

# RWANDA'S STORY:

Progress on health in  
Rwanda: Leadership,  
performance and  
health insurance

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## Development Progress



## Progress on health in Rwanda:

### Leadership, performance and health insurance

#### Key messages

1. Rwanda, a very low-income country, has made significant progress in increasing the quality and quantity of health services and in improving health status, through an effective national but decentralised public health programme.
2. Community health insurance, improved service quality through performance-based financing (PBF), decentralisation and the extension of community-based services have all been critical to improving Rwanda's health status. Government's ability to develop and scale up based on participatory consultation and grassroots evidence has also facilitated improvements.
3. Strong leadership, vision and accountability mechanisms at all levels are vital to successful health sector reforms. Additionally, effective coordination of donor funding and true government–donor partnership have brought ideas and good practices into the country and ensured that aid is used effectively and aligned with national priorities.

“Rwanda has made remarkable improvements in the health status of its population.”

## Summary

Four years of civil war and genocide in Rwanda took the lives of almost 1 million people, leaving the country in a state of almost total collapse in 1994. While 60% of the population still lives below the poverty line, in only 16 years the country has made remarkable improvements on key health indicators, including: infant and child mortality; immunisation coverage; use of family planning; malaria mortality and morbidity; and HIV prevalence.

Progress can be attributed to ambitious reforms in the health sector, including introduction of community health insurance and boosting of services through staff incentives and PBF schemes. Strong leadership, vision and commitment have also been key. Participatory decentralisation, including extensive use and formalisation of community health workers (CHWs), has brought services closer to communities and empowered them to participate in their own development. Meanwhile, effectively coordinated donor assistance has been instrumental in achieving such remarkable outcomes in the Rwandan health sector.

## What has been achieved?

Rwanda has made remarkable improvements in the health status of its population.<sup>1</sup> Although there are still health inequalities between urban and rural areas, among income quintiles and by gender, most improvements have benefited the poor and enhanced equity. However, it is important to recognise that these outcomes started at a very low base post-civil war and genocide.

### Improved life expectancy and reduced child mortality

Life expectancy at birth went down to 25 years in 1994 but recovered to 50 in 2008. Meanwhile, in infant and under-five mortality, the former went from 129 to 62 deaths per 1,000 live births and the latter from 219 to 103 between 1994 and 2007.<sup>3</sup>

A key factor in this is the increase in immunisation coverage: the proportion of one-year old children immunised recovered rapidly after 1994, to surpass pre-genocide levels. Disparities of coverage are also extraordinarily low. While the rich-poor gap remained around 3% in 2000-2007, rural-urban and gender disparities almost disappeared, both going from around 3% to 0.6% in the same period.

**Table 1: Key indicators of progress<sup>2</sup>**

	Pre-genocide	Post-genocide	Most recent	Source
Life expectancy	33 (1990)	29 (1995)	50 (2008)	World DataBank
Under-five mortality rate per 1,000 live births	151 (1992)	219 (1994)	103 (2007)	IDHS 2007-08
Immunisation coverage (measles)	82% (1992)	25% (1994)	90.4% (2008)	IDHS 2007-08
Children underweight under five	24% (1992)	20% (2000)	15.8% (2008)	DHS 1992, 2000, CFSVA & NS 2009
Maternal mortality ratio (MMR) per 100,000 live births	N/A	1,071 (2000)	750 (2005)	DHS 2000, 2005
Total fertility rate	8.3 (1983)	6.1 (2000)	5.5 (2007)	IntraHealth 2009
Contraceptive prevalence	13% (1992)	4% (2000)	54.7% (2010)	DHS 2000, KiIs
Antenatal care (ANC) (at least four visits)	N/A	13% (2005)	25.9% (2007)	DHS 2005, IDHS 2007-08
Births attended by skilled health personnel	26% (1992)	31% (2000)	52% (2007)	Basinga et al. 2008, IDHS 2007-08
Malaria morbidity	N/A	73.5% (2001)	15% (2007)	World Bank 2009, based on MoH 2009
HIV prevalence (Kigali city)	N/A	16% (1998)	11.5% (2007)	World Bank 2009, based on MAP ICR 2009
Health infrastructure	29 hospitals 302 health centres (1990)	29 hospitals 348 health centres (2000)*	38 hospitals 411 health centres (2007)	MoH Annual Report 2000, 2007

Note: \* Most facilities had to be rebuilt between 1990 and 2000.





