

REPUBLIC OF RWANDA



MINISTRY OF HEALTH
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NATIONAL COMMUNITY HEALTH POLICY

JUNE 2015

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ABBREVIATIONS

MOH	Ministry of Health
CHWs	Community Health Workers
UNICEF	United Nations International Children's Fund
CBHI	Community-Based Health Insurance
ASC	Agent Santé Communautaire
DHS	Demographic Health Survey
WHO	World Health Organization
MDGs	Millennium Development Goals
ART	Antiretroviral Therapy
MCH	Maternal and Child Health
iCCM	Integrated Community Case Management
LLIN	Long-Lasting Insecticide-Treated Mosquito Nets
ARI	Acute Respiratory Infections
CPBF	Community Performance-Based Financing
FP	Family Planning
EDPRS	Economic Development and Poverty Reduction Strategy
FAO	Food and Agriculture Organization
CDF	Comprehensive Development Framework
NEPAD	New Partnership for Africa's Development
TFR	Total Fertility Rate
GoR	Government of Rwanda
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
CH	Community Health
CCM	Community Case Management
CBN	Community-Based Nutrition
C-MNH	Community Maternal and Neonatal Health
ANC	Antenatal Care
CBP	Community-Based Provision
MUAC	Mid-Upper Arm Circumference
PNILT	National Tuberculosis Control Program
PNILP	National Malaria Control Program
MPDD	Medical Procurement and Distribution Division

TRANSLATION OF KEY TERMS

Agent de Santé, Binome

Male and Female Community Health Worker

Agent de Santé Communautaire

Community Health Worker

Animatrice de Santé Maternelle

Community Health Worker concerned with maternal, néonatal, and child health

Binomes

Male and Female Community Health Workers

Cellule

Cell: Administrative Unit Comprised of Imidugudu

Comité de la Mutuelle

Committee for the Mutual Health Insurance

Mutuelle de Santé

Community-Based Health Insurance

Imidugudu

Many Villages

FOREWORD

In the last five years, Rwanda has witnessed unprecedented improvement in many health outcomes, including those related to community health (CH). This has largely been a result of the government's commitment to achieving both national and international objectives. As such, the Ministry of Health (MOH) has continued to pioneer health system reforms. In collaboration with development partners, the Ministry of Health has invested in innovative interventions within an increasingly decentralized health care delivery system. Remarkable performance has been demonstrated in infant and child survival, maternal health, combating HIV, tuberculosis, and malaria, community-based health insurance schemes ("mutuelles"), infrastructure developments, and the system of community health workers. The number of trained medical personnel has steadily risen, and their motivation and retention within the health system has been addressed through unique interventions such as performance-based financing.

The Ministry of Health continues to move forward on the above priorities, among others, and is strengthening its strategic partnerships to promote relevant and sustainable interventions for the health of all Rwandans. To this end, the Ministry continues to consider community health as a top priority and as one of the strategies contributing significantly to the nation's socioeconomic development.

In updating this policy, the Ministry of Health is renewing its commitment to the importance of community health in Rwanda, providing a foundation for strategic direction on addressing health challenges at the community level. The Ministry of Health remains cognizant of the complexity of the many community health challenges that still need to be addressed and has articulated these challenges in this policy. Building upon the lessons of our past experiences, the policy takes these challenges into consideration in order to guide concerted efforts to address the community health needs of the Rwandan people. The policy takes a pragmatic approach, acknowledging the genuine challenges to be confronted in the years ahead. It does not consider community health in isolation; rather, it places CH in the wider context of other national commitments and goals, including Vision 2020, the Economic Development and Poverty Reduction Strategy (EDPRS), and international plans of development such as the Millennium Development Goals (MDGs), the New Partnership for African Development, the International Conference on Population and Development, the Convention on the Rights of the Child, and the Africa Health Strategy.

This policy will serve as a cornerstone from which to address the accessibility of CH services and to encourage its integration with services for HIV/AIDS, maternal and child health, and other development initiatives. This policy has been developed at an opportune moment, as Rwanda is embarking on the introduction of community-based provision of family planning and non-communicable disease (NCD) services through Community Health Workers (CHWs). These efforts are anticipated to trigger a paradigm change in the way community health services are provided and accessed in order to contribute towards a healthy and productive Rwanda for all.

Since the Ministry of Health is resolute in taking on this issue using evidence-based approaches while providing room for innovation, positive results are anticipated. The Ministry of Health will continue to reinforce coordination efforts for the alignment of implementation efforts, thus promoting greater efficiency and effectiveness of the Community Health Program.

Finally, the Ministry of Health shall at all stages involve its partners and stakeholders during planning, implementation, and monitoring, and will solicit the active participation of beneficiaries to ensure that services respond to their needs.


Dr. Agnes BINAGWAHO
Minister of Health



1. INTRODUCTION

Over the last decade, rapid expansion in HIV/AIDS funding and other health programs, such as tuberculosis (TB) and malaria, and a renewed interest in child survival have propelled a shift in international thinking towards the large-scale deployment of CHWs (WHO 2006; Haines et al. 2007). The reasons for this appear to be more pragmatic than ideological – the need to address crippling health worker shortages that hampers “national scale-up” of new initiatives in many countries, such as access to antiretroviral therapy (ART) and Maternal and Child Health (MCH) programs. Thus, in 2006, the World Health Organization proposed “task shifting” and training CHWs as core ideas in its “AIDS and Health Workforce Plan” (WHO 2006). The “massive training of CHWs” was also identified as a quick win for achieving the Millennium Development Goals (UN Millennium Project 2005, cited in Abbott 2005).

The Rwandan community health scheme forms an integral part of the country’s health system, and its central function is to promote community-level social and economic transformation. Community health care serves as the first level of contact for individuals and family members in their localities, and brings health care services as close as possible to where people live and work; this constitutes the first element of a continuing health care process as stipulated in the WHO’s Alma Ata Declaration of 1978. The CHWs have the advantage of knowing their community well in terms of cultures, norms, beliefs, traditions, formal and informal networks, support systems, community strengths, and, most likely, their communities’ health problems. Therefore, the introduction of CHWs can lead to customized, desirable results if used and incentivized appropriately.

