

REPUBLIC OF RWANDA



**MINISTRY OF HEALTH
P.O BOX 84 KIGALI**

**COMMUNITY PERFORMANCE BASED FINANCING (PBF)
PROCEDURE MANUAL
SUPPLEMENTAL FOR THE STUNTING PREVENTION AND
REDUCTION PROGRAM (SPRP)**

October 2018

FOREWORD

Since the year 2000, Rwanda has made tremendous progress in all sectors of development and specifically in the health sector, which was demonstrated by achieving most of the Millennium Development Goals (MDGs). The Performance Based Financing (PBF) approach institutionalized in Rwanda since 2008 contributed a lot to the achievement of Millennium Development Goals (MDGs) by boosting the utilization of health services, especially by the vulnerable groups.

During the last decade, the PBF strategy made an important contribution to increased productivity, quality and efficiency in the delivery of health services where Community Health Program through CHWs significantly contributed to Rwanda's achievement of the MDGs, and as indicated by the latest Demographic and Health Survey (DHS Rwanda 2015) the under-5 mortality rate declined from 152 per 1,000 live births in 2005 (RDHS 2005) to 50 per 1,000 live births in 2014 (RDHS 2014-15); the neonatal mortality rate also reduced from 37 per 1,000 live births to 20 per 1,000 live births. The maternal mortality ratio (MMR) also successfully reduced: MMR was estimated at 750 per 100,000 live births in 2005, and at 210 per 1,000 live births in 2014-15 (RDHS 2014-15). Thus, Rwanda met MDGs 4 and 5 targets. For the sustainable implementation of this strategy, the Ministry of Health defined a comprehensive PBF framework with guidance for each level in terms of payment mechanisms, contracts with decentralized levels and PBF control mechanisms.

One of the major challenges faced by decision makers is to ensure sufficient and quality health services provision to respond to the increasing demand by the users and sustain the high level of performance reached. In order to confront these challenges, Rwanda embarked on a number of reforms through decentralization and the establishment of performance contracts between the H.E President of the Republic and the decentralized administrative authorities (Imihigo).

The PBF system is dynamic and its guiding documents need regular review. Over the years, numerous changes have been implemented, such as the link between PBF quality assessments and accreditation at the hospital level, the review of Health Center PBF indicators to include non-communicable diseases and the introduction of individual performance indicators in the community PBF model.

PBF indicators related to Stunting Prevention and Reduction Project (SPRP) have been introduced at Health Centers and Community level in the PBF system which is already operational with various indicators on maternal and child health outcomes. This PBF system will address the challenges faced by adding indicators to combat the high prevalence of stunting, height for age of children under 5.

We therefore, urge all health and local government authorities as well as the population to comply with the guidelines in this procedures manual and to use it wisely so that our health system is effective and efficient for us to embark on the SDGs with determination.

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ACCRONYMS

ANC	Ante Natal Care
BNR	Banque National du Rwanda
CBHI	Community Based Health Insurance
CHW	Community Health Workers
C-CHW	Cooperative of Community Health Workers
CPBF	Community Performance Based Financing
CRDQA	Community Routine Data Quality Assessment
DF	Director of Finance
DGPHFIS	Directorate General of Planning Health Financing and Information Systems
DH	District Hospital
DHS	Demographic and Health Survey
DSC	District Steering Committee
EDPRS II	Economic Development and Poverty Reduction Strategy II
EPI	Extended Program of Immunization
FP	Family Planning
GOR	Government of Rwanda
HC	Health Center
HF	Health Facility
HIV	Human Immunodeficiency Virus
HMIS	Health Information System
HSSP	Health Sector Strategic Plan
IGA	Income Generating Activities
IHSS	Integrated health System Strengthening
IMCI	Integrated Management of Child Illnesses
ITN	Insecticide-Treated Mosquito Nets
MDG	Millennium Development Goals
MOH	Ministry of Health
MSH	Management Sciences for Health
MUAC	Mid-Upper Arm Circumference
ORT	Oral Rehydration Therapy
PBF	Performance Based Financing
PBI	Performance Based Incentive

PO	Payment Order
PS	Permanent Secretary
RBC	Rwanda Bio-Medical Center
RHMIS	Rwanda Health Management Information System
SMS	Short Message Sent
SISCOM	“Systeme d’Information Sanitaire Communautaire”/Community Health Information System
SSC	Sector Steering Committee
TB	Tuberculosis

CHAPTER I: INTRODUCTION

1.1 PBF CONTEXT AND BACKGROUND

Rwanda's overall development objectives are specified in the Vision 2020 and the National Strategy for Transformation (NST1). The Decentralization Policy provided guiding principles for decentralized planning, management and decision making across sectors, including health.

The Ministry of Health (MOH) provides political and technical leadership of the health sector under the framework of the Health Sector Strategic Plan (HSSPIV 2018-2024). It is responsible for coordinating its related institutions, line ministries, the private sector, non-governmental organizations (NGOs) and development partners to improve health care provision and health outcomes in the country. It sets key health policy objectives, identifies the priority health interventions for meeting these objectives, outlines the role of each level in the health system, and provides guidelines for improved planning and evaluation of activities.

1.2 HISTORICAL DEVELOPMENT OF CPBF IN RWANDA

Performance Based Financing started in Rwanda as early as 2001. Several factors led to its introduction. Firstly, NGOs working in Rwanda at the time felt that although they paid health workers a 'bonus' salary supplement, the health services outputs produced at their facilities were stagnating and, in some cases, even deteriorating. Another reason was that innovative experiences from other contexts, such as a pilot health services contracting scheme in Cambodia, proved to be very successful at achieving quality improvements and other significant results in areas seen by the health authorities and partners in Rwanda as critically important. This experience was adapted to and applied in Rwanda through a number of individual initiatives. In 2001, the NGO Memisa/Cordaid started a PBF scheme in Cyangugu (Western province) while HealthNet International (HNI) started one in Butare (Southern province). In 2005, the Belgian Technical Cooperation (BTC) also started a PBF scheme at health centers and district hospitals in Kigali City, Kigali Ngali and Kabgayi Health District. These piloting experience which particularly focused on quality of health care services delivery confirmed PBF effectiveness as a mechanism to achieve significant improvements in quality of services but also in increasing the volume of services delivered.

These models applied by NGOs although with different set-ups, proved that performance-based incentives when well designed and managed are successfully producing sought after results in Rwanda and in 2006, the MoH decided to roll out PBF in all health facilities throughout the country for quantity and qualitative selected indicators improvements.

The Performance Based Financing at community level started as a pilot in 2009; currently it is scaled up throughout the country.