### Child nutrition achievements

While malnutrition is still high, underweight and severely underweight prevalence among children has decreased. However, chronic malnutrition (stunting) is on the rise, going from 48% in 2000 to 52% in 2009.<sup>4</sup> Malnutrition has been identified as a barrier to further improvements in health: in 2009, a presidential initiative prioritised the issue by endorsing a new protocol for its management.

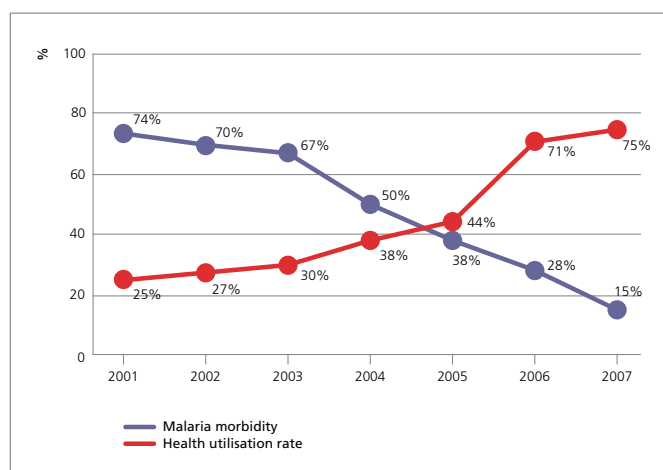
### Reduced maternal mortality and increased ANC and birth attendance

The MMR dropped by 30% between 2000 and 2005. Although no more recent data are available, improvements in use of ANC and birth attendance by skilled staff suggest that the MMR might have fallen further. Improvements in birth attendance were larger in the poorest quintile, going from 17.6% in 2005 to 42.7% in 2007; in the wealthier quintile, the rise was from 61.3% to 70.6%, meaning the poor-rich gap reduced by 36%. The rural-urban gap also reduced, by 34%, and access to ANC in rural areas increased more than in urban areas (84% and 47%, respectively).

### Decreased malaria mortality and morbidity and low HIV prevalence

Malaria morbidity in health centres has reduced<sup>5</sup> and higher use of clinics has helped drive down incidence. The malaria mortality rate has also fallen, from 10.1% in 2001 to 2% in 2007.<sup>6</sup> Meanwhile, HIV prevalence reduced from an estimated 13% in 2000 to 3% in 2007. This drop has been driven by decreases in urban areas; in rural areas, prevalence seems stable, at around 2%.<sup>7</sup>

**Figure 1: Malaria morbidity in health centres and health utilisation rate, 2001-2007**



### Improved infrastructure and personnel

Improvement of infrastructure, especially in rural areas, has expanded access to health services. Nowadays, 60% of the population lives within 5km of a health centre.<sup>8</sup> The sector still suffers from a serious shortage of skilled personnel, although estimates suggest the health workforce increased in the range of 36% to 62% between 2005 and 2008.<sup>9</sup>

### What has driven change?

#### The demand side: *Mutuelles*

Community health insurance (*mutuelles*) has been key to removing financial barriers to health services. Aimed at spreading the financial risk of seeking care across their membership base, *mutuelles* have enabled people to access services at an affordable cost and before their condition worsens, thus also reducing treatment costs. This has led to increased demand and uptake of health services. Those who cannot pay, according to communities themselves, are supported by the government or development partners. The success of *mutuelles* is in part a result of government ability to enforce local implementation.

1 While improvements in health have been analysed within the post-genocide period, when possible data on the situation before 1994 are used to put into perspective the progress made.

2 The periods shown in the table differ as a result of data availability constraints.

3 IDHS (2007-08): MoH, NISR and ICF Macro (2008) *Rwanda Interim Demographic and Health Survey 2007-08*. Kigali and Calverton, MD: MoH, NISR and ICF Macro.

4 Underweight represents low weight for age. Wasting is low weight for height, which is a strong predictor of mortality among children under five. It is usually the result of acute weight loss or significant food shortage and/or disease. Stunting is low height for age and is caused by long-term insufficient nutrient intake and frequent infections. It represents chronic malnutrition and effects are largely irreversible.

5 World Bank (2009) 'Rwanda: A Country Status Report on Health and Poverty.' Kigali: MoH and World Bank, based on MoH (2009) 'Health Sector Strategic Plan July 2009-June 2012.' Kigali: MoH.

