

What changes, and for whom

MedLink attaches a coded, countable reason to every clinical encounter — inside Rwanda's own systems, on Rwanda's own hardware. Nothing below requires a new form, new hardware, or a change to how anyone works.

FOR THE PATIENT

- Treatment that is not working is noticed at the second visit, not the fifth.
- No switch to an expensive second-line regimen when the real problem was a missed refill.
- A referral that was never completed is seen — and can be followed up.

FOR THE CLINICIAN

- Sees what happened to this patient at other facilities — invisible today.
- Two short questions, on a return visit only. No new form, nothing extra to fill in.
- Their judgment overrides the system, and the disagreement is recorded.

FOR THE FACILITY

- Its own results are visible to it as well as to the district — the same numbers, no separate report to file.
- Referrals it sends can be followed through to completion.

FOR NHIC AND ITS ANALYSTS

- A countable reason field inside data NHIC already holds — filtered and aggregated like any other.
- An observation layer across every facility — **which ones have problems, and of what kind** — without a single new report being filed.
- A second read on the surveillance NHIC is already building: counts catch a rise in what was coded; a reason catches the cluster recorded as something else. The two fail differently.

FOR MINISANTE AND RBC

- Separates **drug resistance** from **product quality** from **adherence** — three different responses, at three very different costs.
- Real-world drug effectiveness by district and patient profile, arriving as a by-product of care rather than a commissioned study.
- Shows exactly where the cancer and HIV care pathways break, and in which districts.

FOR RWANDA

- Personal data never leaves the country. The reasoning runs on-premise at NHIC.
- The trained adaptation, the vocabulary and every reason produced remain Rwanda's.
- Completes what eBuzima was built for: a record that follows the patient, not the facility.

It shows NHIC and MINISANTE where the problems are

Rwanda already knows how many patients each facility treated. No statistic currently shows how many of them got better. Accreditation and district competitions measure structure and process — is the protocol followed, is the register complete — because outcomes attributable to a facility cannot be seen today.

A coded reason changes what the count contains: how many were treated and came back, how many referrals were raised and never completed, **where a diagnosis did not hold up at the next visit**. Aggregated by facility and by district, that is a map of where care is breaking down — built from encounters already being recorded, with no new inspection and no new form.

These are the problems that never reach a report: a course that did not work, a condition treated as something else, a patient nobody followed. Individually small, collectively expensive, and each one leaves a trace in the record. MedLink shows where outcomes are worse — **it tells you where to look**.

No new data collection. No new hardware. No change to any prescription.

Year one explains records that are already complete — text only, on the analytics tier, with no regulated device in scope. MedLink never says what to give; a clinician always decides. Where the evidence is insufficient, the system writes nothing at all.