The volume of health care and promotional services provided by CHWs and the number and types of CHWs have been increasing over time. In 1995 when the MOH first endorsed the program, the number of CHW was about 12,000. Ten years later, the number grew to 45,000. From 2005 onwards, there was sustained capacity building for CHWs through training and the supplying of materials, and by 2011, the number stood at 60,000. As of May 2012, the MOH and the Ministry of Local Government (MINALOC) reduced the number of CHWs from 60,000 to 44,619 (as the result of removing the CHWs in charge of social affairs in all 14,873 villages). With the addition of 392 monthly-paid CHWs (“accompagnateurs”), the current total stands at 45,011 CHWs. Each village has a pair of CHWs (binomes) in charge of integrated community case management (iCCM) and one Animatrice de Santé Maternelle (ASM) in charge of maternal and newborn health. The training of CHWs was conducted program by program, focusing on local capacity building until the whole country was covered. CHW elections are organized at the village level. The male and female binomes are elected in each village based on set criteria, and a similar set of criteria is used for a separate election for the CHW in charge of MCH and the ASM.

The National Community Health Policy provides a framework to guide present and future program design, planning, implementation, monitoring, and evaluation. Its implementation will strengthen the decentralization of health structures and services down to the district level and the villages (imidugudu). This decentralization is expected to promote the mobilization of community involvement as individuals, families, and villages in the provision of community health services. Local ownership of health services is expected to empower communities to become self-reliant, to guide their own health development, and to promote sustainability. This policy offers an instrument to build and manage partnerships for community health and also advocates for leveraging health resources. The MOH will utilize this policy to advocate for adequate mobilization and allocation of health resources from the Government of Rwanda (GoR). A crucial element will be the effective coordination and monitoring of the implementation of this policy at the central, district, health center, and community levels. The policy’s obligations will be expressed in a Strategic Plan for Community Health. Overall, the policy provides a framework to improve community health and contribute to the attainment of national, regional, and international goals such as the decentralization outcomes, Vision 2020, and the Millennium Development Goals.

2. SITUATION ANALYSIS

2.1 OBJECTIVES AND METHODOLOGY OF THE SITUATIONAL ANALYSIS

The main purpose of this situation analysis is to assess the progress made during the last five years to inform the development of the new Community Health Policy and Strategic Plan 2013-2018. These documents will ensure that the current health gains are further improved to meet Rwanda's national health targets as outlined in the Health Sector Strategic Plan III 2013-2018. The policy and strategy will capitalize on the documented best practices while exploring the opportunities and addressing the challenges identified in the situation analysis. Community health is implementing several programs and progress and challenges for those programs were outlined under specific interventions, while general progress, opportunities, and challenges were reported in a different table. Specifically, the situational analysis had the following objectives:

1. To assess the current status of the community health program
2. To identify achievements and challenges related to each of the community health interventions
3. To serve as input into the policy and strategic planning processes

The methodology for the assessment was guided by documentation reviews: quarterly and annual reports, the evaluation reports for specific interventions, HSSP II and HSSP III documents, and the DHS 2010. Specific interviews were conducted with the staff in charge of various interventions at the Community Health Desk and partners that support community health. Structured questionnaires were distributed by email to partners and responses were received via email as well. Additionally, field visits were held in three districts in which interviews were conducted to generate additional information about the progress, opportunities, and challenges encountered in delivering community health services.

2.2 HEALTH SECTOR ANALYSIS

The Government of Rwanda is highly committed to improving the health status of its population; the Ministry of Health has achieved most of the prescribed health targets over the last 10 years. The infant mortality ratio decreased from 86 per 1000 live births in 2004 to 50 per 1000 live births in 2010, and the under-five mortality ratio declined from 152 to 76 per 1000 live births over the same period (RDHS 2010). The maternal mortality rate as assessed in 2005 was 750 per 100,000 live births (RDHS 2005) and has been decreasing since then to 487 per 100,000 (DHS 2010). If this rate of decline continues, Rwanda will likely meet the maternal and child mortality MDG targets by 2015. However, neonatal mortality remains of concern, as it hardly decreased since 2007 (28/1000 live births in DHS 2007 and 27/1000 live births in DHS 2010).

The DHS 2010 also indicates that Rwanda achieved a decline in malaria prevalence by almost half since 2007–08 (from 2.6 percent to 1.4 percent among children aged 6–59 months and from 1.4 percent to 0.7 percent among women aged 15–49). An important factor in this improvement is the wide coverage and use of mosquito nets. According to the DHS 2010, 82% of households have at least one long-lasting insecticide-treated mosquito net (LLIN), and 70% children under 5 slept under the LLIN (DHS 2010).

Considerable progress has been made in combating HIV/AIDS, as the HIV prevalence in Rwanda was 3% in 2010 (DHS), one of the lowest in Sub-Saharan Africa. The prevalence of acute respiratory infection (ARI) also decreased significantly (the percentage of children who reported ARI in the two weeks preceding the survey was 17% in 2005 and 4% in 2010). This can be attributed to the intensive scale up of introducing the pneumococcal vaccine. However, diarrhea hardly decreased (the percentage of children who reported diarrhea in the two weeks preceding the survey was 14% in 2005 and 13% in 2010).

In the span of five years, the modern contraceptive prevalence rate more than quadrupled from 10% (DHS 2005) to 45% in 2010. The total fertility rate decreased from 6.1% in 2005 (RDHS 2005) to 4.6% in 2010 (RDHS 2010), underlining the role of family in addressing population growth. This increase has been due to the government and its partners committing to family planning (FP) as a top priority.

The important role CHWs have played in the achievement of each of these positive health indicators listed above cannot be overstated. For example, it is CHWs who ensure that mosquito nets for malaria prevention are well distributed to every household in their community and used appropriately. As another example, it was CHWs who did extensive mobilization in target areas to ensure that the right messages reached the targeted populations for family planning.

Furthermore, the implementation of different community health interventions has significantly contributed to the improved access to health services. Examples of these interventions are Community-Based Health Insurance (CBHI); community Performance Based Financing (PBF), which stimulates demand and supply of health services; and SISCom, a system that improves data collection and timely action. CBHI coverage has attained more than 90% enrollment and, as result, more of the population is seeking care (DHS 2010). Community-Based Health Insurance covers primary health care services that are mainly delivered at the health center level; qualified medical doctors can then refer patients with CBHI for secondary care at district hospitals. If patients cannot be managed at the district level, specialized doctors refer them to a national referral hospital for treatment. CHWs are the foundation of the referral system right from the community level. Community Based Health Insurance has gradually been increasing from 2005 to 2011 according to HSSP III data: in 2005 was at 12%, 2008 at 75%, and 2011 at 91% (HMIS and DHS).

Government spending on health has been increasing since 2005, when it was at 8.2%, reaching 9.1% by 2008 and 11.5% by 2011 (HSSP III Situation Analysis Report, DHS-I and HMIS). The level of government spending on health in 2010 was within the reach of the Abuja Declaration target (15% by 2015) for national budget allocation towards the health sector. As more health interventions shift to the community level, greater advocacy is needed to improve community health financing.

