POLICY BRIEF

Impact of COVID-19 on Rwanda's Health Sector

Noella Bigirimana, Edson Rwagasore and Jeanine Condo

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Context

On 30 January 2020, the World Health Organization (WHO) declared the new coronavirus COVID-19 outbreak as a Public Health Emergency of International Concern (PHEIC) with a strong recommendation for countries to take appropriate measures to interrupt virus spread. By 11 March 2020, the WHO had declared COVID-19 as a global pandemic with the number of cases estimated at 118,319, and the virus had expanded to 114 countries with ripple effects on every aspect of human life. The COVID-19 burden has resulted in unprecedented pressure on the public health systems across the world, including many African countries.

Rwanda is the focus of the current report, as a country which stemmed the spread of COVID-19 with early and decisive measures. This report seeks to document the interventions put in place to flatten the curve of COVID-19 transmission, examine the impact of COVID-19 on health outcomes in Rwanda, and describe interventions to mitigate the socioeconomic impact.

The problem

Following the first recorded COVID-19 case in Rwanda on 14 March 2020, the country had to enforce public health measures, movement restrictions, and lockdown measures. As the COVID-19 outbreak evolved, many health systems struggled to maintain routine service delivery due to a surge in COVID-19 caseload. In Rwanda, existing healthcare delivery approaches had to be adapted to mitigate the potential risk of system failure. Furthermore, other nonmedical sectors such as private sector, education, and commerce were affected by stringent restrictions. These restrictions made households more prone to fall into poverty, especially those in the informal sector.

Background

Rwanda has an estimated population of 13 million, and has averaged 8% annual economic growth pre-pandemic. Rwanda is landlocked with more than 22 border points, including land borders with Uganda, DRC, Tanzania, and Burundi, in addition to growing airline traffic.

The country has a wide network of health facilities with significant geographical coverage, and healthcare packages defined for each level, from the community level up to the referral level. The country's spending on healthcare is often highlighted among the government's priorities, and funds allocation seems to follow the country's disease profile and healthcare priorities.

A total of 11,032 cases and 142 deaths were reported between 14 March 2020 and 17 January 2021 in Rwanda. During this period the epidemic in Rwanda progressed through multiple phases.

Research results

In Rwanda, the first COVID-19 phase (14 March 2020 to 31 May 2020), was characterized by a stable period with cases either imported or linked to imported cases. Phase two had the first clusters of community transmission identified on 31 May 2020 in the district bordering the Democratic Republic of Congo (DRC). This phase had clusters

of transmission in Rusizi district (bordering DRC); other clusters were identified among high risk occupation groups including markets in the country. Phase three was characterized by a drop of cases with decreased number of daily confirmed cases and low case fatality rate. In phase four, which started in December 2020, the number of cases and case fatality rate increased significantly compared to the previous phases. The initial step in responding to COVID-19 in Rwanda involved ramping up the response by enhancing coordination mechanisms and community engagement. More than 400 individuals from government and the private sector were mobilized to support the National COVID-19 Joint Task Force organized in key pillars, including Epidemiology, Administration and logistics, Communication, and Planning. This coordination and leadership were crucial, notably in ensuring adequate distribution of basic personal protective equipment (PPE) and other key logistics requirements including mass distribution and wearing of face masks, hand washing installed in all public places, social distance, as well as mapping high risk individuals and mass screening and testing of COVID-19. The National COVID-19 Task Force is a coordination structure activated under the oversight of the National Steering Committee chaired by the Prime Minister. As part of surveillance, in addition to continuous testing of patients consulting in health facilities for influenza like illness and severe acute respiratory illness, testing is also done in drive-through to enable early identification and initiate contact tracing. Rwanda launched a monthly drive- and walk-through approach in the epicentre of Kigali City and other districts to enable understanding of epidemiological changes over time. In June 2020, Rwanda shifted the centralized case management approach towards decentralization and scaling-up capacities of public health and other interventions to respond to COVID-19, leveraging the existing health system. The paradigm shift involved home-based care for asymptomatic and patients with mild symptoms. The approach aimed to relieve the substantial burden the COVID-19 pandemic has placed on healthcare systems by maximizing available resources for managing and caring for people with more severe illness and also helps maintain essential health services. Currently, Rwanda is experiencing a second wave of infections similar to other regions. The National Task Force has been mandated to deploy surge capacity in terms of epidemic control, testing, contact tracing and home-based care. The findings from HMIS countrywide reports show there was no decrease in the number of visits as a result of stringent measures implemented during lockdown allowing those in need of medical services to access health services immediately in case of emergency. The implemented system was flexible enough to quickly turn medical students and nonmedical staff into frontline health providers for contact tracing and community surveillance, thus minimizing disruption of existing but important healthcare services during the lockdown.

As COVID-19 pandemic has put pressure on key sectors that contribute to the economic growth, a Recovery Plan has been put in place to support businesses and vulnerable households (food distribution, subsidized access to agricultural inputs, cash transfers, etc.). The informal economy workers have been particularly vulnerable to COVID-19

disruptions and have been included in support efforts. Women and girls, who account for a significant number, and in some cases the majority, of workers in high-risk sectors with a high likelihood of disruptions, faced a bleak job security threatening to push back the gains made on gender equality and exacerbate the feminization of poverty, vulnerability to violence, and women's equal participation in the labour force. Mitigating this risk will require high level commitment and more targeted investments to strengthen exiting social safety net programmes.

Implications for policy makers

At the time of writing this report, many countries are experiencing a second wave of COVID-19 infections and reaching new peaks in numbers of confirmed cases daily. Rwanda has sought to leverage previous investments in the healthcare system and preparedness capabilities built on previous outbreaks in the region. The COVID-19 pandemic underlines the need to further strengthen capacities to detect and respond to major public health events and threats. The social protection programmes must take into account poorer households as they are the most at risk to shocks from the pandemic. More effort is needed to mobilize, pool, and share resources during pandemic, including testing capabilities, trained and specialized human resources for health, and infrastructures to facilitate the quarantining of members coming from poor families.

Mission

To strengthen local capacity for conducting independent, rigorous inquiry into the problems facing the management of economies in sub-Saharan Africa.

The mission rests on two basic premises: that development is more likely to occur where there is sustained sound management of the economy, and that such management is more likely to happen where there is an active, well-informed group of locally based professional economists to conduct policy-relevant research.

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Contact Us
African Economic Research Consortium
Consortium pour la Recherche Economique en Afrique
Middle East Bank Towers,
3rd Floor, Jakaya Kikwete Road
Nairobi 00200, Kenya
Tel: +254 (0) 20 273 4150
communications@aercafrica.org