

RWANDA'S PROGRESS ON HEALTH MDGs

The performance of the Rwandan Health Sector, in the last 10 years also, has been impressive. The robust performance is typified by better health outcomes, in which Rwanda is on-track for most health related MDGs. This can be attributed to strong Presidential leadership and a clear vision of purpose interwoven with community participation. The long term vision is spelt out by Vision 2020 and the Health Sector Policy and the MDGs, which are operationalised through a medium term framework defined by the EDPRS and the Health Sector Strategic Plan (HSSP). Both of these instruments are in their second generation of implementation.

The said progress being achieved against several odds due to the war and genocide, which destroyed the social fabric and capital, health infrastructure (both human and material), and significantly reduced health outcomes. For instance, maternal mortality rate increased from 611 in 1992 to 1,071 by 2000. This also makes benchmarking Rwanda's MDGs to 1990 data unrealistic, since the health outcomes worsened in the subsequent years.

MDG1: Eradicate extreme poverty and hunger: MDG Target 1.C: Halve, between 1990 and 2015, the proportion who suffers from hunger.

In the area of fighting malnutrition, the most recent figures available are those from the Demographic and Health Survey (DHS) of 2005, and they indicate that the country is off-track for MDG1. However, we expect child nutrition to improve. Because the major issue here is not actual lack of food but a need to change our people's nutritional habits. In July 2009 following the Presidential visit to Kirehe, a national emergency nutritional plan was developed. All children under 5 years of age were screened for malnutrition, TB and HIV followed by therapeutic feeding and treatment. In November of the same year, a Nutrition Summit was held followed by the elaboration of the National Strategic Plan to eliminate malnutrition. This program bolsters the government's advocacy efforts for a sustained and integrated multi-sectoral response to nutrition.

MDG4: Reduce by two-thirds, between 1990 and 2015, the under five mortality rate.

For MDG 4, child mortality, Rwanda is on-track. For example the under-5 child mortality ratio, during the same 2005-2007/8, dropped from 152 to 103 per 1000 live births, equivalent to 33% drop in number of deaths. Infant mortality dropped from 86 to 62 per 1000 live births in the same period. Going by these trends of drastic decrease in child mortality in a period of 2 years, as well as the GOR efforts to achieve this MDG, Rwanda is definitely on TRAC

for MDG4.

The leading causes of childhood deaths in Rwanda continue to be from preventable diseases such as pneumonia, malaria, and diarrhea. Providing access to oral rehydration therapy, bed nets, immunization, anti-malarial drugs and proper nutrition continues to be a primary priority for the Ministry of Health. The introduction of Community Health Workers (CHWs) is already instrumental in getting children treated within 24 hours of onset of fever, pneumonia and diarrhea.

MDG5: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

The number of women dying while giving birth declined from 1,071 in 2000 to 750 per 100,000 by 2005. During 2008, Rwanda's maternal mortality ratio (MMR) was estimated to be 383 per 100,000 live births. Related indicators show that the percentage of pregnant women attending at least one Antenatal Care visit reached 95% in 2007/8 (DHS). The number of assisted births increased from 28.2% to 45% (DHS 2005-2007/8), and using routine data collection this figure is reported to be 66.2% (HMIS 2009). Going by these changes, Rwanda will be on-track for MDG 5.

The primary causes of MMR are complications associated with spontaneous or induced abortion, post-partum hemorrhage and obstructed labor. These are challenges that require serious solutions.

Several strategies have been put in place to answer the various challenges of health care delivery in Rwanda. We have taken concrete steps to address healthcare financing throughout the country. Community health insurance has been expanded, as has performance-based financing. We are also addressing the capacity of our health workforce to confront challenges we find at various levels of our health system. This is through imparting skills that reinforce family planning, improving antenatal care and obstetrical emergency care, improving access to assisted childbirth, and increasing HIV/AIDS screening and treatment for expectant mothers.

The recent introduction of maternal death audit in early 2009, at community and facility level, linked with IMIHIGO, localizing MDGs, RapidSMS, an SMS based alert system for critical events in the maternal and/or newborn/child cycles up to 9 months, emergency transportation, construction and renovation of health facilities.

MDG6: combating AIDS, TB and malaria

The country has made considerable progress in combating AIDS, TB and malaria and will achieve MDG6 before 2015. It has already achieved the MDG targets for malaria and TB and is on-track for HIV/AIDS.

The prevalence and incidence of HIV is one of the lowest in Sub-Saharan Africa from a high of about 13%. The MDG target for TB detection and cure of 85% has been achieved and surpassed since 2006.

The fight against malaria has entered into the WHO-malaria-defined pre-elimination phase after achieving and surpassing all MDG targets for malaria. For instance, death due to malaria has dropped from 40.6% to 16.2% between 2000 and 2007/8 (DHS) and the number of severe malaria cases fell by 32.3% between 2006 and 2007. The percentage of under-5 children dying from malaria decreased from 5.7% to 0.3% between 2005 and 2007 (DHS). Likewise, the country achieved and exceeded the prescribed MDG targets for using ITNs by children and pregnant women 2 years ago (2008).

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