With regard to human resources for health, there has been an absolute increase in the numbers of public health professionals from 2008 to 2010. The total numbers of staff increased from 11,604 (2008) to 12,465 (2010). The 2009 staff in-post numbers also showed an absolute increase (12,288). During the same period, the number of doctors increased from 363 to 413 while nursing staff also increased from 6154 to 6462 (Human Resources for Health Country Profile, African Health Workforce Observatory, March 2010). The health system in Rwanda has greatly benefited from task shifting in which CHWs are delivering primary health services at the community level. This has relieved the workload at health centers and has reduced patients' travel costs to reach health centers.

The administrative structure is divided into seven levels of health service delivery. At the lowest level, there are 14,837 villages or *imidugudu*. The CHW cooperatives function at this level; the current number of cooperatives as of May 2014 stands at 460. The health infrastructure at the next level, the cell or *akagari* (of which there are 2,148), is the health post (of which there are 252). Next, there are 416 sectors or *imirenge* with health centers. The following level is the district or *akarere*. With 30 districts, there are 42 district hospitals. The provincial level follows the district level and includes five provinces. The health infrastructure at the provincial level is the provincial hospital. There are currently five, though district hospitals are to be upgraded to provincial hospitals. Finally, at the national level, there are an additional five national referral hospitals and 154 ambulances.

2.3 SOCIOECONOMIC, GEOGRAPHIC, AND POLITICAL ANALYSES

Rwanda is a landlocked country in central Africa, bordering Uganda in the north, Burundi in the south, the Democratic Republic of the Congo in the west, and Tanzania in the East. It has a population of 10.5 million (2012 National Census), of which approximately 40% are less than 15 years of age. Its mountainous terrain averages an altitude of 1700 meters and is suitable for producing agricultural products such as coffee, tea, and ornamental flowers. A major challenge for Rwanda is the growing population. The population density is high (431/km² in 2010 according to the World Bank), resulting in many families having less than one hectare of land, a size that the FAO in Rome states is inadequate for food production for the average family. Rwanda's population grows at about 2.4% per year (EDPRS), and some regions must accommodate the influx of citizens who fled the country

prior to and during the war and 1994 genocide. A doubling of the population in the next twenty years is a serious consideration for Rwanda's economists.

On the other hand, Rwanda has special resources, such as streams and waterfalls, which provide the possibility for hydroelectric power. Rwandans are ambitious, eager for more education, and the country is responding by building more schools, including technical trade schools, and expanding existing universities and paramedic schools. The World Bank and other sources reported Rwanda's economic growth rate, negative after the genocide of 1994, at 7.5% in 2012.

Culture plays an important role in enhancing the adoption of health practices. Any cultural norms in conflict with the delivery of health services should be identified and discussed with communities, as this is the only way for communities to change for the better. A supportive environment needs to be created so that communities do not feel threatened by societal changes.

2.4 INTERNATIONAL CONTEXT

This policy draws from the regional and the international policy obligations committed to by the Rwandan government in describing Rwanda's role in harmonizing the health sector. The Government of Rwanda is committed to fulfilling its regional and international obligations; the MDGs push the international community toward a renewed vision of development, one that vigorously promotes human development as "the force that will sustain social and economic progress in all countries and recognizes the importance of creating global partnerships for development" (World Bank, Millennium Development Goals, The Road Map). According to international agencies for development, achieving the MDGs by 2015 will require increased focus on development outcomes and inputs in order to effectively track national progress towards meeting these goals. Information on action at the community level needs to be communicated from the community to the higher levels of administration. Rwanda's community health sector information system is right on track. In keeping with the recommended financing mechanisms of health sectors in sub-Saharan Africa, Rwanda has already taken steps to adapt these to support the reduction of poverty, improve financial access to health care, and achieve a better distribution of public expenditure benefits in the context of ongoing decentralization and democratization. Rwanda also adheres to the Lusaka Declaration on decentralization and district health systems (WHO, 1997). Three strategies are promoted:

1. The decentralization of the health system using the health district as the basic operational unit of the system
2. The development of the primary care system through eight core components
3. The reinforcement of community participation in managing and financing health services

As mentioned in the introduction, over the last decade, increased funding for HIV/AIDS, TB, malaria, and other programs restored interest in child survival to highlight the key role of CHWs in progressing towards the Millennium Development Goals. More recent reviews of CHW experiences suggest that under the right conditions, scale-up of community health programs is feasible, can lead to health gains, and can produce a wider range of social benefits over sustained periods of time (Haines et al. 2007; Lehmann and Sanders 2007). Examples of successful contemporary programs worldwide include, but are not limited to, the Programa dos Agentes Comunitarios de Saude in Ceara, Brazil, the Mitanin program in Chhattisgarh, India (Sundararaman 2007), and the CHWs' contribution to improvement of MCH outcomes in Rwanda (External Evaluation of Health Sector Strategic Plan, MOH, November 2011 and DHS 2010). The right conditions for the CHW programs to flourish include high-level political support, community inclusiveness, health training, strong supportive supervision, and remuneration and incentive systems (Bhattacharyya et al. 2001; Lehmann and Sanders 2007).

2.5 POLICY ANALYSIS

The general orientation of the Rwandan Ministry of Health in community health revolves around three major strategies: Vision 2020, EDPRS, and the National Health Policy, all of which are briefly described below.

2.5.1 Vision 2020

One of the major aspirations of Vision 2020 is the integration of human resources development to address demographic, health, and gender issues. Community health services will advance these causes in areas such as total fertility rate, under-five mortality, infant mortality, maternal mortality, under-five malnutrition, rate of AIDS prevalence, malaria-related mortality, etc. As a further example, the community health workers will be composed of a male-female binome, ensuring gender equity. They will be educated in health along with all the other community health workers that occupy their cell.

2.5.2 Economic Development Poverty Reduction Strategy (EDPRS)

EDPRS' main objective in the health sector is to improve the quality, demand, and accessibility of healthcare in the country. In particular, healthcare "accessibility in remote areas has been improved with the development of community health programmes" (EDPRS, 2013-2018). EDPRS recognizes that the problem of access to primary health care is not only a health sector issue, rather a multi-sector challenge that proposes all sectors to work together in synergy to deliver a comprehensive community health package with full community participation through CHW cadres.

