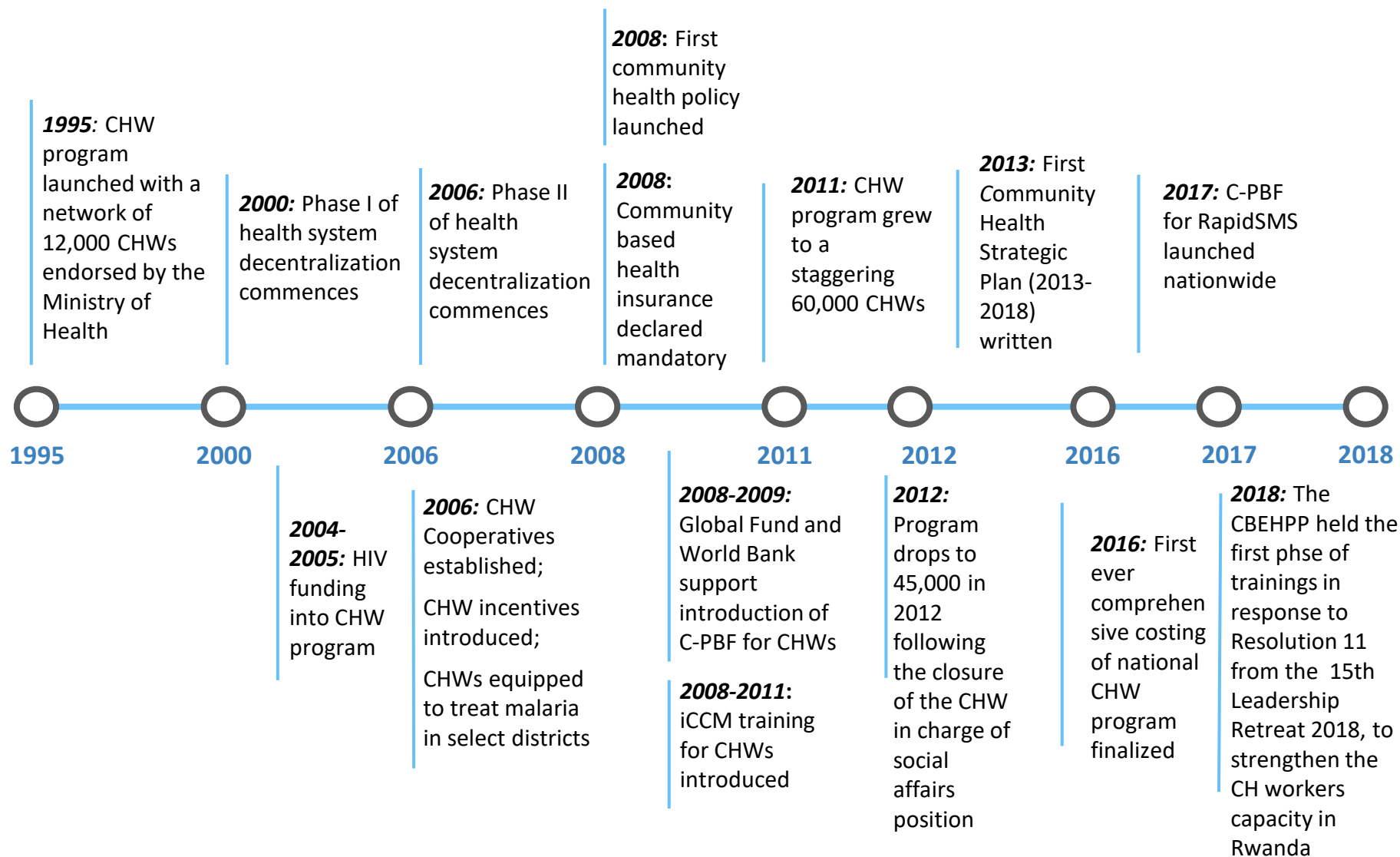


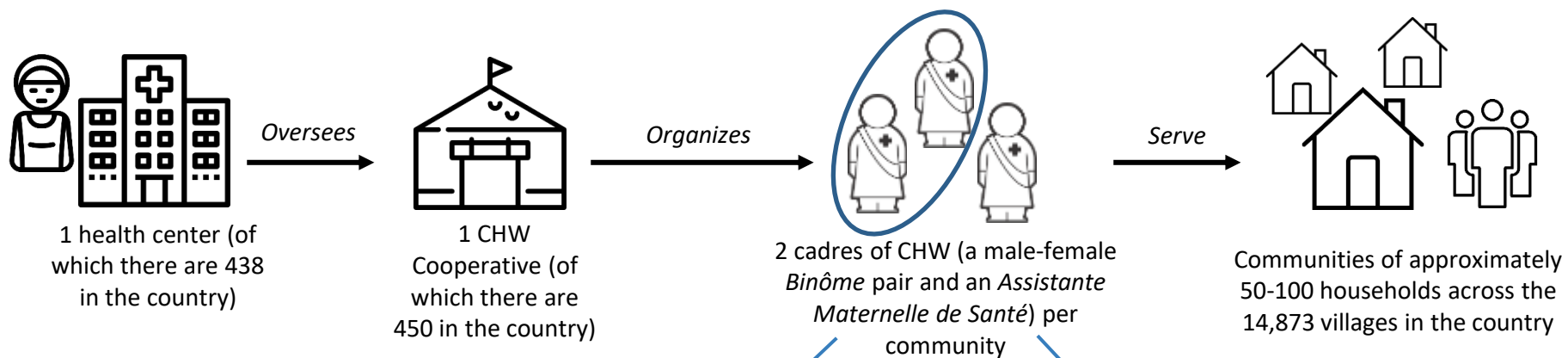
Financing Alliance for **Health**

Country Case Study: Rwanda

Rwanda's national CHW program was introduced in 1995, shortly after the culmination of the genocide



Rwanda's CHW program includes ~45,000 CHWs (approximately 30,000 *Binômes* and 15,000 *Assistante Maternelle de Santé*)



Male *Binôme*

&

Female *Binôme*

Assistante Maternelle de Santé

- **# in workforce:** 45,011
- **Time spent:** 5-8 hours per week
- **Interventions:** 1) iCCM 2) malnutrition screening 3) community-based provision of contraceptives 4) DOTS for TB 5) NCD sensitization 6) BCC 7) regular household visitation
- **Selection:** One female/one male per community, between 20 and 50 years, literate, primary school graduate
- **Training:** receive 3–5 days of training on maternal, infant, and young child nutrition, and community information systems and reporting. 10 days of training in the community-based provision of family planning is also offered to some CHWs.
- **Health system linkage:** RapidSMS
- **Incentives:** Varies (based on performance and functioning of cooperative)

- **# in workforce:** 15,000
- **Time spent:** 5-8 hours per week
- **Interventions:** 1) visitation of pregnant women and newborns 2) malnutrition screening 3) community-based provision of contraceptives 4) NCD sensitization 5) BCC 6) regular household visitation
- **Selection:** One female per community, between 20 and 50 years, literate, primary school graduate
- **Training:** varies
- **Health system linkage:** RapidSMS
- **Incentives:** Varies (with performance and functioning of cooperative)

Rwanda's CHW program has been historically well supported across multi-sectoral policies and through strong, nationally-owned coordinating bodies

