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Learning from Success: How Rwanda Achieved the Millennium Development Goals for Health

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Summary. — Although it is one of the poorest countries in the world, devastated by the 1994 Genocide against the Tutsi and heavily aid-dependent, Rwanda has achieved most of its Millennium Development targets for health. This article discusses how it managed this, when many countries in Sub-Saharan Africa failed to achieve theirs, and assesses the sustainability of its solutions. Determined government policies involving investment in health and education and their energetic implementation with the support of development partners are identified as ultimately responsible for this success in improving the lives of ordinary Rwandans. The major mechanisms for implementation have been the provision of relatively local health centers, payment of health providers by results, setting up an affordable health insurance scheme (with support for those most in poverty) and the appointment of volunteer Community Health Workers who are unpaid but are encouraged and supported to form cooperatives for their own and their families' support. The effectiveness of this level of community involvement suggests that the "Sustainable Development Goals" which replace the MDGs may also be attainable. A marked reduction in Official Development Assistance because of the success would be counterproductive, however, probably putting the cost of medical and preventative supplies beyond the reach of the average Rwandan citizen.

Key words — Rwanda, Sub-Saharan Africa, Millennium Development Goals, community health provision, official aid for health provision

1. INTRODUCTION

Rwanda is one of the poorest and most aid-dependent countries in the world. It is the most densely populated country of the African mainland, depends on agriculture, is landlocked, hilly and heavily forested, lacks exportable natural resources, has a workforce that is still not well skilled or educated (despite determined efforts to overcome this) and has spent the last twenty years rebuilding its physical, economic and social infrastructure after the devastating 1994 Genocide against the Tutsi. Its colonial background is more like that of the Congo, which struggles even to maintain itself as a coherent state, than that of the remainder of the East African Community, which it is outperforming in several respects. Nonetheless it has achieved its MDG targets for health. This paper discusses how it managed this, against the odds, when many countries in Sub-Saharan Africa failed to achieve their targets. The article concludes with a discussion of some of the challenges Rwanda still faces in improving the health of the country in the context of the post-2015 Sustainable Development Goals.

In 2000 the United Nations agreed a set of Goals with measurable targets to be achieved by 2015, the Millennium Development Goals (MDGs), for reducing poverty and improving the health, wellbeing, and quality of life of people living in developing countries. The underlying aim of the MDGs is to give people control over their lives and let them follow a way of life that they value (Sen, 1993). The MDGs have formed the basis of a global partnership for development and have become a key metric for measuring the performance of developing countries in addressing critical development challenges, including health. While originally framed as global targets they have been widely applied as national ones, with regular updates published by the United Nations on the progress that countries are making. They measure progress to achieving the targets between 1990 and 2015 with indicators that are to reach 100% (for example, 100% of one-year-olds vaccinated against measles), or achieve a proportional reduction/increase (for example, reducing the maternal mortality rate by three quarters between 1990 and 2015), or else they just express an open-ended expectation of progress.

Rwanda has been widely recognized as one of the most successful countries in Africa for the general social and economic progress it has made over the last 15 years (Collier, 2010) and specifically for developments in health (Abbott, Sapsford, & Rwirahira, 2015a; Chambers & Booth, 2012a; Collier, 2010; Farmer *et al.*, 2013; Pose & Samuels, 2011). Not only has it made significant progress on a range of development indicators, but on many of these it has narrowed the gap between the poorest and the better off. Rwanda's success has been attributed to Developmental Patrimonialism and the political settlement among potential ruling groups—see Golooba-Mutebi and Booth (2013). ("Patrimonialism" involves a mix of impersonal/bureaucratic and personal/clientelistic forms of rent allocation, but the qualifier "Developmental" is intended to convey that the aim is enhancing their own *and others*' income in the long run, rather than short-term income maximization, and is allied in their writings with a political settlement which looks beyond clients or allies to the population as a whole—see Booth and Golooba-Mutebi (2012). The priority has been investment in the development of the country, with government through dialog and consensus, a rigorous suppression of corruption at all levels and mainly pro-poor evidence-based policies. Despite high aid intensity, Rwanda has managed to develop the good institutions which

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are arguably essential for social and economic progress and to increase its own tax revenues.

The MDGs were set as eight goals with targets for 2015 and a series of indicators for measuring progress. Three of the Goals were specifically related to health: a substantial reduction in child mortality; a substantial improvement in maternal health, and a reduction in the incidence of HIV/AIDS, malaria and other diseases (represented by tuberculosis)—see Table 1. We also include improving child nutrition and eradicating extreme poverty and hunger, a target under MDG 1.

The data used to measure progress are mostly taken from Rwanda Demographic and Health Surveys for 1992, 2000, 2005, 2010, 2014–15 and the Interim RDHS 2007/8. These are referred to throughout the report as RDHS. The data are mostly taken from the published reports which are available on the website of the National Institute of Statistics of Rwanda (http://www.statistics.gov.rw/publications) or from original analysis of the microdata available there (http://www.statistics.gov.rw/surveys). The surveys have been carried out by the Government of Rwanda with support from teams of international experts, on large representative samples, and have been approved by the Rwandan National Research Ethics Committee.

2. RWANDA'S PERFORMANCE

(a) *Child malnutrition*

There has been a decline of 20 percentage points since 1992 in the proportion of underweight children in the population, and the MDG target of 14.5% was achieved between 2005 and 2010 (Figure 1). However, nearly half of all Rwandan children show other signs of malnutrition, with 38% stunted (under height for age)—see RDHS (2014/15). Stunting is an avoidable condition and is not simply a product of poverty

Table 1. *Millennium development goals for health*

Goals and targets	Indicators for monitoring progress
Goal: Eradicate extreme poverty and hunger	
Target: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	• Prevalence of underweight children under-five years of age • halving the proportion of people who suffer from chronic hunger (i.e., those in extreme poverty)
Goal: Reduce child mortality	
Target: Reduce by two-thirds, during 1990–2015, the under-five mortality rate	• Under-five mortality rate • Infant mortality rate • Proportion of 1 year-old children immunised against measles
Goal: Improve maternal health	
Target: Reduce by three quarters, during 1990–2015, the maternal mortality ratio	• Maternal mortality ratio
Target: Achieve, by 2015, universal access to reproductive health	• Proportion of births attended by skilled health personnel • Contraception prevalence rate • Adolescent birth rate • Antenatal care coverage (at least one visit and at least four visits) • Unmet need for family planning
Goal: Combat HIV/AIDS, malaria and other diseases	
Target: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	• HIV prevalence among population aged 15–24 years • Condom use at last high-risk sex • Proportion of population aged 15–24 years with comprehensive correct knowledge of HIV/AIDS
Target: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	• Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	• Incidence and death rates associated with malaria • Proportion of children under 5 sleeping under insecticide-treated bed nets • Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs • Incidence, prevalence and death rates associated with tuberculosis • Proportion of tuberculosis cases detected and cured under directly observed treatment short course
Goal: Develop a global partnership	
Target: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	• Proportion of population with access to affordable essential drugs on a sustainable basis

Source: United Nations (1999).

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