The national Community Performance-Based Financing (CPBF) strategy is based on the significant achievements registered through rewarding health facilities for good performance, and the community PBF scheme has been implemented over the past six years. The goals of CPBF are defined as increased utilization and improved quality of services. CPBF emphasizes output financing mechanisms as well as community participation rather than relying solely on input-based financing. It is critical for the MOII to continue supporting and strengthening PBF efforts at all health system levels to promote results-based financing, planning and program management as well as institutional and system-wide accountability.

Since 2009, there have been many changes in indicators reported, payment mechanisms, and contracts -- and the last CPBF review was conducted in 2012. For these reasons, this Procedures Manual takes into account all changes made in the community health program.

1.3. OBJECTIVES OF COMMUNITY HEALTH PROGRAM AND CPBF

1.3.1 Objectives of Community Health Program

The overall objective of the community health program is to provide holistic and a sustainable package of health care services to communities with their full participation. The specific objectives of the program are to:

1. Strengthen the capacity of decentralized structures to allow community health service delivery.
2. Strengthen the participation of community members in the community health activities.
3. Strengthen CHWs motivation through CPBF to improve health service delivery
4. Strengthen coordination of community health services at the central, districts, health centers and community levels

1.3.2 Objectives of the Procedures Manual

The overall objective is to help all actors understand their roles and responsibilities and to ensure that the CPBF scheme is managed in an organized environment.

The specific objectives of this manual are to:

- Avoid the conflict of interest by defining the separation of functions in the CPBF model;
- Define the reporting and payment mechanisms;
- Identify the evaluators and counter-evaluators in CPBF scheme;

- Define the way the CPBF funds are utilized
- Describe the way CPBF data is managed and used to calculate incentives and monitor progress through CPBF indicators for Community Health Workers
- Establish rules and regulations to prevent fraud, and define sanctions and penalties imposed should fraud occur.

1.4 ORGANIZATION OF HEALTH SYSTEM IN RWANDA

Rwanda's overall development objectives are specified in the Vision 2020¹ and the National Strategy for Transformation (NST1)², which all aim to improve the well-being of the Rwandan population. As part of this vision, the Government seeks to overcome the illnesses linked with poverty and ignorance, and to develop a proactive and well performing health system capable of anticipating and appropriately responding to the health needs of the population.

1.4.1 Strategy and Priorities for the health system in Rwanda

As elaborated in the HSSP IV (2018-2024), the Rwanda health system has a number of key priorities. These are around maternal, neonatal and child health, community health and many others as summarized below;

1. **Maternal, Child and Community Health (MCCH):** Improve and sustain quality of MCH services with critical focus on decreasing maternal and neonatal mortality, increase ANC and Postnatal care uptake and improve community mobilization to increase facility delivery.
2. **Nutrition:** Community education and awareness on dietary and complementary feeding practices, establishment and using Early Childhood Development (ECD) as an entry point of provision health interventions, specifically nutrition and prevention and management of malnutrition (acute and chronic).
3. **Community Health:** Support the Capacity building of CHWs and ensure the sustainability of CHW Program.
4. **ASRH & GBV:** Improve access and quality to FP services with a focus on long term methods as well as scaling up post-partum FP education and provision.
5. **Health Financing:** Ensure financial sustainability of Health sector (increase budget, optimization, efficiency, collaboration with the private sector and PPPs, promote new innovative financing mechanisms for high impact interventions and emerging diseases and ensure periodic revision of health insurance package.

¹Vision 2020

²National Strategy for Transformation (NST1 2018-2024)

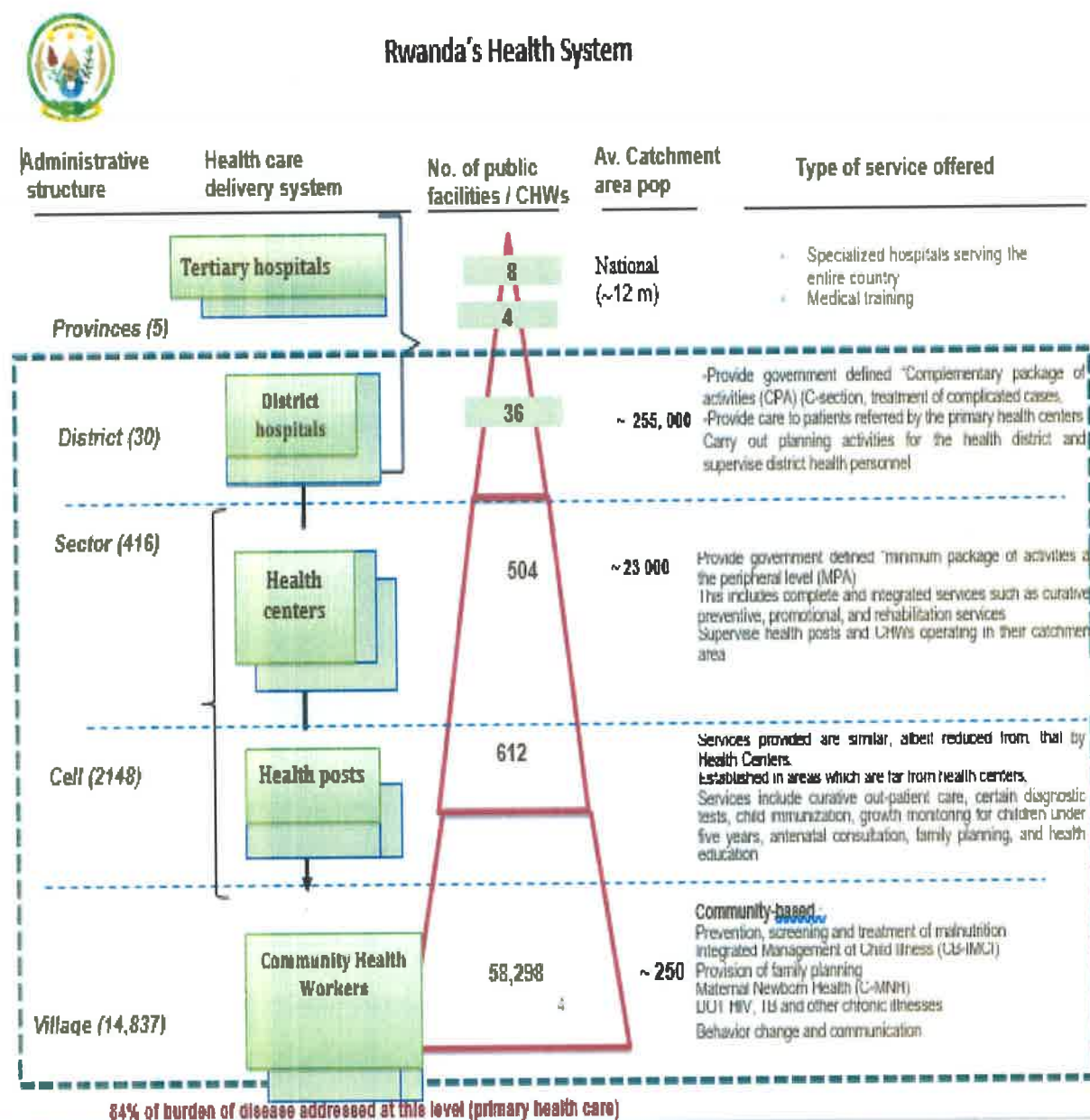
6. Coverage of essential health interventions such as infectious diseases, NCDs, mental health, health promotion and environmental health as well as epidemic surveillance.
7. The other key priority is on health systems as inputs like human resources, medical products, service delivery and quality improvement, leadership and governance as well as health information systems.

