

Progress in the Wake of Destruction: a Theoretical Analysis of Post-Genocide Rwandan Public Health Funding

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Abstract

In the years following the Rwandan Genocide, Rwanda found itself utterly devastated on all fronts. Infrastructurally incapable of addressing the dire circumstances of its citizens, the Rwandan Patriotic Front—led by current Rwandan President Paul Kagame—was tasked with rebuilding from a level of destruction few countries have ever witnessed. Despite the seemingly irrecoverable scenario, in a matter of decades, the country boasted one of the most developed public health systems in East Africa, with HIV treatment now universally accessible in Rwanda, and maternal/infant mortality rates improving dramatically. In the wake of this progress, the question as to how Rwanda’s Ministry of Health was capable of accomplishing such unprecedented public health improvements is raised, especially in the context of the often fraught process of developing countries attempting to fund their own progress. The path to progress for Rwanda hinged on the Ministry of Health’s ability to adequately garner and distribute funding without hindering or distorting the goals of existing policy, and this paper is dedicated to understanding how this was accomplished. Methodologically, this involves the synthesis of two theories of political economy (neopatrimonialism and dependency theory) to develop a coherent structure on what political-economic aspects of funding (and other forms of resource allocation) stagnate growth the most. This structure, based on three variables (policy equity, policy appropriateness, and funding source) is used to then understand how these stagnating features were circumvented by the Ministry of Health, through analysis of annual public health reports published by the government and related organizations, along with external case studies. It is concluded that ministerial autonomy in policy creation and implementation through distribution of funding was significant in accomplishing desirable public health outcomes.

Keywords

Rwanda, Post-Genocide, Public Health, Funding Source, Autonomy, Neopatrimonialism, Dependency Theory, Political Economy

Introduction

In the years following the Rwandan Genocide, Rwanda found itself utterly devastated on all fronts. Infrastructurally incapable of addressing the dire circumstances of its citizens, the Rwandan Patriotic Front—led by current Rwandan President Paul Kagame—was tasked with rebuilding from a level of destruction few countries have ever witnessed. Some of these rebuilding projects seemed virtually impossible—such as the attending to of the enormous HIV infection rate following genocide-provoked mass sexual violence. Millions of rural, suffering Rwandans had no health resources or medical support (Drobac, 2014). Furthermore, infrastructural collapse exacerbated existing problems with malaria, cholera, and childhood malnutrition; less than 5% of the country had access to clean water in the genocide’s aftermath (WHO, 2012).

Infrastructural eradication as catastrophic as what Rwanda experienced often ends in a vicious cycle of stagnation for developing countries. The same destruction that brings immense suffering for the populace simultaneously makes it impossible to improve the situation, as adequate resources to do so are no longer present. This often leads countries in Rwanda’s situation to rely on the prayer of “aid,” otherwise known as goodwill from institutions of the Global West, compelling the flow of capital from those who have it to those who need it to survive. However, this is not a sinless transaction in itself. Many theories of political economy describe weaknesses in the paradigm of aid, capable of causing corruption or exploitative relationships argued to be worse than the initial circumstance itself. At the turn of the century, every possible path for development for Rwanda—of which there were few—carried its own ruinous perspective.

The ending of this story bears miracles that should not be left for the conclusion of this paper; HIV treatment is now universally accessible in Rwanda, and by 2014, two decades after the genocide, the rate for mothers dying in childbirth and children dying before age five decreased by 50% and 75% respectively. The reformed Ministry of Health, now in an infrastructural position to provide advanced health services such as vaccinations and nutritional plans similar to countries with GDP many percentiles above Rwanda, acts as one among many sources of stability for Rwandans that pulled a million citizens out of poverty between 2005 and 2011 (Drobac, 2014).

This astounding progress—especially from the complete and utter devastation it rose from—stands for many institutionalists as one of the most profound accomplishments of the developing world in working with systems of the Global West. However, as the dire circumstances of many other developing countries stand to contradict the efficacy of the current global system, we stand to gain invaluable knowledge for the future of global development by asking the core question: what made Rwanda the exception? In order to understand this question, an analysis of sources was conducted, including subsequent distributions of Rwandan public health

funding from the late 1990's to the present. These findings underwent interfacing of theoretical expectations and outcome data found through censuses, ministry reports, and external data collection to determine the domestic and foreign aspects that were significant in creating the unprecedented progress in public health Rwanda. Our findings can likely be transposed to developmental public policy as a whole, as the political economic theory outlines relationships of resource allocation found outside exclusively public health. Yet, within this sphere, where funding allocation is so incorrigibly tied to the well-being of a group of people, theoretical expectations become established at their most intimate and dire.