2.5.3 National Health Sector Policy

The updated National Health Sector Policy describes the role of community-based service delivery as contributing positively to the health status of the community. The policy says that the functions of the health district include: (i) the organization of health services in health centers and the district hospital in terms of the minimum and complementary package of activities, (ii) administrative functioning and logistics, including the management of resources and supply of drugs, under the responsibility of the district management team, and (iii) supervision of community health workers who operate at the village level (*umudugudu*).

2.6 COMMUNITY HEALTH PROGRAM ASSESSMENT (2008-2012)

In preparation for the new community health policy 2013-2017 and supplementing the HSSP-II evaluation, an assessment of the implementation of the community health strategic plan was carried out in the second semester of 2012. Achievements, challenges, opportunities, and key solutions for the community health program are summarized in this chapter.

2.6.1 Community Health Program Components: Achievements, Challenges, Gaps, and Proposed Solutions

The MOH recognizes that the problem of accessing primary health care is multi-sector and that such a challenge needs collective efforts by all sectors to deliver a comprehensive package of care through CHWs (HSSP II 2009-2012, External Evaluation Report). The services in question are mainly curative, preventive, and promotional interventions. Consequently, the full community health package is made up of Integrated Community Case Management (iCCM), Community Maternal and Neonatal Health Program (C-MNH), Community-Based distribution of Family Planning services (CBP), Behavior Change Communication (BCC), Supply Chain for Community Commodities, Community-Based Nutrition Program (CBNP), Community Performance-Based Financing (CPBF), Community Health Workers Cooperatives (CHWC), Community Health Information System (RCHMIS), and Non-Communicable Diseases and HIV/AIDS (NCD and HIV/AIDS).

Integrated Community Case Management (iCCM)

iCCM is the new terminology for integrated community case management, formerly “community integrated management of childhood illnesses”, or C-IMCI. The main objective of iCCM is to prevent, detect, and provide early treatment for childhood illnesses, with foci on fever, diarrhea, respiratory disease, and appropriate detection and referral of severe disease and malnutrition. Child immunizations are cost-effective ways of ensuring the prevention of childhood diseases and the improvement of child health. Rwanda has achieved very high levels of immunization coverage, and CHWs have made an important contribution to vaccination programs by identifying and referring non-vaccinated children. The main achievement of iCCM over the last three years has been its implementation countrywide. CHWs (binomes) were trained and are now treating all children in the community according to established protocols and the iCCM package of services. The main challenges cited include increased workload for the CHWs, inability of some CHW to use tools properly, attrition by some CHWs, and insufficient staff at the MOH to supervise CHW activities and conduct training. The main opportunities are the strong commitment of the government and its partners to attain national and international infant and maternal health targets.

Community Maternal and Neonatal Health Care (C-MNHC)

The community health desk implemented C-MNH using a third CHW in each village called Community Health Worker in charge of Maternal and Newborn Health, or ASMs, who are tasked with identifying and registering women of reproductive age, promoting family planning service utilization, identifying pregnant women in the community, and encouraging them to utilize antenatal care (ANC) services (especially all four visits to achieve birth preparedness and delivery at health facilities). ASMs have also been involved in the follow-up of postnatal women and newborns in the community, referring them to health centers in case of danger signs. ASMs even accompany women in labor to health facilities so they can get delivery assistance by qualified personnel. Despite these efforts, there are some challenges to the program, including low knowledge of MNH (which should be rectified by doing refresher trainings country-wide). Although human resources were not cited as a challenge from the central level, the respondents from district hospitals and health centers believe that ASMs lack the educational background to comprehend the current training designed on C-MNH.

Community-Based Provision of Family Planning (CBP)

The purpose of CBP was to increase the use of modern contraception methods in Rwanda and improve access in rural areas. The intervention was also developed as a pilot program to build evidence for spearheading initiatives to improve contraceptive supply, stimulate demand, create a supportive environment for FP services, and scale-up interventions to the entire country. The pilot started in three districts with the potential to be expanded gradually to at least 22 districts by end of June 2013 (and subsequently to the entire country by the end of 2013). CHWs involved in the CBP program have been trained to teach about and provide condoms, oral contraceptive pills, and the Standard Days Method. Challenges that persist revolve around some community-based services not integrated in CBP and gaps in service delivery between the health center and community levels.

Community-Based Nutrition Program (CBNP)

The DHS 2010 shows that malnutrition rates among under-five children and women aged 15-49 years are decreasing. However, the percentage of stunted children under five remains high: 44%, with acute malnutrition at 3% and underweight at 11%. The main objective of the National Strategy to Eliminate Malnutrition (NSEM) is to cut back all forms of malnutrition through implementing a joint action plan initiated in 2012 and strengthening the multi-sector approach. Strategies of the NSEM include bolstering early identification and management of under-nutrition (including the response to their underlying causes) and scaling up community-based nutrition programs (CBNP) to prevent and manage malnutrition in children less than five years. CBNP has a particular focus on children under two years and pregnant or lactating mothers. Other initiatives include promoting nutritional support and management of vulnerable groups, promoting food security at the household, community, and national levels, promoting nutrition in preschool education and school environments, and improving monitoring

and evaluation for nutrition interventions. CHWs do monthly growth monitoring and promotion (56% coverage, SISCOM 2011) using Mid-Upper Arm Circumference Measurement (MUAC) tape and a scale to measure weight to check weight-for-age. Community demonstrations of kitchen cleanliness and how to plant nutritional gardens have been effective ways to increase community buy-in and prevent reoccurrences of malnutrition.

The large number of children participating in monthly growth monitoring presents a challenge for CHWs. The materials and commodities required for growth monitoring (e.g., length boards) are also often lacking. Additionally, communities need more support to truly demonstrate ownership of the CBNP.

Non-Communicable Diseases (NCDs), HIV/AIDS, and Communicable Diseases

Providing home-based care for people who suffer from life threatening diseases is a hallmark of a humane and caring society. Many people within Rwandan society, however, have little or no preparation at a personal level for dealing with death and bereavement, and yet dying is a natural process. It is expected that the Ministry of Health will promote strengthening of linkages within different services to improve the quality of care for those who need it. Ideally, when communities are well prepared for the introduction of services, every sector of the community can identify with the care provided. This ownership goes a long way towards ensuring the acceptance and continuity of services. Motivated communities have been known to validate and support community health workers, family caregivers, and community care volunteers, in addition to mobilizing local resources for care.