1.4.2 Rwanda Health System Organization

The health system in Rwanda forms a pyramid, where the base, represented by the community health, is large and the top, representing the central level, is small. In between there are different levels representing the provincial, district, sector and cell levels, with, at each level, a corresponding category of health facility (HF) and a well-defined referral system. The figure below shows an overview of the structure of the Rwanda health system.

Figure 1: Overview of Rwanda's Health System Hierarchy

Figure 1: Rwanda Health System



1.4.3 Organization of Community Health Program

The Community Health program in Rwanda plays a key role, since there are CHWs in all villages across the country that provide preventive, curative and promotional activities to the population. They are accepted and trusted by the population to whom they provide primary health care for common diseases (including malaria, pneumonia and diarrhea), and refer complicated cases to health centers. CHWs play a vital role in providing primary health care at community level where 80% of disease burden is addressed.

1.4.3.1 CHWs selection

The Community Health program is a formal part of the national health strategy, it is primarily run by Community Health Workers who are elected by the village members based on defined criteria such as: ability to read and write; aged between 20-50 years; willing to volunteer; living in the local village; is honest, reliable, and trusted by the community.

1.4.3.2 Number of CHWs

Each village of about 100-150 households has three CHWs (one woman for maternal and newborn health, named "*Agente de Sante Maternelle*" (ASM), and a male and female multi-disciplinary pair of CHWs, named "*Binome*", who provide care to under 5 children) as well as another CHW regardless of gender who is in charge of Non-Communicable Diseases (NCDs) and Mental Health care. With a total of 14,837 villages, Rwanda has 58,298 CHWs.

1.4.3.3 CHWs Coordination

A cell coordinator, selected from among the CHWs in each cell's catchment area, assumes the direct supervision of CHWs in his/her area, while the Health center has an Environmental Health Officer (EHO) who is dedicated to coordinate all community health activities done by CHWs in the HC catchment area.

At the District Hospital, among the team of supervisors, one is responsible for CHWs activities as well as supervises the Environmental Health Officer based at HC.

At the Administrative District level, the District Health Unit (DHU) is responsible for overall coordination of the Community Health program in its catchment area.

At the central level, the Ministry of Health has a PBF unit, in the Planning, Health Financing and Information Systems Directorate that manages all PBF schemes, including community PBF.

The Maternal, Child and Community Health (MCCH) division in RBC ensures the technical coordination of the Community Health program, while the Community Health Unit is responsible for day-to-day implementation of the national Community Health program.

1.4.3.4 CHWs Service Package

There is a well-established community health package of services that includes community mobilization (sensitization), prevention, curative and promotional activities.

CHWs who don't have any medical background are highly valued and respected by the communities they serve.

Over the years, the package of services offered by CHWs became more complex and now includes a range of services (see *Annex 1*).

CHAPTER II: COMMUNITY PERFORMANCE-BASED FINANCING PRINCIPLES

2.1 DEFINITION OF CONCEPTS

This section first provides the definition of the most common PBF-related concepts and terms, followed by sub-sections on key CPBF principles used in the program

Indicator: a performance measure which is objectively verifiable. In the general context of the contractual approach through PBF, there are quantity indicators (found in service units) and quality indicators (an act/procedure/service which is properly executed /offered according to the quality standards). Most indicators in CPBF are not simply outputs, but rather calculated performance indicators (such as the *Ratio of Post-natal visits to Deliveries reported*) and payment is based upon ranking the performance of cooperatives and CHWs into different performance quintiles (5 levels of performance).

Regulation: The act of ensuring proper operation of a complex system (like a health system) by setting standards and monitoring their adherence. This role is the mandate of the Ministry of Health which sets standards in form of national health policies and at district level through decentralized health entities.

Contract: An agreement by which various parties (individuals, institutions etc...) freely bind themselves to do or not to do something. The PBF contract can be entered into at different levels, between different partners and under different modalities (Ministry-District, District-Health Facilities committees, Health Committees – Health staff).

The PBF contract fits into the separation of function principles between performance and financing of health services. There are two categories of contracts; the national contract in which the partners sign with the facility and the individual contract between the facility and each staff.

Performance: optimal results that one can get in a particular field (through competition, in other words, the capacity to compete favorably). The required performance for PBF is that of health staff who must be “performing, active, innovative and competitive” to get better quantitative and qualitative results. In the case of CPBF, performance is calculated based on composite indicators and CHWs and facilities are ranked on their average scores – they are not paid specific tariffs for individual output indicators.

Performance- Based Financing refers to the transfer of money or material, goods on the basis of a concrete, measurable action or the attaining of a pre-determined target. The funds are received

at regular intervals based upon verified results. The proposal to manage the performance through performance based financing in the current context is founded on the strategy for contracting the stakeholders in the provision of basic health services.

Attaining the goal of universal access to health services requires special efforts from which the need to clarify the roles and responsibilities of stakeholders so as to ensure not only performance by the health workers but also and especially the performance of health services delivery system.

Provider/Vendor: The entity that sells the produced indicators according to the terms/conditions of the contract between him and the buyer. The PBF vendors also vary according to the level of the contract; the last vendor is the service provider.

Purchase: acquiring something, a good or a service after payment. PBF procurement entails a certain number of indicators for health facilities.

Purchaser: The entity that buys the produced indicators according to terms /conditions of the contract between him/her and the provider. Like in PBF contract, the buyer can be different depending on the level of the contract.

Quality: A trait which attaches more or less value to a product. The quality of care provided to the population for a specific service involves technical quality (compliance with norms and set standards for health care delivery). Technical quality control is achieved through quarterly quality supervision and evaluation. In the CPBF model, the scale is so large that it is not possible to assess each service output and as a result quality is not factored into the payment amount in the same way. However, key indicators have been selected that reflect quality of care, for example: the ratio of neonatal follow-up visits to deliveries and the ratio of follow-up visits made to the number of sick children treated.