Theory

Connections

To answer the core question of Rwanda's exceptionality, it is necessary to isolate specific aspects relevant to our independent (funding source) and dependent (public health efficacy) variables. To accomplish this, the methodological framework must be zoomed out to acknowledge existing work in uniting these variables outside of public health, as a paradigm of resource utilization and outcome detailed in political economic theory.

The two theories (dependency theory and neopatrimonialism) interfaced in this paper describe specific junctures between political-economic entities in which resources become allocated in a manner harmful to the growth (in this case public health development) of a developing country. Public health reform, like any other manner of state progress, relies on the proper allocation of resources to function—the state must be capable of adequate sustainable funding and equitable distribution of this funding to address the needs of its population, which necessitates circumventing the natural weaknesses (corruption, exploitation) of these polity junctures.

Dependency theory examines the juncture between the state and Western states/entities, in which the capability for the latter exploiting the former's resources stifles growth. It posits that the relationship between the developed and developing countries themselves (or the "core" and "periphery") is what keeps some nations underdeveloped, and developing nations prosperous. Andre Gunder Frank, its father, outlined an exploitative trade relationship from the periphery nations to the core, in which resources extracted from the periphery at a low cost flow to the core, and in exchange, the periphery receives the necessary finished goods and technology that only the core countries are in the infrastructural position to create. Because of the reliance on these core nations for these finished goods, along with ensnaring loaning and financing practices from core countries and their institutions, the periphery forever remains dependent on the system that stagnates it.

Accordingly, applying a lens of dependency theory on the international financing of Rwanda's domestic public policy creates the expectation of diminished policy appropriateness for the domestic circumstance at hand, all else being equal. As the core-periphery relationship remains in the funding paradigm, with capital from the core replacing domestic infrastructural progress as the vehicle for policy execution, the priorities of the core become reflected in domestic policy. This could be reflected in policy incentive structures with clear capital flow back into the NGOs or their home countries that supported it in the first place; possibly through landleasing in infrastructural restoration projects or microfinancing risk pools. Of course, nothing in this sphere is executed without some personal gain, but we can examine the rate at which west-oriented policy decreases or increases as the circumstances of the Ministry changes.

Neopatrimonialism examines junctures between the domestic party (which takes a uniquely authoritative role in Rwanda's case), state organizations (the Ministry of Health being the primary organ under assessment), and its citizens in which improper party usage of resources stifles growth. The theory describes a source of developmental stagnation in which state resources (finances, land, or in drastic cases military action) and their orderly pathways are hijacked by the existing regime to maintain loyalty in a nation's population, otherwise known as clientelism. This clientelism is attributed to being the main cause of underdevelopment in post-colonial nations, primarily in Africa. To achieve desired development in these nations, these neopatrimonialist systems of maintaining order must undergo bureaucratic reform and finance management to organize manners of generating party compliance and following development. The neopatrimonial expectation for RPF control of funding schemes for ministerial public policy is that policy equity will be diminished as state resources are used throughout informal structures with a focus on securing party compliance, as a part of the circumstance of a developing, and particularly a post-colonial, nation.

As dependency theory focuses on international junctures and neopatrimonialism focuses on domestic ones, the blind spots of one theoretical framework are often attended to by another. Therefore, converging them is paramount, as dependency theory can be used to analyze the capital transactions of the Rwandan government at a scale involving foreign entities (primarily through aid), and then, neopatrimonialism can be used to examine how that capital is distributed to execute policy on a domestic scale. This convergence allows us some form of analytical parallax, as the combination of the two theoretical lenses upon the image of outcomes illuminates specific aspects of interministerial and foreign policy reform inaccessible in a single framework.

Theoretical Applications and Variable Identification

To analyze the role of funding in Rwanda's public health policy efficacy, the concept of policy efficacy has been split into two dependent variables, the former detailing quality of content and the latter detailing quality of execution: policy appropriateness (the relevance of policy to the domestic circumstance) and policy equity (the fairness of policy resource allocation to target groups). The manner in which policy appropriateness diminishes with internationalization of funding is outlined in the theoretical expectations of dependency theory, while the manner in which policy equity diminishes with funding domesticization is outlined in the expectations of neopatrimonialism. As Rwanda's international funding ballooned in the late 90's, and then shrank throughout the mid-2000's, we are capable of comparing real outcomes in policy efficacy against both theoretical expectations concerning both variables that compose policy efficacy itself, coming to a greater understanding of the causality of the real outcomes themselves.

