DEVELOPMENTS IN HEALTH IN RWANDA AFTER THE GENOCIDE

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Background to Rwanda

General

- Small landlocked country dependent on transport by road/air
- Temperate tropical climate; four seasons with dry season from June till mid-September; 2/3 harvests/year
- Altitude varying between 1,200 and 2,000m, Volcanic area in North-West ("Country of the thousand hills")

Economy

- 85-90% subsistence farming
- Coffee and tea main exports, no major mineral deposits found
- GNP increased by 60% during 1980-1989, while per capita income during the same period increased by 10%
- Increased defence spending from 1990 onward

Demographics

- Population approx. 7 million inhabitants
- Population density highest in Africa, 300 400 INH/KM2
- Population increase approx. 3.5%, doubling every 20 years; fertility rate high i.e. 6.7 live births/woman (one of highest in world); post-war/genocide baby boom
- 50% of population below 18 years
- 70% of households female-headed

Political

- German and Belgian colonial past
- Independence from Belgium in 1962
- Centrally run by one party till 1994; Since July 1994 broad based transitional government
- Country is divided into 12 regions, 150 communes, 1,000 sectors and 8,500 'cellules'.

National Health Policy

Main Orientations of National Health Policy

- Integration of National Health Policy in the National Development Policy

- Equity
- Integrated Primary Health Care

Main Strategies

- PHC Approach
- Decentralisation District Health System
- Community Participation
- Human Resource Development
- Development of Pharmaceutical Sector
- Legislation: Medical and Nursing Councils, Private Sector, Pharmaceutical Sector
- Strengthening of Health Information System

Health systems

Health Services

- 286 Health centres, 32 District/Rural Hospitals, 3 Referral Hospitals and 1 Specialised (Psychiatric) Hospital, 134 Private Clinics
- Hospitalisation capacity, primary and secondary levels: 1 bed per 600 people (bed occupancy rate 35% at the Health Centre Level)
- Infrastructural development ambitious with big health centres and absence of standards for equipment
- Human resources inadequate in quantity and quality

Type of Services

- 48% Government-run health facilities
- 40% Church-owned health facilities
- 12% Private, mainly in urban setting
- Traditional sector with 1,500 traditional healers and unknown number of traditional birth attendants

Expenditure in Health Sector (Data from 1984)

Contributors	
• Domestic	50.2%
• Foreign/External	49.8%

MOH Budget (Data from 1984)

- 19.3% Primary Level, 60.3% Secondary Level , 20.4% Tiertiary Level
- Total expenditure on PHC[12] 1984 was 8% of total expenditure on Health and 20% of MOH Expenditure:
- Domestic 66% (Government 17%, Individuals 49%)
- Foreign/External 34% (Bilat/Multilat. 31%, NGOs/Missions 3%)

Equity Access

- 80% of population lives within 5km / 1 hour's walk from H.C.
- Cost Recovery system introduced early 80s by church-owned facilities and in 1989 by Government facilities; mainly drug revolving fund, charges for curative and preventative services, including MCH services

Situation after the war and genocide

- 80% of qualified human resources killed or became refugees, including 110 of 310 required medical doctors, 700 of 2,300 required nurses and 0 of 1,400 required midwives in country
- Senior Health Professionals have insufficient previous exposure to management and planning process
- Looting and destruction of health infrastructures and capital items on a large scale. Evaluation September 1994 calculated $30million required for physical rehabilitation and replacement of equipment and capital items of primary and secondary facilities
- 91 % of Health Facilities operational, 47% of infrastructures completely rehabilitated and 41% of Health Facilities are equipped according to standard equipment requirements (NB: standard equipment list introduced in 1994)
- 95% of Health Facilities re-introduced user charges
- GOR revenue extremely limited, economic recovery very slow => hea vy dependence on donor finance
- Donor funding channelled through multilateral and bilateral agencies and international NGOs

Challenges in the New Economic Order

- Continued instability in the Great Lakes Region
- National Health Policy programme = PHC, DHS
- The MOH budget 1996: 3.9% of GOR budget (=$0.7/INH./YR versus $12 recommended by the World Bank)
- Low motivation of Health Professionals
- Financing of Health System problem. New approaches necessary
- Planning process started, constrained by lack of experience and pressure of international community
- Donors have own agenda; focus on financing of parts of National Health Programme; irrational expectations of human resource development (too much funds for too few people with time for and experience in training)
- Emphasis of donors on capital investments; insufficient focus on recurrent costs.