The NCD program started in January 2012, and the National Non Communicable Diseases Policy (April 2014) provides an overview of the program's objectives and rationales. The CHD has developed a comprehensive tool that will integrate NCD and HIV/AIDS into the existing home-based minimum package of care, including a training module. The main challenges met so far are that some CHWs do not know how to read and write while others have difficulties with managing the initial intensive implementation processes. The minimum education level for CHWs to enroll in community health activities is primary school, which is relatively low compared to the expected level of knowledge and output from each CHW, especially when it comes to writing reports.

The Rwanda Biomedical Center (RBC) is one of the agencies for MOH that exists at the central level, linking the central level to the community in terms of prevention, education, adherence to treatment, and counseling. Thus, it makes sense to combine HIV and AIDS prevention with TB and malaria control within the activities run by the community health desk.

Health Promoting Services – Behavior Change Communication (BCC)

CHW have played an important role as “MOH cadres” involved in the sensitization of communities on disease prevention measures using BCC strategies, such as proper hygiene and sanitation, use of insecticide-treated mosquito nets, early health care seeking behaviors, breast feeding, infant and young child feeding/nutrition, disease surveillance, etc. The main tools for the BCC strategy of the Rwanda Health Communication Center (RHCC) have been developed and disseminated to the CHWs. A major challenge has been acquiring the technical know-how, especially in developing appropriate media messages for specific groups of people and conducting regular monitoring to evaluate message penetration, accuracy, and impacts on target beneficiaries. District level and health facility staffs that were interviewed said that there is currently insufficient staff both in quality and quantity to support supervisions.

Community Health Information System

SISCom

RCHMIS is a community health information system that gathers data generated by CHW activities. At the end of each month, the CHWs who work together in the same village meet and consolidate data from their individual registers and fill out a village level CHW monthly report form, which is then sent to the cell. The two CHW cell coordinators collect all the village level reports and send a cumulative document to the CHW cooperative, where

the president of the cooperative submits it to the health center. At the health center the data entry in the RHMIS occurs, to be completed no later than the 5th day of the month after the month being reported.

RapidSMS

RapidSMS is free software used in many parts of the world for different interventions. In Rwanda, it has been customized to accelerate the reduction of maternal mortality. It is used to track the pregnancy life cycle, neonatal care (or newborn care, NBC), postnatal care (PNC), integrated community case management (iCCM), and nutrition status (CBNP) for a complete monitoring of the mother and newborn over the first 1000 days.

Current challenges encountered by the RapidSMS system include:

- Phone upkeep, maintenance, and charging in areas without electricity
- Geographic accessibility is still a problem for patient transport; RED ALERT response time is too long
- CHW attrition or moving out of assigned catchment area

Community Performance Based Financing (CPBF)

The CPBF approach is aimed at accelerating health results by focusing on high-impact community-level health interventions. In 2009, a more improved form of community PBF was started where CHW cooperatives were compensated based on performance on predetermined maternal and child health indicators. Exit data indicated that CPBF has improved the performance of CHWs by motivating their efforts to reach performance indicators (External Evaluation Report, HSSP II 2009-2012). The payments to the CHW cooperatives are made when a proof of the agreed-upon level of performance has been reached. Achievements of the CPBF are related to improvements in the supply side, where indicators at the community level have improved quite significantly. There has been an increase in staff motivation (CHWs and HC staff), improved quality of care, improved data collection, and increased timely reporting.

Challenges to CPBF faced at a collective level include the following:

- Donors decrease the CPBF budget and thus the unit cost per indicator decreases, adversely affecting the funds designated for CHW cooperatives (i.e., CHWs receive less than they were receiving previously).
- This reduction in budget funds also presents a challenge to the sustainability of CHW cooperatives' income generating activities.
- It has proven difficult to achieve the targets set before implementation began (e.g., indicators related to ANC visits and family planning were set at overly high levels).
- The definition of paid indicators has changed many times: if indicators are not understood in the same way by all parties, then c-PBF payments might not be paid.
- CHWs who do not work regularly or even rarely work demotivate fellow CHWs who perform their duties regularly.
- Data discrepancies between HMIS data and data validated by the sector steering committees are often attributed to the non-verification of data before data entry or a lack of counter-verification of data by the sector steering committees and the health centers.

Supply Chain for Community Commodities

CHWs were trained to use simple tools and procedures designed to facilitate information and product flow between CHWs and their resupply point, but a critical prerequisite is ensuring that CHWs always have enough CCM products to serve clients. Staff in charge of community activities at all levels collectively said that supply gaps exist at each level: between the MPPD, the district pharmacies, the health centers, and the community. Although precisely quantifying this gap was not possible, these respondents said that the most profound gaps exist between health centers and the community supply.

Thus, to ensure a constant availability of products, the MOH in collaboration with partners has been actively involved in improving the supply chain of community commodities. Community health partners have devised different interventions and strategies to identify, improve, demonstrate, and institutionalize supply chain

management practices that improve the availability and use of selected essential health products in community-based programs. One example is the introduction of Quality Improvement Teams (QIT) at the health center level to address the gap between the health center and the community levels. Another example is the implementation and rollout of eLMIS countrywide.

Community Health Workers Cooperatives (CHWC)

The idea of putting CHWs together into cooperatives started in 2009 with the aim of organizing all the CHWs under an umbrella organization. Currently, there are 475 CHW cooperatives formed amongst all the health centers. CHWs are accountable for two main activities: delivering predetermined health services, as measured by PBF indicators, and carrying out income generating activities through their cooperatives. Examples of income generating activities include crop and animal farming such as poultry, rearing of modern goats and cattle and off-farm activities such as transport, sale of foodstuffs among others; these activities are meant to generate profits that are shared by CHWs on an annual basis or any other time frame that they might deem favorable. In order to create a revolving capital base and ensure sustainability of the cooperatives, CHWs share 30% from the total amount transferred by the central level whereas 70%, is invested into their economic activities. Once they get benefits for the business they share 30% while 20% is set aside by the cooperatives in their legal reserve fund for re injection into the business whereas the remaining 50% of net profit will be pooled to a central account. This fund will be used to cater for community health needs such as trainings, tools for CHWs, and further remuneration. The approach was adopted as a way of making CHWs more sustainable. In terms of control and technical advice, a private company with expertise in cooperatives development was hired to give day-to-day technical assistance to CHWs cooperatives especially regarding conception of viable economic projects and implementation, financial management skills, regular and accurate reporting, auditing, etc. Furthermore, all CHWs cooperatives have hired a competent manager in relevant cooperative economic project as well as enhance proper reporting systems through the Community Health Workers Financial Tool (CHWCF) that is being upgraded and will be rolled out by end of 2015. This tool will ensure proper financial management and fewer cases of mismanagement and/or funds embezzlement.