When converting theory into practice, how will these variables be identified?

Policy appropriateness itself is the relationship between the things needed to be addressed within the domestic situation and the content of the policy addressing it- the further those two diverge, the less appropriate the policy is. We can determine the things needed to be addressed through affirmations of such things by Rwanda and humanitarian organizations; statements on what is needed to be done in multilateral agreements, or within the minutes of tribunals and committees assessing the damage done by the genocide, etc. The content of the policy will be compared to such assessments in determining appropriateness.

Policy equity is a slightly more subjective undertaking, but it can still be reliably demonstrated in variations of policy access across certain demographics; rurality, gender, and economic status are the three demographics most worth paying attention to, considering the target groups of Ministry policy.

Before we enter the outcomes themselves, we can unify theoretical expectations into a preliminary historical hypothesis: as international funding increased sharply from the late 90's to the early 2000's, we can expect the appropriateness of public health policy to decrease, while equity would be relatively high. As international funding waned starting in the mid-2000's, we can then expect the opposite, as the policy content would be controlled by those more close to the domestic situation, and increase in unconditional party control of funding would diminish policy equity. When synthesizing these two variables, the hypothesis for efficacy as a whole is that shifts in funding source would bear an inconclusive effect on the effectiveness of Rwandan public health policy.

Outcomes and Theoretical Assessments

Funding Source and Policy Appropriateness

In the aftermath of the genocide, the Rwandan public health sector was met with massive increases in funding from many major NGOs including the U.S. Public Health Service, the World Health Organization (WHO), UNICEF, Save the Children Fund, and many others, along with aid from countries of the Global West such as the U.S., France, and Germany (Ministry of Health, 2003). This funding was directed towards a Community-Based Health Insurance system (CBHI), focused on decentralizing a variety of existing traumacare initiatives which were originally put in place to return the country to pre-genocide rates of HIV, malaria, and PTSD. This system also aimed to tackle long-term issues such as malnutrition and vaccination for diseases such as HPV, rotavirus, and measles. The expressed means of the program included the establishment of referral hospitals throughout rural districts that were especially affected by the genocide due to their lack of Kigali-based health access. Also executed was the dispersal of upwards of 45,000 CHWs (community health workers)--an average of three in every village--who focused on childhood tuberculosis and malnutrition screenings, as well as short-term curable diseases such as malaria or diarrheal disease. These CHWs then brought their attention to long-term genocide-influenced disease throughout the early 2000s, including HIV and cancer. These facility-based healthcare services, along with a revitalized system of staffing, lead Rwanda to become one of the first countries in Africa to have more than 80% of their population able to access universal HIV care (Drobac et al., 2014).

In the previous section, a relationship was established between funding source and policy appropriateness as a valid measure in assessing developing entities' circumvention of the exploitative pitfalls outlined in dependency theory. Funding ostensibly internationalized in the genocide's aftermath; what is much less concrete is determining the policy appropriateness of this CBHI initiative to the domestic situation. We can build an understanding of what the domestic view of their situation actually was, and compare that to the policy execution and results, assessing whether that view was accurately reflected.

The Rwandan government expressed aims for public health development at the outset of the Kagame administration with Vision 2020, formulated in 2000 and revised in 2012. 'Pillar Four' of Vision 2020, "human resources development and a knowledge-based economy," outlines domestic public health targets to be met by 2020, tracked annually in the Ministry of Health's (MoH) progress reports. The pertinent public health goals in 2000's Vision 2020 go as follows: a reduction in the infant mortality rate (107 to 50 per 1000) and the maternal mortality rate (1070 to 200 per 100,000) and malaria and other potential epidemic diseases will have been controlled and the AIDS prevalence will have been reduced from 11.2% to 8% (Ministry of Finance and Economic Planning, 2000).

In comparison to the implementation of decentralized post-atrocity healthcare, all Pillar Four goals are attended to through the CBHI system.

