	2,453	n/a <sup>3</sup>

1 The data reported in this table are up-to-date as of September 30, 2017. Please refer to Appendix 2 of the [PMI Annual Report](#) for year-by-year breakdowns 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 2018 PMI activities in Rwanda, please see the [Rwanda Malaria Operational Plan](#).