Motivation: An emotional state, a behavior which pushes someone to act so as to attain a goal or results. Health staff motivation in PBF is aligned to performance in the production of services. Performance in production of good quality services entails increased revenues for the contracted health structure and subsequently can contribute to the individual health worker revenue and vice versa. However, it is important to note that there is usually a need for both intrinsic motivation and extrinsic motivation, which are complementary, in order to have a complete motivation and results.

Verifier: an individual or entity that verifies the accuracy of data reported and confirms that services were actually delivered.

Cooperative: A cooperative is an autonomous association of persons united voluntarily to meet their common economic, social, and cultural needs and aspirations through a jointly-owned and democratically-controlled enterprise, according to internationally recognized co-operative values and principles.

2.2 SEPARATION OF FUNCTIONS IN CPBF

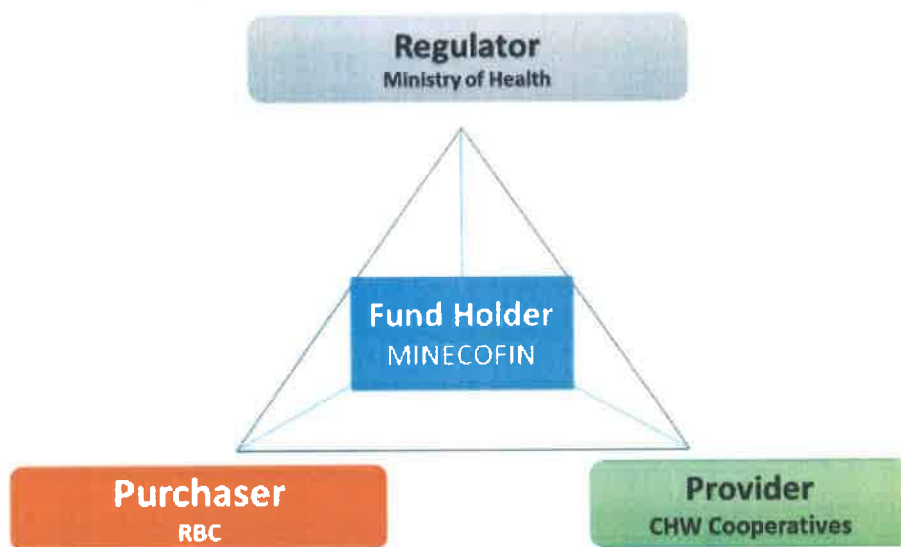
This section describes the institutional setup in CPBF implementation ensuring separation of functions, roles and responsibilities. Separation of functions is paramount to effectively and efficiently implement the CPBF strategy and to avoid conflict of interest. These imperatives require that the regulator, the fund holder or the purchaser and the provider all be different from one another.

The CPBF approach is based on 3 principles:

- The separations of functions
- The contractual approach
- The indicators to be purchased

Figure II below shows the functions and respective institutions involved in PBF implementation at Community level. The MOH is the regulator and sets policies and procedures. The providers are the CHWs Cooperatives delivering health services to the population whereas the purchaser is RBC.

Figure 2: Separation of functions in CPBF



The regulator - Ministry of Health

The overall management of the PBF is the responsibility of the MoH. The MoH is the regulator with main functions including; regulation (setting the policies, norms and procedures), supervision/facilitation of the CPBF implementation strategy, resource mobilization and resource allocation.

➤ The Purchaser

The Rwanda Biomedical Center (RBC) is the purchaser of performance results for the SPRP project.

➤ The provider

As earlier defined the provider is the entity that implements strategies and activities that will improve the volume and quality of services in view of producing results meeting or surpassing the targets or goals agreed-upon according to the terms and conditions of the contract established with the purchaser (buyer). The role of provider is played by all CHWs through Cooperatives taking part in the CPBF system.

2.3. Contractual approach

In Rwanda, the CPBF contract is signed between the provider and the purchaser. Here the providers are CHWs Cooperatives and the purchaser is the GoR through the RBC.

2.3.1 Importance of contracts

The contract allows different parties in the separation of functions to be accountable for their responsibilities. In the Rwandan model, the contract is signed between the purchaser and the provider. Here the purchaser is the RBC that represents the interests of the population and the providers are the cooperatives of the community health workers.

The purchaser is responsible for paying the provider after making sure that the terms of contract have been respected. The provider is responsible for delivering qualitative and quantitative services to the population in need. In the CPBF model, the CHWs deliver a specific health service package to the population.

CPBF contracting approach should aim to avoid conflict of interest through rigorous respect of the principles of separation of functions.

2.3.2 Types of Contracts

In the Rwandan CPBF model there are two types of contracts as explained below:

2.3.2.1 Contract between the Executive secretary of the sector and the members of the SSC

The district is the decentralized local government entity that functions under a district council. Every year the district mayor signs a performance contract with His Excellence the President of the Republic of Rwanda (*Imihigo*). He also signs contracts with the structures under his authority to allow him achieve the required performance set into *Imihigo*.

In this manner the district mayor signs performance contracts with the executive secretaries of the sectors. The sectors also sign performance contracts with the steering committees to ensure that CHWs deliver good services to the population.

Among other objectives, the contract between Executive Secretary and SSC is to;

- Carry out data verification of CHWs monthly reports;
- Analysis and feedback of performance of CHWs on the indicators including nutrition which is a key performance pillar;
- Ensure quality improvement;
- Follow up of cPBF funds payment to CHWs to ensure their motivation.

The sector steering committee is supported, monitored and evaluated by the district steering committee (DSC).

2.3.2.2 Contract between the Sector Steering Committee and the President of the Cooperative

The district is divided into sectors, the sectors into cells and the cells into villages. In each village there are three to four CHWs who prepare a village level month report. The CHW cell coordinator compiles their reports and aggregates them at cell level. The Environmental and Community Health officer then compiles all the reports at CHW cooperative level. The president of the Sector Steering Committee signs a contract with the president of each cooperative operating in the sector.

The members of the cooperative are all CHWs from the villages in the catchment area of the health center. There is only one sector steering committee (SSC), but there could be more than one cooperative, given the number of health centers in the sector.

Similarly, this contract outlines obligations for both parties including;

- Ensure CHWs deliver quality primary health care to the population at community level including growth monitoring of children;
- Ensure timely and accurate reporting on part of the CHWs;

CHAPTER III: COMMUNITY PBF MONITORING AND EVALUATION

3.1. Introduction

According to Rwanda's decentralization framework, the central level MoH is responsible for policy development, monitoring and evaluation. For the CPBF scheme, the MoH is represented by the District Steering Committee, which ensures support, monitoring and evaluation of the sector steering committees (SSC) and the validation of health centers' data.

