

**REPUBLIC OF RWANDA**



**MINISTRY OF HEALTH**

**PO BOX 84 KIGALI**

**PROCEDURES MANUAL FOR COMMUNITY HEALTH WORKERS PERFORMANCE  
BASED FINANCING**

**June 2021**

## Foreword

Rwanda's agenda towards achieving Universal Health Coverage (UHC) has been focused on strengthening primary healthcare services. Starting from the community level, a national Community Health Workers (CHWs) program was established to support Health Promotion and Disease Prevention efforts at the village level. For the past two decades, the CHWs Program has grown stronger, and it plays an essential role in primary healthcare delivery in Rwanda. The Ministry of Health recognizes CHWs as full-time voluntary workers who play a key role in extending services to the communities, and commends their contributions towards Rwanda's Health Systems Strengthening. To strengthen the retention of CHWs in the program and support their motivation, the Ministry of Health established a Community Health Workers Performance Based Financing Program in 2008, with a special emphasis on maternal and child health services. While the community PBF has greatly contributed to the uptake of maternal and child health services, its countrywide guiding documents have not been revised since 2009. Moreover, the 2015 Health Sector Policy, the 2016 evaluation of the Community Health Program, and the Health Sector Strategic Plan 2018-2024 have all recommended more investment in the capacity building and incentivization of CHWs to sustain health care services delivery at community level.

It is against that background that the Ministry of Health decided to review the 2009 Community Health Workers Performance user guide so as to accommodate new developments and policy changes which occurred over the last twelve and half years.

As the health sector continues to evolve with various innovations, so does the programs include CPBF. Thus the need to revise the procedure manual so as to accommodate these strategic changes and address challenges in the program such as reinforcement of CHWs Cooperatives income generating activities, mentorship, supervision as well CHWs assessment, digitization to improve reporting, minimize data discrepancies, speed up evaluation and PBF payments.

Furthermore, there was the need to incorporate additional service packages for CHWs such as maternal and neonatal and nutrition indicators as well as taking into account the restructuring of the community health program such as moving CHWs from specialized tasks to making them polyvalent or multi-task CHWs.

The reviewed Community PBF procedures manual will help users to comply with PBF principles and take into account all modifications as the PBF scheme continues to expand.

I therefore urge all stakeholders to comply with guidelines described in this procedure manual. Complying and effectively using this manual will be a huge contribution towards the sustainability and strengthening of Rwanda's health system.

  
**Dr. NGAMIJE M. Daniel**  
Minister of Health



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## Acronyms

ANC	Ante Natal Care
ASRH	Adolescent Sexual and Reproductive Health
BNR	Banque Nationale 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
DPM&EHF	Department of Planning, Monitoring & Evaluation and Health Financing
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
GBV	Gender Based Violence
GOR	Government of Rwanda
HC	Health Center
HF	Health Facility
HIV	Human Immunodeficiency Virus
HMIS	Health Information System
HSSP IV	Fourth Health Sector Strategic Plan
IGA	Income Generating Activities
IMCI	Integrated Management of Child Illnesses
ITN	Insecticide-Treated Mosquito Nets
MDG	Millennium Development Goals
MINECOFIN	Ministry of Finance and Economic Planning
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
SSC	Sector Steering Committee
TB	Tuberculosis

## **Introduction**

### **1.1 Background**

Rwanda aspires to become a high-income country by 2050. This is expressed in the country Vision 2050 and translated in mid-term strategies of seven years (National Strategy for Transformation - NST1 and the fourth Health Sector Strategic Plan- (HSSP IV) which highlight the contribution of the health sector to the country social transformation agenda of improving the wellbeing of Rwandan population.

HSSP IV aim at sustaining the gains of the country in achieving the health related MDGs (maternal and child mortality decrease) and shape the path towards attaining the SDGs 3 (for health) in the framework of achieving Universal health coverage (UHC) by 2030 as well. UHC principles are simply about continuing to advance our agenda of increasing access to quality services by ensuring equity in service provision and financial protection to avoid people to incur financial burden while seeking service. As per the current data on the services utilization rate, services are sought at the primary health care level with the first service delivery point which is at the community level. So, strengthening the Community Health program to improve maternal, child health including nutrition has been identified among the HSSP IV priorities.

The CHWs program has played a pivotal role in the Rwanda's achievements of health-related MDGs. This is the reason why the Ministry of Health has resolved to capitalize on it and further strengthen its technical and financial capacities to ensure that it again contribute to the achievement of HSSP IV targets.