6 WHO (2009) 'WHO Country Cooperation Strategy, 2009-2013 Rwanda.' Brazzaville: WHO Regional Office for Africa.

7 Abbott, P. and Rwigira, J. (2010) 'Millennium Development Goals Rwanda Country Report 2010.' Kigali: UNDP.

8 MoH (2009).

9 World Bank (2009).

“Partnership between government and donors has been crucial to Rwanda’s progress.”

### The supply side: PBF and human resources

The government instituted PBF to boost the quality and quantity of health services. PBF incentivises health outputs/results by supplementing health facilities and the salaries of health workers on a performance basis. It establishes a direct link between service delivery, results and payment through a set of quantitative and qualitative indicators against which performance is measured.

Service delivery has also been strengthened by improving staff quantity and quality, eliminating salary disparities for comparable jobs within the sector and training and encouraging staff to improve their qualifications.

### Political leadership, accountability mechanisms and policymaking

Rwanda’s central leadership and control structure is devoted to development, and there is a national commitment to using (multidimensional) poverty reduction as a means of healing. Strong leadership and vision have been key to the strategies and policies that lie behind health sector reforms.

Leadership from the tip has also been critical in developing effective governance and accountability procedures for implementing policy: performance contracts are a means of enforcing social duties and obligations, and all levels have to comply with systematic evaluations and standards. Additionally, policies are evidence-based and informed by participatory consultation with all sectors of society. Once a pilot initiative proves successful, it is scaled up to national level.

### Decentralisation, community participation and CHWs

Decentralisation of health services has given district health departments the responsibility for organising district health services, managing resources and drug supplies in hospitals and supervising CHWs.<sup>10</sup> Being closer to the people, the district is better positioned to identify and address needs more efficiently and effectively. In addition, integration of CHWs into the local government health structure means they have become the final tier in the decentralisation of health care at village level. They have a key role

in sensitising the population and intervening in and preventing health problems before they become serious.

### Coordination of development partners

Partnership between government and donors has been crucial to Rwanda’s progress. The government has played a proactive role in coordinating and leading donors, getting them to live up to Paris Declaration principles of alignment and harmonisation in support of government ownership and leadership. More donor finance is now channelled through sector budget support, and global fund programmes are better integrated with national needs, thereby reducing distortions in priorities. Donors, meanwhile, have played a positive role in spreading ideas and good practice.

### Lessons learnt

The Rwanda case offers important lessons. Note that the commitment of very powerful national leadership to effective implementation and accountability at local level has driven success in Rwanda: other countries may have differing capacities to take advantage of these lessons.

- Strong governance and accountability mechanisms and zero tolerance of corruption are essential to the successful implementation of strategies and policies. Good communication between levels, together with regular evaluations, ensures rules are followed and objectives accomplished according to quality standards.
- Political leadership has fostered Rwanda’s health reforms and accountability mechanisms and been decisive in engaging the population in the country’s development.
- *Mutuelles* have increased utilisation of health services by underserved populations. Major changes in health-seeking behaviour and in ownership have come partly from the financing and partly from the participation that comes with membership.
- Performance-based incentives enhance staff commitment to work to higher quality standards. Strict controls and quality checks are essential to monitoring and evaluation of performance.

10 Basinga P, Sekabaraga C. and Soucat A. (2008) ‘Scaling Up Innovation in Services Delivery of Primary Health Care: Case of Rwanda.’ Prince Mahidol Award Conference 2008. Bangkok, 30 January-1 February.



- Evidence-based policies and piloting of strategies prior to scale-up also contribute to more successful outcomes.
- Involving all stakeholders in the planning process, including development partners and the community, is more likely to result in successful outcomes and in ensuring they match people's needs.
- Decentralisation allows local government to deal directly with local needs, and involving communities guarantees ownership. A clear decentralised structure of responsibilities also reduces overlap between different administrative levels, and the proximity of sectoral departments favours multidisciplinary approaches. Effective decentralisation depends on national leadership and accountability systems, though, which may not be present in other countries. Effectively integrating CHWs into the decentralised health system has also enhanced the uptake of basic health care services and the sensitisation of community members on health, hygiene, nutrition and sanitation.
- International donors have played an important role, through both budget support and generation of evidence on other successful schemes. Constant dialogue and coordination between donors and government has ensured funding is aligned with national priorities and used effectively and efficiently.
- Integrating vertical funds in the health sector has strengthened the health system, allowing for the support of underfunded components.

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