The SSC purchases the performance of the CHWs grouped into cooperatives. Twice a year, it validates the data and counter-verifies if need be. This is done by making random field visits to check the report books of CHWs as well as stock of commodities and talking to some of the beneficiaries in the community.

In the CPBF model, the HC is the right arm of the SSC. It brings technical skills to evaluate the quality of the data from the cooperatives and advises the steering committee whether there is need of counter-verification or not.

At cell level, the cell coordinator gathers all information coming from the CHWs of different villages verifies the completion and accuracy and sends a consolidated report to the health center.

The village is the level where services are delivered by the CHWs. Figure 3 below, depicts the Administrative model for the CPBF scheme in Rwanda.

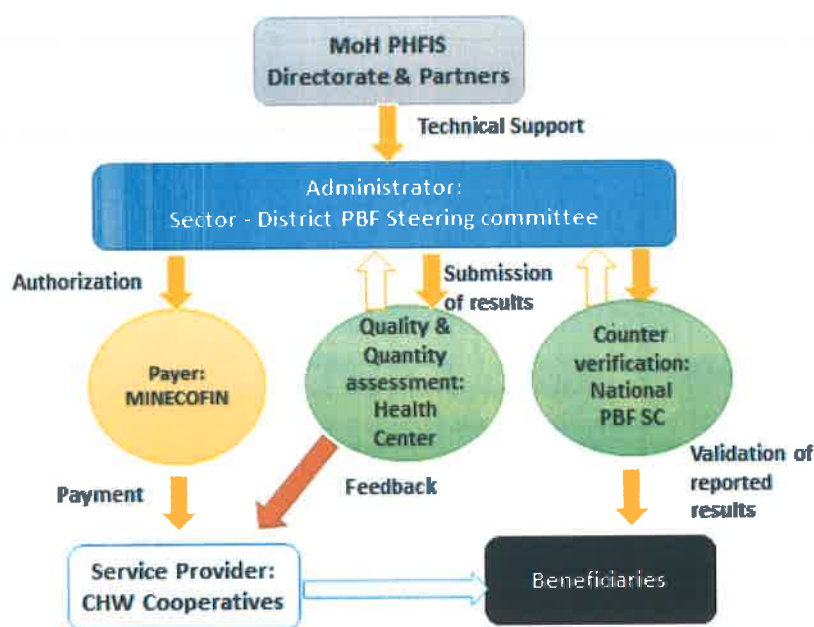
The CPBF model differs substantially from the other models in several ways:

- The model was initially designed to finance investments in income-generating activities by CHW cooperatives – with the hope that in future years CHW incentives would come from dividends distributed from the cooperative's profits and the scheme would become self-financing.
- Indicators selected for CPBF include some for individual CHW performance (from RapidSMS) and others that reflect the overall performance of the cooperative (from health center data reported through the RHMIS).
- Instead of purchasing specific outputs at fixed tariffs, the CPBF scheme uses a ranking system to calculate performance based on a set of indicators. All funds available during a quarter are allocated to individual CHWs through their cooperatives.

3.2 ROLES OF DIFFERENT ACTORS IN THE OPERATIONALIZATION OF CPBF

Various committees at the national level support PBF implementation at the Community level. These include the National PBF Steering committee, District and Sector Steering committees.

Figure 3: Community PBF Administrative Model



3.2.1 The Ministry of Health (MOH)

The Ministry of Health is the key agency when it comes to CPBF policies. Its specific roles include:

- Defining the policy related to the community health and community performance based financing;
- Supporting the district in implementation of the health policy which includes Community health;
- Mobilizing funds from government and donors to support the implementation;
- Evaluating the progress and make changes on the policy or capitalize on the success.
- Arranging the payment of PBF indicators
- Reviewing CPBF indicators and tariffs
- Following up to make sure beneficiaries (CHWs) received their rightful PBF funds

3.2.2 The District Steering Committee (DSC)

The DSC is the overall coordinator of the PBF strategy in the local government. Representing the mayor of the district for all health matters, it is the coordinating entity of clinical PBF in the health facilities and CPBF in the community.

It is responsible for implementing the incentivizing strategy, for verification, accuracy, control, decision and sanctions. It is accountable for making the PBF strategy a success.

It is a forum for discussion of different health-related matters including the community health services and community health workers' cooperatives.

The DSC is responsible for:

- Supporting and supervising the sector steering committee
- Monitoring the implementation of C-PBF at local level
- Ensuring the coordination between the central level and the peripheral level
- Developing capacity of the Sector Steering Committees
- Assessing quarterly the performance of the Sector Steering Committees
- Monitoring the progress of the C-PBF indicators
- Counter-verifying the C-PBF indicators at sector level and if necessary at cell and village levels
- Monitoring and evaluating the CHW cooperatives activities.
- Resolving conflicts occurring between SSC and CHWs cooperatives.
- Providing a quarterly report on C-PBF funds received by the cooperatives (Annex 3)
- Elaborating a financial report on Income Generating Activities of the cooperatives in his/her catchment area

3.2.3 Sector Steering Committee

3.2.3.1 Roles of the Sector Steering Committee

The Sector Steering Committee has the following roles and responsibilities:

- Supervises, trains and evaluates the community health workers;
- Analyses and corrects monthly reports of the CHWs sent by the in charge of community health in the health centers;
- Ensures the quality of data reported by CHWs;
- Manages archives of all community health PBF documents (reports, Invoices, payment orders);
- Counter-verifies the data at cell and village levels before the validation;
- Supports the CHW cooperatives in the elaboration of their action plans (See the task on annex 5).
- Provides a quarterly report on C-PBF funds received by cooperative (Annex 3)

- Elaborates the financial report on income generating activities for the cooperatives in their catchment area (Annex 4)

NB: If the sector has more than one cooperative, the committee will be represented by six more members per cooperative

Each administrative sector has at least one health center, but there can be more than one. The HC at the sector level plays the role of verifier of the quality of community data. The HCs must ensure transparency and independence in the verification exercise, and this is monitored through annual internal and external audits conducted from the central level.

The HC through the sector steering committee is an organ which purchases and oversees the functioning of the community PBF – if a sector has more than one HC, then a joint sector steering committee is established. Every community health worker individually provides health services included in his package, and reports his/her activities through the SISCom monthly report at the village level. These village level reports are consolidated by the cell coordinator at cell level, and finally all cell reports are consolidated at health center or cooperative level into one report.

3.2.3.2 Composition of the Sector Steering committee:

The sector steering committee is composed of:

- Executive Secretary of the Sector, or delegate (President)
- Head (Titulaire) of the health center (Vice-President)
- Staff in charge of CHWs at Health center level - EHO (Secretary)
- Community Health and Hygiene officer at Sector level.
- President of the cooperative
- Data manager at the health center

3.2.3.3 Sector steering committee functionality

Instructions for sector steering committee meetings

➤ *Participants' quorum*

The number of members of the sector steering committee is defined in the SSC contract signed with the executive secretary of the sector.