The attention to childhood and maternal healthcare of the CBHI system, found through initiatives to increase access to specific maternal health resources through CHWs, would become the foundation for the Mutuelles de Sante system. Similarly, attention to HIV was very pronounced in this stage of Rwandan public health development.

In terms of outcomes, 2010 objectives for Vision 2020 were passed far before when was expected. In particular, HIV/AIDS prevalence declined to below 3%, indicating extreme effectiveness of the initiative, and infant and maternal mortality both decreased to 54/1000. (Ansoms et al., 2012) The alignment of policy content with expressed aims in Vision 2020, combined with the evidence of high policy success, lies in opposition to the hypothesis that increased reliance on international aid would detriment the appropriateness of policy to the domestic circumstance.

We must examine more deeply how the hypothesis operates in the first place to understand the whys of its significance in many cases while being circumvented in Rwanda. Increased reliance on international funding, through the lens of dependency theory, will create a systemic domestic dependence on international capital, where a lack of infrastructure makes foreign aid the only suitable vehicle for progress. Because of this, policy action funded by international aid will be skewed to fit the aims of the Global West in hopes of maintaining or strengthening funding. Alternatively, policy may be skewed through a division of operations as NGOs participate and influence initiatives, to an extent acting in their own favor, or decreasing policy coordination as action is spread across multiple organizations. Either way, this power dynamic between the sources of international aid and domestic policy makers can create a discrepancy between the appropriate policy for the domestic circumstance and the internationally influenced resulting policy.

The Rwandan Ministry of Health underwent two broad ministerial shifts in the late 1990's and early 2000's crucial to circumventing both of these dependency theory expectations: decentralizing to access the district level, which had been planned since the mid-80's, and avoiding division of policy action across not only themselves and other organizations but multiple ministries intergovernmentally. During the influx of financial aid starting in the late 1990's, the MoH prevented division of public health operations among organizations responsible for their funding (Iyer, 2018). Not only was this scenario deliberately avoided, but the matter of circumstance prevented its presence as well. Due to the rural and highly decentralized dispersal of those affected most by the genocide, the already-decentralized MoH could access patients much more efficiently than NGOs despite lacking infrastructure, as in the case of Partners in Health, where "many rural families had to travel six hours or more to reach the nearest health facility", de facto compelling Ministry action alone (Drobac, 2014).

This MoH protocol prevented the expected connection between international funding and decreased policy appropriateness by organizing itself in a decentralized manner where only it could adequately access many of the groups in need; their agenda of prioritizing coordination through unified, intraministerial efforts further protected their autonomy and alleviated risks of policy dilution across multiple NGOs.

To strengthen our understanding of the significance of this protocol, we can use Burundi in the same time frame as an example of an alternate pathway in which these steps were not taken. Policy appropriateness was consumed by the pitfalls dependency theory warns of, as decreased coordination resulted from operations diluted over multiple organizations, reducing the effectiveness of the system. (Ivey, 2018). In this sense, securing autonomy in terms of policy action regardless of funding source is significant in ensuring appropriate policy content and implementation.

Funding Source and Policy Equity

Entering the late 2000's, the Rwandan government's infrastructural accomplishments, including the widely dispersed referral hospitals of CBHI, were now developed enough to support a long-term healthcare system beyond the internationally funded traumacare of the past decade (Lu et al., 2012). Existing as a pilot program in 1999 across select districts, then further expanded throughout the early 2000's as an institutional manifestation of CBHI (primarily focusing on low-cost maternal and under-five healthcare), Mutuelles de Sante officially became the primary arbiter of the Rwandan healthcare system in 2008 when its management, organization, and the necessity for all Rwandans to have healthcare was codified into law (Twahirwa, 2008).

As this infrastructure became suitable for autonomous public health financing and development, the relative dependency of the Rwandan government on financial aid decreased from 85% in 2000 to 45% in 2010 (Action Aid, 2011). The vacuum in funding left behind by this decrease was made up for with 50% of funding coming from "annual premiums (standardized in January 2007 to the equivalent of US\$1.81) per person, per year. Where citizens cannot pay the individual or family premium up-front, microfinance domestic institutions provide individual loans for the premium, to be paid within a year of disbursement with a 15% rate of interest," (Ministry of Health, 2007). The rest of funding comes from the ministerial budget, other sources in the Rwandan government or the remaining participating NGOs. This increase in domestic financing and its effects will stand as our independent variable for assessing the theoretical expectations of neopatrimonialism.