“We appreciate support from the outside, but it should be support for what we intend to achieve ourselves. No one should pretend that they care about our nation more than we do; or assume that they know what is good for us better than we do ourselves. They should, in fact, respect us for wanting to decide our own fate.... While this is encouraging, we know the road to prosperity is a long one. We will travel it with the help of a new school of development thinkers and entrepreneurs, with those who demonstrate they have not just a heart, but also a mind for the poor.”

(President Paul Kagame as cited in Government of Rwanda, 2014)



Policy

- Community Health Policy (launched 2008; updated 2015)
- Community Health Strategic Plan 2013-2018
- Economic Development and Poverty Reduction Strategies (EDPRS I and EDPRS II)
- Vision 2020
- Seven-Year Government Program 2010-2017
- Health Sector Strategic Plan 2012-2018
- National Strategy for Community Development and Local Economic Development



Governance

- Rwandan Ministry of Health
- Rwandan Biomedical Center
- Ministry of Local Government
- Performance-Based Financing Department
- Sector PBF Steering Committee
- Development Partners Coordination Group
- CHW Cooperatives

A 2016 evaluation of the program nationwide (led by UNICEF in partnership with the Ministry of Health and Rwanda Biomedical Center [RBC]) found the community health program – on an operational level – to be highly in line with national policies and plans.

Financing to the CHW program comes through three major channels

Channel 1: Domestic Resources

Description

Flows via Ministry of Finance. Includes budgetary support and “targeted budgetary support,” govt funds, and program-specific funds from some donors

% of total community health program funding

~13%

Channel 2: Donor Resources

Flows via Ministry of Health. Includes pooled donor funds and program-specific funds from some donors; high level of govt oversight and alignment with govt strategies