### **1.2 Community health program**

The health system in Rwanda is built on a pyramid, where the bottom is the community and the top is the central level. In between there are different levels representing the provincial, district, sector, cell and village level, with at each level a correspondent category of a health facility (HF) With the following key responsibilities:

- The central level has the responsibility for policy making, overall monitoring and evaluation, capacity building and resources mobilization.
- The peripheral level with districts hospitals and health centers has the mission of delivering health services.
- The community level main purpose is focused on preventive, promotional, rehabilitative and some curative health activities.

As in the pyramid below, at the bottom we find the Community Health Workers (CHWs) who provide direct health care to the population, various reports of assessments and evaluations indicate that CHWs manage a big percentage of the disease burden. The incentives of CHWs are derived from their service package where payable indicators are formulated and CHWs work on an individual basis to fulfill the indicators.

The community health program is organized in a way that the first line of technical supervision is Cell coordinator followed by the Community and Environmental Health Officer (CEHO), while administrative sector assumes administrative issues. At the district hospital there is a Community Health Supervisor

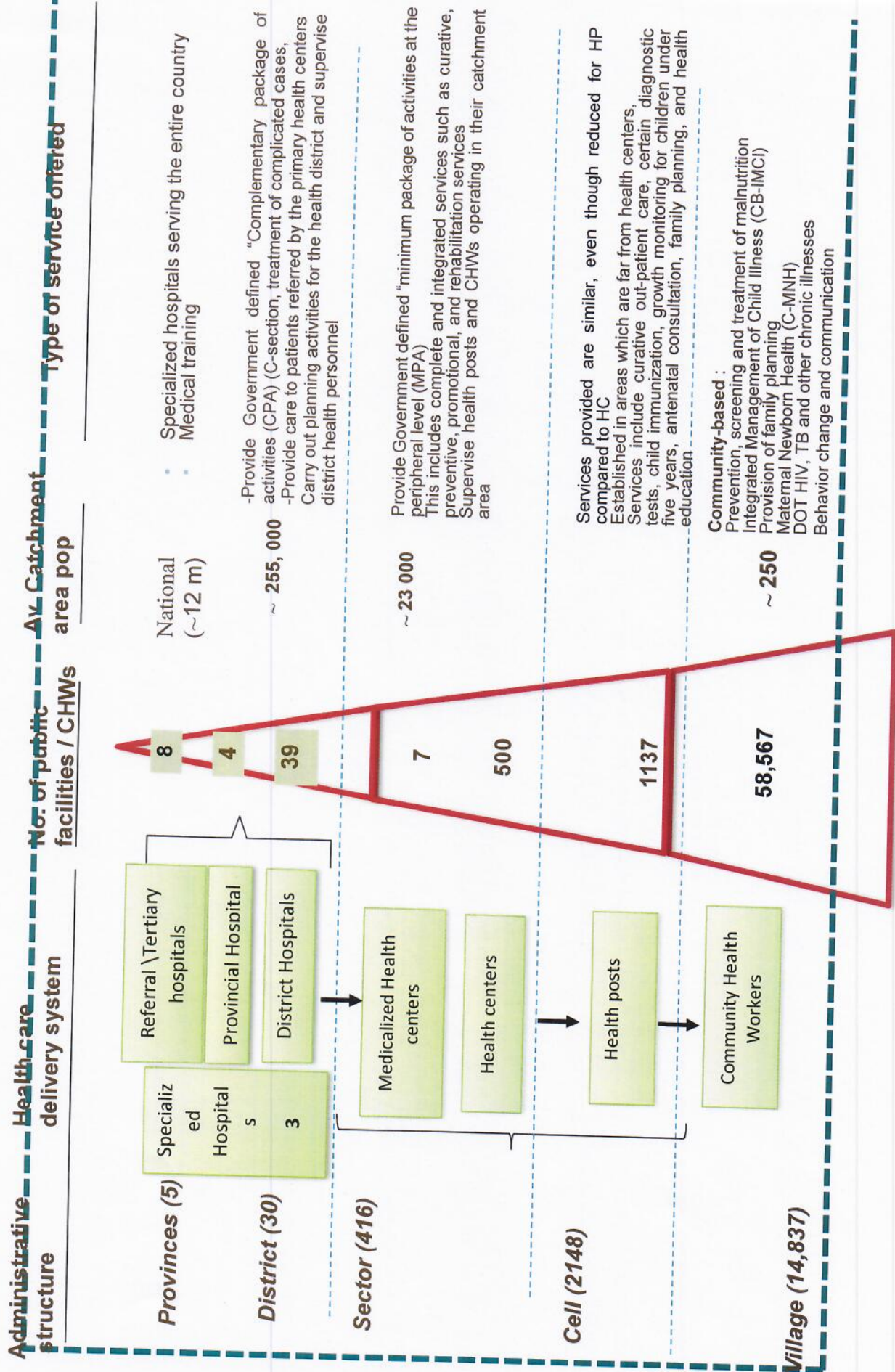
whereas at the administrative district we find the district health unit which oversees all health-related activities. The central level role is to mobilize resources, policy making and M&E of the program in general