The main challenges for cooperatives include outsiders who mislead cooperative members into investing in non-profitable activities for their individual selfish interests, inadequate skills in viable business planning, and small profits shared per individual due to great numbers of CHWs. In addition, cooperatives require a period of time to generate profits, and this causes discontent among some members. However, the MoH has devised ways to mitigate these challenges through, for example, training in relevant skills, partnering with NGO and other individuals who can give technical support to the cooperatives, and encouraging cooperatives to diversify their economic activities so as to maximize profits.

2.6.2 Opportunities

The community health programs have presented with various opportunities. To produce even better results, these opportunities need to be earnestly pursued. While new, improved approaches must be continuously sought out, this strategy outlines of some of the most important existing opportunities:

1. Political will and commitment to improving population health provides an opportunity for resource leveraging
2. The presence of well-structured local governments from the district level all the way down to the village level
3. Increased collaboration among partners: the private sector, local and international NGOs, community based organizations (CBOs), faith based organizations (FBOs), and local associations that provide services and financial and technical support
4. The presence of CHWs elected at community level who can offer various health services has become an important component of the health systems strengthening force
5. The presence of cell coordinators elected at the cell level who coordinate and monitor all CHWs.

6. The presence of well organized and incentivized CHW cooperatives, with additional remuneration to be considered in order to provide further motivation
7. CHWs have improved confidence as time goes by, so investing in them can be more productive for service delivery in the long term

2.6.3 Cross-cutting Challenges and Gaps

1. <i>CHWs' Workload</i> : A real risk is that three CHWs per village are not enough to cover the tasks that are remunerated and also those tasks that are not remunerated. Also, there is no clear information on how many hours CHWs spend on health related activities or on work for their cooperatives (CHWs are still volunteers except for the minimal PBF payment they receive for some activities).
2. <i>Non-Retention of CHWs</i> : Trained CHWs move out of the cooperatives.
3. <i>Transportation for Supervision</i> : The technical supervisor (nurse at the HC) and/or the manager of the cooperative often lack transport means to supervise and support CHWs out in the villages.
4. <i>CHWs' Motivation</i> : All those interviewed think motivational benefits for the CHWs need to be increased to match the level of their efforts. The respondents in the field reaffirm this and add that most cooperatives take time to generate profits, decreasing the motivation of CHWs. It is important that as CHW workload increases their labor days are properly compensated; that is, their compensation is commensurate with their labor. The community health desk through the GoR and partners can support compensation of CHWs through newly created cooperatives at health centers.
5. <i>Cooperative Management</i> : There are reports of weak management systems by cooperatives' leadership. Although technicians/managers were hired, they still need to be trained in proper financial management procedures to enhance performance.
6. <i>Misunderstandings of Local Leaders</i> : There are reports of a lack of goodwill to assist in the development of cooperatives by some local leaders both at sector and district levels. At the district level, leaders do not take extra care of the CHW cooperatives the way they do for other cooperatives. They think this is solely the work of the MOH.
7. <i>Accountability and Professionalism</i> : Quality assurance is weak due to a lack of accountability and professionalism. The main community based packages of services should be integrated into quality assurance programs, the performance of CHWs needs to be promoted, and professionalism should be encouraged by the MOH with the help of existing professional bodies.
8. <i>Replacing Incompetent CHWs</i> : In some districts, the CHWs/ASMs have a low level of knowledge and often cannot provide adequate services to the community. However, replacement is a challenge because additional training programs must then be organized. Perhaps the financial tracking tool recently developed to track CHW cooperatives can be used to identify poor performance and plan for a timely replacement.
9. <i>Logistical Management Skills</i> : Gaps are mainly seen in the forecast of the supplies between the health centers and the communities. The MOH and partners supporting the supply system should institute a well run logistics system that ensures supplies are in good condition and delivered in a timely manner. The system should control costs by eliminating overstocking, spoilage, and improper waste disposal.
10. <i>Walking Distances for CHWs</i> : Most CHWs expressed their main challenge as the geographic inaccessibility of some health facilities (PBF TB External Evaluation Report 2012). A portion of CHWs believe that provision of transportation means such as bicycles is the best way to solve this problem, since some areas' CHWs have been given bicycles, and this has improved service delivery significantly. Financing transportation can thus be an effective boost to CHW functions.
11. <i>Sustainability</i> : Cooperative sustainability is a big challenge. It would be ideal to conduct a study on the cost of programs compared to their efficiencies so that community health actors can understand where funding goes and how to best use the community health resources. Alternatively, the MOH can think of using CBHI premiums to support components of the CHWs' activities.
12. <i>CHW Materials</i> : In the PBF TB External Evaluation Report 2012, CHWs expressed that they lacked educational materials for use in communities, leading to insufficient numbers of sensitization campaigns and insufficient distribution of knowledge on new interventions.

13. <i>Stigma</i> : There is a challenge related to culture and stigma whereby some community members have a tendency to keep their conditions private (for example, those suffering from HIV/AIDS or TB). There is therefore a need to improve the levels of sensitization and counseling within communities in order to increase knowledge on stigmatized diseases and intervene at the community level.
14. <i>Supervision</i> : Lack of supervision from both the central and district levels is a real problem, as some CHWs go many months without being supervised.
15. <i>Traditional Beliefs and Practices</i> : There are insufficient strategies and guidelines to address issues of harmful traditional practices affecting maternal and child health.

2.6.4 Proposed Solutions to the Cross-cutting Challenges and Gaps

Over the course of implementing the new community health strategic plan, the Desk should devise innovative strategies and operational approaches to overcome the above challenges and gaps. Some ideas are outlined below:

1. Focus on capacity building of the health staff involved in the community health program at central, district, and decentralized levels:
 - a) Program design, implementation, M&E, and coordination of community health activities at all levels
 - b) Development of a curriculum and training plan for existing CHWs and new CHWs to provide quality community health services
 - c) Continue trainings of trainers (ToT) for new HC staff to then train and supervise the CHWs
 - d) Continue refresher trainings on community routine data quality assessments (c-RDQA), and RCHMIS to ensure efficient use of mobile phones to submit real-time, quality data
 - e) Evaluation of CHW cooperatives, especially for community health care
 - f) Hands on application of new technologies to (i) better inform providers and decision makers and (ii) generate quick evidence-based actions and decisions
 - g) Supportive supervision of community health activities needs more reinforcement
 - h) Comprehensive national evaluation of the community health program
2. Strengthen the coordination of community health services between the local and national levels and within these levels
 - a) Mobilize and empower communities towards full participation in health care provision and disease prevention
 - b) Reinforce the integration of holistic community service delivery to offer comprehensive and coordinated community health interventions
 - c) Reinforce sustainable community drug supply chains and storage via improved drug forecasting and effective supply channels
 - d) Advocate for and mobilize resources to support implementation of the community health programs
 - e) Ensure continuous training, supervision and monitoring cooperatives activities to close gaps of mismanagement and embezzlement of funds.
 - f) Ensure timely quarterly payment through C-PBF, based on data reported by CHWs
 - g) Strengthen existing partnerships between local leaders, government services, development partners operating in the area, civil society, and private sector organizations for a joint effort to improve community health at the local and national levels
 - h) Expand the existing monitoring system to capture all community health activities and provide real-time feedback and guidance for targeted formative supervisions and audits