International funding arrives conditionally, through a web of expectations and contracts; a bank can threaten default, as an NGO can offer stipulations as to how their funding is used; these exact conditions are what threatens policy appropriateness, as was analyzed in the previous section. However, when these conditions are no longer present, a different

set of pitfalls emerge. As international funding diminishes, and those that produce wealth are the same group as those that allocate it, the opportunities for stagnation through clientelist structures become a legitimate concern. So, framing an assessment of neopatrimonial features in the established variables: is equitable distribution of policy resources affected by a decrease in international funding?

In totality, almost every group receives some benefit from Mutuelles de Sante, with considerable improvements in rates of maternal and infant mortality, childhood vaccination, and nutrition (Ansoms, 2012; Drobac, 2014). However, there are existing discrepancies in access to Mutuelles divided on economic and geographic lines. Rwanda's rural poor still received considerably worse healthcare responses than its urban/suburban poor or middle class, with a major dropoff in rates of utilization and catastrophic health response as you descend into the poorest quintile of Rwandans. However, as represented by the mass decentralization efforts of the Ministry across the decade before (60 percent of government funds for the health sector were directed to services in outlying areas by 1999 (Ministry of Health, 2001)), geography was likely no longer the barrier to equitable care. Despite dramatically lower costs compared to the sparse privatized systems beforehand, the microfinancing loaning system along with the heavy reliance on paid premiums for program financing likely created a cohort of potential enrollees that were essentially refused access due to living below the extreme poverty line of \$0.32 USD in 2012 (Lu, 2012).

On the surface, as compared to the findings of the last passage, this may indicate an outcome supportive to the notion that neopatrimonial structures could be a stagnating factor towards public health development, as policy equity is diminished based on funding schemes created and allocated by the state.

However, the evidence of these patron-client structures in Mutuelles de Santé, due to its already highly decentralized nature preventing a bottleneck necessitating compliance, is either not capable of being produced or lacking in evidence demonstrating it.

There are other factors that may be causing the inequitable access to the rural poor. Most prominently, the decreased reliance on international funding, that was initially footing the bill for much of the rural access, may have necessitated the formation of programs that, to some, are cost-prohibitive, to keep the health insurance system afloat. While it was predicted that the existing infrastructural improvements would mitigate high inaccessibility to rural populations (to be fair, it largely did (Ministry of Health, 2001)), the data demonstrates that this was not fully prevented.

However, since the discovery of this inequity, there has been existing reform to Mutuelles in the name of improving access for those below the poverty line. The most prominent of these reforms was the proposal for a revision to the Rwanda Community Based Health Insurance Policy in 2010, focused on decreasing copayments for those unable to afford them

(Ministry of Health, 2010). The following year, the Rwandan government has fully subsidized Mutuelles copayments and premiums for Rwanda's poorest, with this policy still being continued today (Sayinzoga, 2016). Definitive research still has yet to be done on the long-term effects of these policies both for program sustainability and the demographics they target, but this demonstrates considerable state action towards diminishing inequity across the past decade.

Due to this immediate response of the Rwandan government, and existing literature demonstrating the benefits of subsidizing Mutuelles copayments on a district by district basis for the rural poor (Dhillon, 2011), it remains inconclusive that this is due to party-ordained neopatrimonial structures. It is likely that this inequity emerged as a symptom of the intermediate stage of weaning programs off of international funding while simultaneously developing new domestic funding strategies. More importantly, as these weaknesses in domestic funding emerged, they were subsequently addressed throughout the past decade, both in terms of legislature and ministerial reform, indicating strong ability for development and change.

Policy Trajectory and Alternative Interpretations

In the previous section, an apparent stumble into an expected pitfall of neopatrimonialism- policy inequity- was unearthed. The decentralized and party-isolated nature of the Ministry, initially mentioned when discussing policy appropriateness, was raised to put forth an alternative pathway- one where short-term cracks in a new system will emerge, but will be resolved with time, instead of perpetual symptoms determined by a systemic circumstance.

While there is some included evidence of reform in the previous section, it is significant to examine 1. A more holistic understanding of Rwanda's public health progression in which more than just the successes are passed through the theoretical sieve and 2. the weaknesses in the sieve itself (especially in the case where neopatrimonialism was *not* present, and yet somehow my framework still detected its presence).