The minimum number of members required for a meeting to be held and make decisions is at least 3/4 of the members, including at least:

- One representative of the sector
- The Titulaire of the Health center or his deputy
- The Representative of the cooperatives

- And one person among the technicians of the health center (Data manager, In charge of CHW or in charge of environmental health).

➤ **Meeting procedures**

- Scheduling of the meeting: An invitation letter containing the agenda, the venue, the duration and the date is sent by the president to all members, three days before the scheduled date (**agenda format annex 7**).
- Preparatory meeting for data analysis by the health center team: The Titulaire of the health center, the in charge of CHWs and the data manager, prepare the data to be presented to the SSC. The data reported by the CHWs cooperatives and the data reported at the HC level must be equivalent. If there is a discrepancy; the team must look for an explanation, otherwise conduct a counter-verification exercise to identify the problems.
- Meeting process: Before starting to cover the points on the agenda, the secretary of the committee reads the previous minutes and the members suggest any amendments required, before the president signs to send it to the higher levels: The District Steering Committee and the district hospital. Then the committee follows the agenda for the meeting. If necessary, after agreement of attending members, the meeting can add other items to the agenda.
- Minutes of the meeting: Written minutes must be prepared in an appropriate format that documents discussions, decisions taken and follow-up actions.
- Transmission of Minutes: Before submission to the higher level, the minutes must be approved and signed by the Executive secretary of the sector within two days after the meeting. A copy is kept at the sector and another is transmitted to the in charge of CHW at health center level.

3.2.4 Community Health Workers Cooperatives

The community health workers from the catchment area of each Health center (HC) are gathered into a single cooperative.

The CHW cooperatives have a double role:

- On one hand they deliver health services to the community in order to achieve the desired performance for the selected community health indicators
- On the other hand they manage the cooperative's income generating activities (IGA).

Each CHW cooperative has one or more Income Generating Activities (IGA). Both activities are complementary and they get benefits from all of them.

CHWs perform multiple roles in order to improve community health services through provision of quality primary health care to the population in prevention and treatment of childhood illnesses, reduction of malnutrition as well as several interventions in maternal and newborn care. These include:

- Increasing awareness of the population with the purpose of combating diseases through sensitization, awareness and behavior change.
- Managing the health care problems included in the CHW package
- Collecting, consolidating and verifying data related to CHWs activities and the population in the catchment area of the health center.
- Submitting monthly reports to the health center
- Monitoring the performance of the indicators at their level and recommending measures for improvement if necessary.
- Elaborating revenue generating projects and implementing income generating activities that vary from one cooperative to another depending on factors like location, opportunities available and many more. Income generating activities being implemented by CHWs cooperatives include livestock and crop farming, bee keeping and honey production, transport, poultry farming and real estate among others.
- Monitoring the management of their cooperatives and sharing the monthly report of the cooperative through general assemblies and other mechanisms.

3.2.5. Organization of the Community Health Workers Cooperatives

CHW cooperative structure & organs/organization (Primary cooperatives, UNIONS, Federation)

Primary cooperative

A primary cooperative is an autonomous association of persons united voluntarily to meet their common economic, social, and cultural needs and aspirations through a jointly-owned and democratically-controlled enterprise, according to internationally recognized co-operative values and principles.

Cooperative Unions

Three (3) or more cooperatives may join together to form a cooperative union. Such a cooperative organization is referred to as a secondary cooperative organization. Only primary cooperative organizations may be members of a cooperative union. No primary cooperative organization is allowed to be a member of two (2) cooperative unions at the same time. Such organizations do not yet exist in CHW cooperative system, but will be possible in the future, if the contribute to the sustainability of the member cooperatives.

Cooperative Federation

Three or more cooperative Unions may join together to form a cooperative Federation at national level. Such a cooperative federation shall be referred to as a Tertiary Cooperative Organization.

CHWs Umbrella Organization

Community Health Workers may also be organized under an Umbrella which oversees their welfare as well as challenges faced while performing their activities. The CHWs umbrella has district representatives who together form the umbrella's general assembly as well as the national committee. The umbrella is tasked with doing advocacy, needs assessments for CHWs as well as being the link between CHWs and MOH, RBC and other partners. Unlike primary cooperatives, unions and federations, the CHW Umbrella organization does not manage an income generating activity.

3.2.6. Monthly Reporting Procedures

Data collection and Reporting

The three CHWs of the village record all data related to the activities they perform on a daily basis using registers and ICCM treatment forms. At the end of the month they tally this data and send it to the cell coordinator on the village level SISCom monthly reporting form. This gathers all the reports from the village in one report. The cell coordinators then aggregate the data from all of the villages in the cell and send the Cell level SISCom report to the HC level. Reports from the cell coordinators are aggregated into one cooperative report by the staff in charge of CHWs at HC level and analyzed for verification and feedback.

The cooperative level SISCom report is entered into the SISCom website on the HMIS servers at the national level (www.hmis.gov.rw/healthfinancing), by the data manager at health center level. A hard copy of the report is sent to the hospital for analysis and verification of data entered in the SISCom database and then feedback is sent to the health centers. Counter-verification of data is done at the cell and, if necessary, at village level.

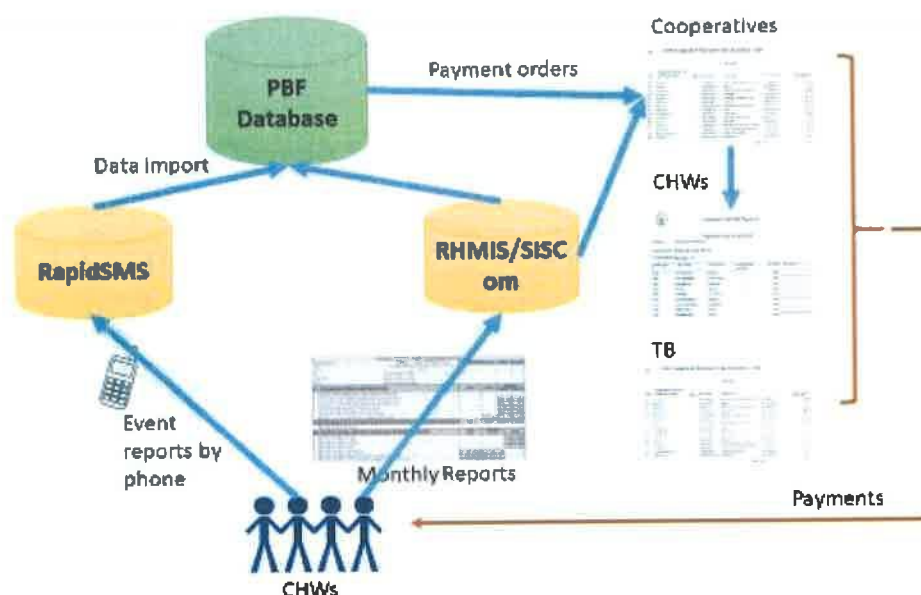
After the data are validated by the Data manager, the HC in charge of CHWs (EHO) and the HC Data Manager organize a feedback session for the CHWs at the end of the month as part of their monthly meetings. The monthly meetings are meant to discuss data quality, performance indicators, challenges in activities and reporting as well as cooperative development.