3. POLICY ORIENTATION

An integrated community prevention package for TB, malaria, and HIV/AIDS for use by the community health workers was developed by CHD in collaboration with RBC, and CHWs were trained to use an information package to teach themselves and others about these diseases. The CHWs currently engage in active case finding

of NCDs (including cardiovascular diseases, chronic obstructive pulmonary diseases (COPD), different types of cancers, diabetes, injuries and disabilities, oral and eye diseases, and kidney diseases) at the village level. This strategy signals a new direction for the community health program and will continue into the future.

3.1 VISION

The vision of the National Community Health Policy is to ensure the provision of holistic community health care services so as to guarantee the well being of the entire population of Rwanda by increasing production and reducing poverty within an environment of good governance (National Health Sector Policy, 2014). The policy embraces health as a human right and the values of equity in service distribution and solidarity with the disadvantaged who seek health care. It also embraces the highest standards of ethics as services are implemented so that gender, age, and positive cultural norms in relation to healthy lifestyles are respected. The policy capitalizes on active participation by communities in the planning process, implementation, monitoring, and evaluation of programs and projects geared towards improving their health with an emphasis on improving feedback mechanisms.

3.2 MISSION

The mission of the National Community Health Policy is to promote and sustain community health services that reduce child, infant, and maternal mortality rates, improve the general health of the population, and contribute to the improvement of the MDG indicators and ultimately the indicators from the post-2015 development agenda, thereby enabling the entire population of Rwanda to contribute to the country's sustainable development.

3.3 GUIDING PRINCIPLES OF THE COMMUNITY HEALTH POLICY

3.3.1 People-Centered Services

Gender Equality and Equity in Community Health

If scaling up community health prevention and care activities is to become a reality at the district and community levels, men need to be more involved and to share responsibilities with women. After all, men have a great deal of influence in communities as traditional leaders and decision makers, making it possible for them to provide leadership and support to prevention and care activities.

Equitable and Equal Access to Services for All Levels of Society

Equity in health care is a basic right of all citizens of the country. The Ministry of Health will ensure removal of socioeconomic, gender, age, geographic, and cultural inequities in health care. The principle of equity in health care includes access to health for all children, including children with disabilities.

3.3.2 Integrated Services

Integration

Integrating community health services at every level is very important as it improves the quality of services for the clients by reducing missed opportunities that often result from vertical programs. Integration also saves on costs, as it compels program managers to look for areas where combined financing can be achieved to reduce the duplication of services.

Decentralization

Decentralization offers the potential for communities to be more involved and participate in decisions that relate to their development. This is expected to lead to an improvement in the health of the population if it enables an

increase in the quality of health inputs and if these health inputs are adjusted to the particular needs of local citizens.

Effective Referral Systems

A smooth handover and takeover of patients from health institutions to the community strengthens the relationship between the communities and the health care system while also ensuring that patients get the needed medical care. It is important for the Ministry of Health to establish effective discharge guides that prompt institutions to refer patients to specific levels for continued care.

3.3.3 Sustainability

Community Participation

Community participation in planning, implementing, monitoring, and evaluating services for the community is essential to building sustainability and self-reliance. All sectors of the community, including young people, traditional healers, women, men, and community associations, should be mobilized to participate in health care delivery.

Quality Assurance and Supervision

CH programs will be continuously reviewed as time goes by to ensure that regular updates are made. Each update will be followed with CHW training and capacity building. Conducting integrated supervision to ascertain that services are provided at the highest level of quality possible is key to quality assurance and setting community level standards.

3.4 POLICY GOAL

The goal of the National Community Health Policy is to provide clear guidance for the provision of holistic and sustainable health care services to communities with their full participation.

3.5 POLICY OBJECTIVES

1. Strengthen the capacity of decentralized health structures to improve community health service delivery
2. Strengthen the participation of community members in the community health activities
3. Improve the monitoring and evaluation systems and coordination of community health services at the central, district, health center, and community levels
4. Strengthen the motivation of CHWs to improve health service delivery and access in the community

3.6 POLICY DIRECTIONS

The National Community Health Policy and the concomitant Ministry of Health policies, s, and projects aim to improve the health of the Rwandan people through their full involvement and participation in the health delivery system at all levels. A specific sector strategic plan is going to be put in place to address the challenges and gaps identified in community health. A monitoring and evaluation (M&E) plan will also be put in place to ensure successful implementation of the policy. The following directions corresponding to the above objectives have been identified:

Objective 1:

Objective 1: Strengthen the capacity of decentralized health structures to improve community health service delivery

- Reinforcing integration of community services and supervision at all levels
- Advocating and mobilizing financial and human resources to support implementation of the community health programs

- Strengthening the capacity of community health workers to provide quality community health services
- Strengthening integrated community health package of services for all CHWs.
- Ensuring the development review , update and distribution of Guidelines and supervision tools to all CHWs
- Improve the Supply chain of community essential commodities and materials for community health
- Reinforce the innovations specialized community health services.

Objective 2: Strengthen the participation of community members in the community health activities

- Strengthen the recruitment system of the community health workers to ensure the community health services delivery
- Mobilizing communities for their full participation in community health services (promotional, prevention, and curative) with the involvement of men and women.
- Involvement of the communities in the process of analyzing local health needs and propose solutions

Objective 3: Improve the monitoring and evaluation systems and coordination of community health services at the central, district, health center, and community levels.