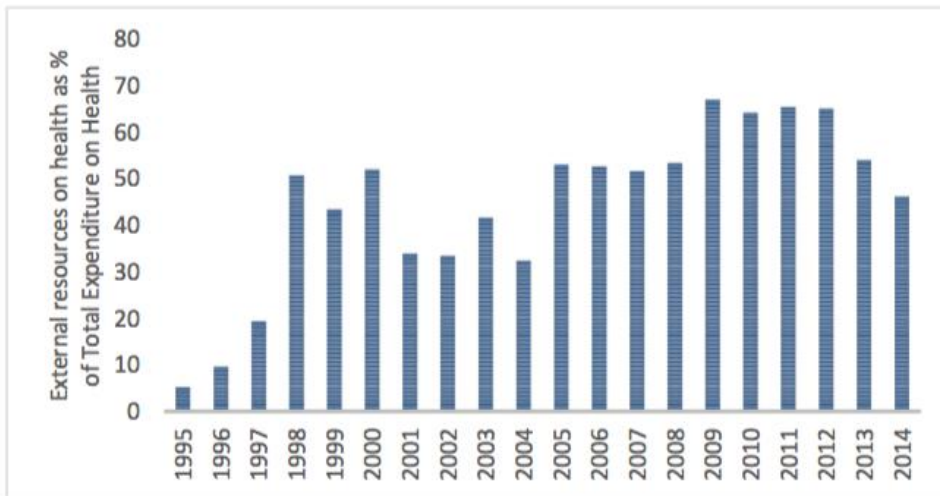
~87%

Channel 3: CHW Cooperatives

Percentage of CHW Cooperative earnings flows back into program operations primarily in the form of CHW incentives

Negligible. If 100% of cooperatives were generating a profit (up from 33%) only 20% of the total cost of the CHW program would be covered

Several challenges lie ahead that could hinder the CHW program from achieving financing sustainability...



External resources for health as % of the total expenditure on health (1995-2014)

Though the government has been picking up an increasing proportion of the total community health bill over time, there remains a heavy reliance on ever-decreasing external funding.

As donor interest in contributing to a health system deemed successful and self-sufficient wanes and sights turn to more pressing humanitarian and global health security crises, the country must urgently face the challenge of how to pitch the “maintenance” argument. Macroeconomic questions emerge for imminent consideration as the country assesses the ability of its growing fiscal space to sustain the robust, post-genocide program comprised of one of the country’s largest workforces.

Five key lessons have emerged from Rwanda's CHW program

- 1 Strong **political commitment** from the highest levels of government has led the national CHW program forward since its inception. Political leadership has proven to be key in a number of ways including but not limited to rolling out a highly decentralized system, and securing funding and strengthening rapport with key funders.
- 2 Rwanda's community health strategy and program design has gone through numerous iterations over time. Such **incrementalist implementation** has allowed the program to reflect the fluid context in which it is deployed, respond to the burden of disease, and react strategically to the available envelope of resources.
- 3 A **strong overarching policy and strategic plan**, with one coordinating body that is committed to harmonization and collaboration with broader pro-poor, development, and health equity initiatives has promoted the program's widespread success. Centralized and decentralized accountability and a robust system of checks and balances are well-understood and well-maintained across all levels.
- 4 The introduction of an evolving **community performance-based financing (C-PBF) system** has led to a direct focus on and valuing of high performance and has positioned the country to build strong evidence of CHW contributions to health and development targets.
- 5 **Heavy reliance on CHW Cooperatives** has proven to be an insufficient strategy for financial sustainability. Though cooperatives may be an effective means to assemble and manage CHWs, and while they may offer additional income generation opportunities, the experience in Rwanda suggests that they can neither stand as the sole sustainability strategy nor can their income generation activities replace a livable wage.

Other countries can apply these lessons based on their own contexts

Lessons from Rwanda

Key considerations for other countries

1 Political commitment

In the absence of top-down political will, consider strategic evidence-based advocacy

- Different political contexts may require investments in relationship building and targeted advocacy with key actors, including the use of data and evidence on impact/cost-effectiveness

2 Iterative implementation

CHW programs must be designed with flexibility to adapt to changing demographic and epidemiologic profiles, as well as to a fluid financial envelope

- A sustainability mindset and clear strategies at the outset (including a plan for financial sustainability, government absorption of program operations, mapping of innovative sources as part of initial budgeting and resource mobilization plans)

3 Strong overarching policy & strategy

Establish centralized and decentralized policies, systems, and units to improve coordination and harmonization and take tangible steps to organize community health programming under one umbrella

- Mechanisms for community health governance (i.e., dedicated directorate) and partner coordination (e.g., joint forum) are key first steps; each of which govt. should lead

4 Community performance-based financing (C-PBF)

Rigorous tracking of CHW contributions to health targets not only establishes and feeds a platform for evidence generation but also contributes to the formal institutionalization of the cadre within the health system

- A C-PBF system, which directs CHWs to focus efforts on key, high-yield interventions, and rewards high performers relies on robust monitoring, evaluation, and quality systems and should not be built in their absence

5 Community-level structures for organization

Build local, community-owned structures (such as cooperatives) to decentralize program operations and enable income generation that can fuel program operations

- Decentralization should extend down to the community level
- Embedding CHW-only cooperatives in communities can foster a range of benefits such as income generation and local oversight of program operations