Every CHW reports directly for some emergency cases by mobile phone into the RapidSMS system and is incentivized individually according to the number of cases reported during a month.

3.2.7. CHWs Reporting system

Unlike the Hospital and HC PBF models which have their own parallel reporting tools, the CPBF model relies on data collected through three complementary reporting systems: the electronic phone-based system known as **RapidSMS** and Rwanda Health Management Information System (**RHMIS**) through the community component known as **Système d'Information Sanitaire Communautaire (SISCom)**.

Figure 4: Flow chart of cPBF payment order processing



SISCom: Système d'Information Sanitaire Communautaire (SISCom) is the reporting component for community indicators and is also housed under the Rwanda Health Management Information System (**RHMIS**). It is an information system that is both paper-based and web-based tools. CHWs maintain a variety of registers (Household, Maternal, Child & Stock) during their day-to-day work. At the end of each month, the data from each village are tallied by the 3 CHWs into a single monthly reporting form. A copy of this report is sent to the CHW Cell Coordinator, who consolidates the data from all villages in his/her catchment area onto another version of the same report. This Cell level report is sent to the Health Center where the EHO consolidates the cell level data into one HC or CHW Cooperative report. This is then entered into the SISCom web database with help from the data manager before the 5th of the following month. A final check for completeness is done at the district hospital level. This report contains aggregated data about treatment of malaria in adults and family planning and is used to calculate the performance.

Rapid SMS: As part of their service package, CHWs monitor individual health events that affect mothers and children under 2 years. These include: pregnancy, ANC care, PNC, health risks,

nutrition status and immunizations among other indicators. All CHWs have a cell phone that they use to send SMS messages about individual health events to a central server via a toll-free number. These messages are automatically imported into the RapidSMS database where they are analyzed and immediate feedback sent, where necessary. These individual data are linked to individual CHWs who provided the services (through their phone number) and the individual patient or client using the NID. Validity of data reported in the RapidSMS is checked through (1) programmed logic checks, (2) triangulation with CHW records, and (3) during supervision visits. For the CPBF program, these data from the above indicators are then aggregated into program broad indicators such as: the number of pregnancy related events reported, number of pregnant women who gave birth at a health facility, etc. These indicators reflect both the Binomes and ASMs reporting. Data collected from SISCOM and RapidSMS are analyzed at decentralized and centralized levels for policy decision making.

CHAPTER IV: QUALITY ASSURANCE

4.1. Community Data Quality Assessment

Community data quality assessment is done at all levels: Cell level, Health Center, Sector steering committee, District steering committee, district hospital and Ministry of Health.

4.1.1. Strategies used for community data quality assessment

The CPBF scheme uses multiple strategies to ensure that data of the highest quality are entered into the system. These include:

- Monthly supervision of CHWs of every village by the cell coordinator
- Data quality supervision by the HC
- Meeting of the technical committee before the meeting of the sector steering committee
- Quarterly counter-verification by the sector steering committee members
- Quarterly counter- verification by the district hospital
- Data evaluation and counter-verification by the PBF team from the MoH every semester.

4.1.2. Community data assessment tools

In order to reduce the discrepancies of the data reported by the CHWs, tools have been developed to help assess and maintain good quality. They are used by different actors of the community PBF system. Assessment tools vary depending on level.

Community Routine Data Quality Assessment tool

The CRDQA1 tool helps the various supervisors from Cell Coordinator, Environmental and Community Health Officer (EHO) and District Hospital Community Health Supervisor to identify discrepancies between the register and the monthly reports maintained by CHWs at the village level.

4.2. Quality Performance Assessment

The qualitative performance assessment in the community PBF is done quarterly by different evaluators at the level of SSC, CHW cooperatives and individual CHWs.

4.2.1. District Steering Committee

Generally, the district steering committee looks at and analyses health indicators and priorities and compare them with performance in their district. Here they can be able to determine those indicators that are doing very badly so that they can take necessary action to improve them.

4.2.2. Sector Steering Committee

The sector steering committee analyses data validated by the health center data manager and then make field visits to CHWs to look at their reports (source documents) plus interact with some beneficiaries (population) in the village about the quality of care they received from CHWs and other aspects.

4.2.3. Community Health Workers Cooperatives

The performance assessment of the CHWs cooperatives is done quarterly by the sector steering committee. Its performance is based on the way it functions and on the quality of the report.

4.2.4. CHW Cell coordinator

The cell coordinator should be evaluated once a quarter by the in charge of community health at health center level (EHO). His/her performance indicators are as follows:

- Quarterly supervision of the CHWs
- Monthly requisition of drugs used by the CHWs
- Counter-verification of monthly reported data by the CHWs of his catchment area

4.2.5. Community Health Workers

Individual community health worker performance assessment is done quarterly by the cell coordinator. The level and quality of reporting through rapid SMS by each CHW allows her/him to earn more money than those who didn't report. In addition, several quality of service indicators are calculated using RapidSMS for each cadre of CHWs that determine the continuity of care they provide. For example, ASM's are ranked on the ratio post-natal visits to deliveries reported. The more post-natal visits reported per delivery, the better their performance.

CHAPTER V: COMMUNITY PBF PAYMENT MECHANISM

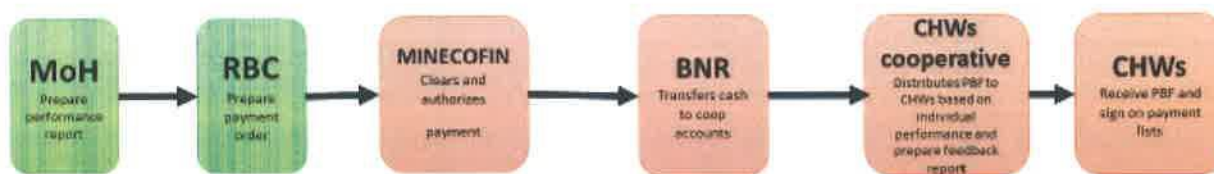
5.1. Source of funds for the SPRP

The Government of Rwanda in partnership with the World Bank and the Global Financing Facility (GFF) allocated funds for the SPRP meant to reduce and eventually eliminate stunting in Rwanda. These funds will among others be used to remunerate on performance the selected indicators performed by CHWs through their cooperatives. PBF remuneration is done on quarterly basis after evaluation of individual performance of CHWs.