- Capacity building of the Ministry of Health staff for coordination of community health activities at all levels
- Building partnerships for community health through regular stakeholders meetings.
- Developing a monitoring system that will also capture community activities at the community level
- Develop and make regular review of keys community health indicators to improve the community health reporting system To improve data quality collection analysis and use

Objective 4: Strengthen the motivation of CHWs to improve health service delivery and access in the community

- Advocating for additional funding for the CPBF
- Compensating CHWs through CPBF, CHW cooperatives, and in-kind compensation
- Strengthening CHW cooperatives business activities that belong to community
- CHW performance indicators updated and reviewed to respond to national priorities
- Regular assessment of financial needs/gaps for the implementation and sustainability of CPBF
- Put in place the innovative strategies for CHW retention to sustain the community health services
- Improve the collaboration and communication between local leader's communities and CHW

4 GOVERNANCE FRAMEWORK

4.1 ORGANIZATION AND MANAGEMENT OF COMMUNITY HEALTH PROGRAM

The community health program is integrated in the national health system at each level: central (the Community Health Desk at the Ministry of Health), district (referral hospitals and district hospitals), sector (health centers), cell (cell coordinators), and village (CHWs).

4.2 MANAGEMENT AND STEWARDSHIP

The Ministry of Health leads the process of developing guidelines, preparing training manuals, and building capacity on all levels for coordination and reinforcing adherence. Districts will then be charged with overseeing the implementation of this policy.

The roles and responsibilities at each level of the decentralized structure of the community health program are as follows:

Ministry of Health

- Regulation through issuing guidelines and setting policies that are aimed at bringing quality and affordable health care closer to the population
- Prepares training manuals
- Provides routine integrated supportive supervision to ensure proper performance at various levels
- Provides funding for health activities at the various health facilities in the country
- Coordinates directly and indirectly health related activities to ensure efficiency

District Level and District Hospitals

Under the Ministry of Local Government, the district is the unit of decentralization. This level provides administrative support to the district hospitals and health centers. A district health expert is in charge of community health and works closely with district and health center health facilities in the district catchment zone to coordinate and manage community health-related activities. The district hospital continues to coordinate and directly oversee the implementation of the community health activities, including the CPBF program. The district focal person is also responsible for implementing community activities including analyzing and entering the data into the RCHMIS and for verifying the data reported and submitted from the health center. This staff will also be responsible for ensuring that the CPBF program is implemented in the community through the coordination and management of the health center staff also in charge of community health activities.

Sector Level and Health Centers

The sector level is the central unit to the implementation of community health programs. It is at this level where CHW cooperatives sign the CPBF contract with the local sector administrator (mayors' delegate). The Sector PBF Steering Committee oversees this contract—along with its other responsibilities, the committee approves the payments, which are effected by health centers to the CHW cooperatives.

Cell Coordinators

The cell coordinators are *binomes* or ASMs chosen as the supervisor of around 15-20 CHWs at the cell level. Cell coordinators possess a higher level of formal education than most other CHWs.

The cell coordinator conducts peer supervision visits, and is responsible for compiling and submitting CHW reports, including drug quantification and requisition to the health center.

Steering Committees

At the level of each administrative sector, there is a steering committee that is comprised of the following individuals:

- In charge of social affairs at sector level who heads the committee
- Head of the health center (i.e., the *titulaire*)
- In charge of community health activities at health center
- President of CHW cooperative
- Representative of civil society
- Health center accountant

The sector steering committee is charged with the following:

- Analysis of monthly and quarterly reports done by CHWs
- Approval of the above reports after scrutiny to ensure accuracy in reporting
- Approval of PBF payment to CHW cooperatives

4.3 PARTNERSHIP AND COORDINATION

At the national level, the Ministry of Health will coordinate and provide leadership for the implementation of this policy. District authorities, with clear central guidance and support, will coordinate at the district level. At the community level, the local health center or a designated community structure with clear mandates, guidance, and support from the district authority will oversee coordination. The MOH will develop an effective system to then coordinate all community health services provided by the Ministry of Health, other government ministries,

international agencies, international NGOs, local NGOs, FBOs, CBOs, and directly by the communities, with emphasis on the following:

1. There must be explicit policy direction on what partners can do in response to community health needs.
2. There must be explicit guidance in the strategic framework on how to include other partners.
3. Capacity strengthening for health institutions should respond to the needs of new partners offering community health services. Capacity building for new partners is needed to improve their skills, knowledge, and attitudes, since poorly prepared partners find it difficult to fit into the broader partnership, and this tends to derail the national efforts.
4. There must be a shared vision with partners and clearly defined roles at the district level, thus promoting commitment to the national goals and allowing for joint planning, evaluation, and monitoring as needed.

Developing an effective coordination system is critical for the success of community health services. Coordination means organizing leadership to manage, direct, synchronize, harmonize, and combine activities that otherwise would have been separate entities. As there are many organizations such as FBOs, NGOs, CBOs, and international partners providing health services at the district and community levels, the Ministry of Health will establish a clear coordination system at the central, district, health center, and community levels that will build a cohesive team. As the local health center forms the link between the district and the community, the capacity of these health facilities to coordinate community health activities will need to be developed so that they can lead, supervise, and support communities and other organizations implementing health projects at the community level. However, for the local health center to perform its duties of coordination and collaboration adequately, it will need sufficient support from higher levels to be nurtured into a position where it can perform well. Guidelines for coordination should be explicit in how, when, and what to coordinate.

Government Commitment

The role of the MOH in will be to advocate with other ministries, such as the Ministry of Finance, MINALOC, MIGEPROF, and MINECOM for resource allocation to the CH policy's implementation. It will also advocate with other partners, such as international agencies, to mobilize external resources and acquire technical support. In the process of this advocacy, effective partnerships with different organizations in accordance to their comparative advantages should be developed and managed effectively. The Ministry of Health will identify funding sources for the implementation of this policy.

4.4 MONITORING AND EVALUATION AND ACCOUNTABILITY

Monitoring and evaluation of the policy implementation process and outcomes is critical for informing the MOH on the progress being made. For monitoring and evaluation of community health activities to be effective, there must be a monitoring and evaluation package developed which sets out a minimum of clear, achievable, and time-bound objectives, outputs, and outcomes; realistic targets, meaningful indicators, and standardized tools for data collection are also necessary. These must be backed by the National Health Policy and National AIDS, CH, MCH, and FP policies. This package will be accompanied by monitoring and evaluation plans implemented at the central, district, health center, and community levels, in addition to ongoing bottleneck analyses at the local level. Community health indicators will be collected and regularly reported through the various e-health systems, including RapidSMS (comprising the RapidSMS commodities component), RHMIS, and community LMIS.

The Ministry of Health will have to review the monitoring tools to assess their adequacy for the monitoring of the policy implementation. Disaggregated data collected locally will need to be interpreted, discussed, and then used to inform the local structures for improving their health and policy planning. The MOH may need to assist the districts to develop databases where they do not exist.

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