While this paper intends on examining about the first fifteen years post-genocide, as afterwards, the public health profile of the country shifted from uniquely post-atrocity to one more typical of Sub-Saharan Africa, acknowledging assessments after this period is important to understand the trajectory within the timeframe, and the true ramifications of policy within it.

As described earlier, the primary thorn of Rwandan public health policy has been the level of access that the rural poor have to Mutuelles programs relative to their richer, central counterparts. Despite the policies above attempting to alleviate these existing disparities (especially considering that the worst offenses of the genocide were most directed at rural populations themselves), this remains a challenge. According to a 2018 World Bank health report, stunting, a significant risk for children in

areas of high malnutrition, affects the poorest-quintile Rwandan children at a rate of 49% compared to the top quintile's 21%; the rate at which the latter is decreasing is also quite steeper than the former (5% annual reduction compared to 2%) (World Bank, 2018). The same report discusses renewed commitments on the Rwandan government's behalf to diminish stunting to 19% by 2024, in line with high impact nutrition programs the World Bank supports. According to the Ministry itself, this had decreased to 33% by 2021, yet a DHS report the year prior gives the same overall statistic, but claims the same rate of stuntedness for Rwanda's poorest quintile- but an almost halved rate of 11% for its richest. (MoH, 2021; DHS, 2020) This implies that the inequality in nutrition progression has only increased in the years after the scope of this paper.

As this is an issue of inequity, an expectation of neopatrimonialism, examining the domestic funding schemes laid out in this time period from 2018 to 2021 is worthwhile. According to the same Ministry of Health report, performance-based financing has become the main strategy in domesticizing public health funding; not only that, but the primary recipients of these bolstered PBF schemes has been rural-accessing programs, such as the maintenance of referral hospitals and the payment of CHWs. This increase in domestic funding aligns with a plateau in decreasing poor children's stunting rates; however, it is also not unwarranted, as a primary concern of the Rwandan economy as a whole is the sustainability of international funding programs given a quickly accumulating national debt (World Bank, 2023). Ultimately, this issue remains a balancing act of the expected policy shortcomings of domestic funding schemes, and the long-term economic threat of international dependence; while the Ministry was successful in sharpening their policy content to domestic relevance through centralizing decision-making in the wake of internationalized funding, maintaining that equity in a domestic shift has proven to be a central challenge.

Another concern in theoretical methodology for analyses such as this is the presence of expected pitfalls hindering the ability to fully assess the nature of the pitfalls themselves. For example, if the Rwandan government was truly consumed by clientelist structures, and was corruptly using resources to assure compliance, a rational assumption would be that they would improperly use administrative capabilities to generate optimistic health data, which would assuredly aid in party compliance. However, the very presence of optimistic, or equitable health data would superficially indicate a *lack* of neopatrimonial interference, despite such data only existing because of its presence. This offers a methodological paradox only solved by integrating a broader range of health data that is outside of the RPF's realm of control and thus offers a greater level of reliability, such as the World Bank, the DHS, or independent accredited researchers. This reaches unique significance considering the authoritarian nature of the RPF. In comparison to outside organizations, Ministry data remains accurate; but subtextually comparing the two can be a litmus test for

clientelism itself; the MoH, in its 2021 report, includes valid, DHS-corroborated data on levels of stunting. What it omits, however, is a quintile-based analysis of stunting data that would then illuminate that the systemic issues of health access for its rural poor have not improved- the existence of this omission, despite NGOs claiming this as a primary concern for years now, has an effect on how we can reliably assess Rwanda's development through these frameworks.

Conclusion

Interfacing Policy Results

The contrast between the hypotheses of dependency theory and neopatrimonialism and the outcomes of 21st century Rwandan public health policy provides insight into the heightened importance of certain actions on policy effectiveness (appropriateness and equity). According to the outcomes of Rwanda and other countries of similar developmental circumstance, domestic autonomy in policy creation and implementation is significant in escaping the expectations of policy ineffectiveness hypothesized by both theoretical frameworks. Domestic autonomy includes not only centralized allocative abilities between the state and foreign entities, but also between ministerial actors and other governmental entities with varying party control. Policy inequity on demographic lines such as class or rurality remains a challenge for Rwanda, as expected by neopatrimonialism, but steps are being made to lessen this disparity.

Interfacing Policy Results

There is still more research to be done in a variety of areas to further affirm these findings, including the effects of current policy rectification in Rwanda.

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