5.2. Payment of Community PBF Funds

The dispatch of Community PBF funds is done based on individual performance of CHWs where amount of payment varies from one CHW to another. The total payment due is sent to the cooperative along with the list of individual CHWs and amount he/she should receive based on the report received. The amount to be paid is determined using data from RapidSMS and SISCom. First, this data is imported into the PBF Database to generate the total amount to be paid. Then, the MoH prepares a consolidated performance report based on the community PBF indicators and submits to RBC to prepare the payment orders which are then sent to MINECOFIN.

FIGURE 5: DIAGRAM SHOWING CASH FLOW FROM THE CENTRAL LEVEL TO THE FINAL BENEFICIARIES



Rwanda PBF payment:

On a quarterly basis, data on individual CHWs performance on various indicators is imported from the Rapid SMS database and SISCom.

Depending on individual events reported by CHWs, calculations are done and CHWs are given their total PBF payment at the end of the quarter. Sometimes, unit cost of the indicators may change from time to time depending on the total available budget in comparison with the total number of produced indicators.

Payment Orders (OPs) are made for both HIV, TB and Stunting program budget lines and sent to MINECOFIN and BNR for payment. The OPs along with the lists of beneficiaries' bank details are sent once payment is done. The lists have details of cooperatives, in turn once the sum is received by cooperatives, there is a list of individual CHWs and amount to be received by each

CHW. Distribution of PBF funds to individual CHWs is done by giving each one their cash and they sign against their name on the list. However, some few cooperatives organize themselves and deposit the respective amounts on CHWs accounts in local savings schemes if they wish.

Just like HIV and TB funds, CHWs will also take home all funds based on individual performance from the Stunting program.

The following table lists the indicators used to evaluate CHW individual performance under the SPRP:

Table 1: CHWs performance indicators for SPRP

I. Community PBF		
N°	INDICATORS	Unit Cost (Frw)
1	Number of joint community nutrition education sessions conducted monthly by CHW	66
2	Number of pregnant women referred by CHW for the first ANC visit during the first trimester	528
3	Number of pregnant women taking IFA tablets as prescribed by health provider	528
4	Number of children under 5 years screened for malnutrition (growth monitoring) at village/community level.	132
5	Number of children at risk of stunting receiving regular follow up home visits by CHWs	528
6	Number of children under 5 who graduated from red/yellow to green (W/A)	792
7	Number of children who participated in community height visualization as part of growth monitoring exercise	396

CHAPTER VI: COMMUNITY PBF AUDIT AND COUNTER VERIFICATION

6.1. COMMUNITY PBF AUDIT

In Community PBF, there are two types of audits required:

- Internal audits
- External audit

Internal Audit

An internal audit will be conducted regularly by different organs through the health system from the HC, SSC, DSC, DH-and the central level. The objectives of the internal audit will be to identify early any implementation challenges and propose the solutions, in order to make sure that the system is transparent.

The regular internally assessed aspects are:

- The performance of every structure defined in the Community PBF model (District steering committee, sector steering committee, health center, Community health workers cooperatives and community health workers).
- The supervision of the community health workers for those dedicated to that activity through the system, the counter verification of the data and the performance assessment of every village, sector and cooperative'
- The respect of the payment modalities of the community health works cooperatives, sector steering committee for their performance.
- The clients' satisfaction of the services received by the CHWs and the entire community health system.

Who conducts the internal audits?

- DGPHFIS/ PBF technical committee
- The Community Health Workers Unit from Rwanda Bio-Medical Center
- District steering committee,
- District hospital
- Health center
- Cell coordinator

External Audit

The external audit is a complement to the internal audit. It will be conducted once a year and will aim to guarantee the compliance of the community PBF model to the established procedures. The external audit should be conducted by an independent body hired by the MOH to guarantee the transparency and efficiency of the community health system. Selection may be based on; systematic random selection using a formula, selecting those deemed problematic as informed by local authorities or CHWs themselves.

- It will assess whether there is any conflict of interest, especially at the HC level, which supervises the CHWs, does the data verification and is member of the sector steering committee.
- It will assess whether the validation process of the quantitative data by the sector steering committee is done rigorously with respect to the procedures manual.
- It will ensure that the payment made compared to the reported data are equivalent and confirm the transparency of the C-PBF system.

The external audit of the C-PBF system will specifically focus on the following procedures:

- Implementation modalities
- Implementation procedures
- Client satisfaction and community involvement
- Improvements in the social status of CHWs due the benefits from the revenue of their cooperatives.

Annexes

Annex 1: CHWs Service Package

- Community-Based Nutrition Program (1996);
- Care and treatment to Tuberculosis patients in the community through the Direct Observation Treatment (DOT) (2004);
- Integrated Community Case Management (iCCM) of malaria, pneumonia, and diarrhea (2008);
- Community-Based Provision of contraceptives (CBP);
- Community Maternal and Newborn Health care (c-MNH) (2010);
- Infant and young child feeding and community-based nutrition programs (CBNP) including growth monitoring, screening of children U5 for W/A and linkage of at risk children for stunting to CHWs for regular community visits;
- RapidSMS (2011);
- Diagnosis and treatment of malaria for adults (2016);
- Sensitization of the population on vaccination;
- Sensitization of the population on Voluntary Counseling and Testing (VCT) of HIV/AIDS;
- Sensitization of the population to enroll in the Community Based Health Insurance (CBHI).

In order for CHWs to perform their activities efficiently, they receive the following tools, materials and drugs. Each CHW received a box that contains the following:

- A kit of drugs (Coartem under two forms called primo Red and primo yellow to be given according to age, Amoxicillin, ORT, iron, folic acid, TB drug for referred patient from DH or HC, Condoms, Contraceptives pills etc..).
- Registers and reporting forms used at the CHW level
- MUAC for arm examination to assess nutrition status
- Timer for respiratory examination
- Baby scale and adult scale for weighing children and adults

Annex 2: Project location and target beneficiaries:

N	District	Number of HCs	Number of Hospital
1	Nyabihu	15	1
2	Ngororero	15	2

3	Karongi	22	3
4	Rubavu	13	1
5	Rutsiro	17	1
6	Rusizi	19	2
7	Nyamagabe	19	2
8	Huye,	18	1
9	Nyaruguru	16	1
10	Ruhango,	15	2
11	Gakenke,	23	2
12	Kayonza,	15	2
13	Bugesera	16	1
	Total	223	21