The figure below shows the summary of the Rwanda health system

Figure 1 : Rwanda Health System



Rwanda's Health System



### 1.3 Organization of Community Health Program

The Community Health Program in Rwanda plays a key role and they provide preventive, curatives and promotional services to the population at community level. According to various assessments that have been done over the past years, the results consistently indicate that CHWs manage a huge burden of disease at the community level thereby relieving the population in terms of access to care.

#### 1.3.1 Selection criteria and the current Number of CHWs

The community health program is among the key pillars of the health system. It is primarily run by Community Health Workers who are elected by the village members based on defined criteria such as ability to read, write and calculate, having completed at least primary level education, aged between 20-50 years, willing to volunteer, being a resident of the village, he/she is elected to serve; not being a local leader or a remunerated health worker at a health facility, honest, reliable, and trusted by the community.

Each village of around 100-150 households has four CHWs (One woman for maternal and new born health, male and female CHWs named Binôme and one in charge of health promotion); Rwanda boasts around 58.567 CHW for a total number of 14.837 villages across the country.

#### 1.3.2 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 community they serve. Over the years, the package of services offered by CHWs became more comprehensive and now includes a range of services. (See Annex 1).

#### 1.3.3 CHWs Remuneration

Community Health Workers are remunerated through monetary incentives and non-monetary incentives.

- a) **Monetary Incentive:** Other motivation sources include the community Performance Based Financing (PBF) which is a monetary scheme where individual CHWs are evaluated on a quarterly basis on set health indicators such as family planning uptake, nutrition and growth monitoring, number of pregnant women followed up for Ante natal checks as well as accompanying them to health facilities for delivery. These and more indicators are set based on national priorities.

- b) **Non-monetary incentives:** CHWs are motivated by in-kind/non-monetary incentives such as mobile phone handsets, solar lighting systems, umbrellas, bags, boots, aprons that assist them to perform their activities

#### **1.3.4 Capacity building**

The Government of Rwanda through the Ministry of Health and other stake holders ensures that continuous capacity building is considered as one the approach to boost the CHWS performance, as they do not have medical background as formal education. They get Initial training, refresher trainings, supportive supervision, mentorship and supplies to be used are mainly provided by Health centers, District hospitals, and central level institutions in collaboration with development partners.

#### **1.3.5 Organization of CHWs Cooperatives**

The CHWs' Cooperatives are organized into three levels: Primary Cooperatives, Unions, Federations and the Umbrella.

##### **a. Primary cooperatives**

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

##### **b. 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.

##### **c. Cooperative Federation**

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

##### **d. CHWs Umbrella Organization**

Community Health Workers are 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 the Ministry of Health. Unlike primary cooperatives, unions

and federations, the CHW Umbrella organization does not manage an income generating activity and is regarded as a civil society organization.

### **1.3.6 CHWs Coordination**

A cell coordinator, selected from among the CHWs in each administrative Cell, assumes a direct supervision of CHWs in that area, while the Health Center coordinates, monitors and supervises all activities done by CHWs in the HC catchment area. The Community and Environmental Health Officer (CEHO) based at the Health Center is in charge all CHWs activities. At the District Hospital, a Community Health Supervisor is responsible for the coordination and monitoring of CHWs' activities as well as supervision of the CEHO 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 desk in the department of Planning, Monitoring & Evaluation and Health Financing (DPM&EHF) that manages all PBF portfolios including community and clinical PBF.

## **2. Performance Based Financing in Rwanda**

The Performance Based Financing scheme has been identified as one of key interventions to improve the quality and quantity of services through enhancing the performance of health care provider motivation and retention.

### **2.1 Historical Background of PBF**

This scheme started in Rwanda as early as 2001 in pilot health facilities. Several factors led to its introduction. Firstly, Non-Governmental Organizations (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 those 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 identified 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 NGOs Memisa/Cordaid started a PBF scheme in Cyangugu (Western province) while HealthNet International (HNI) started 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 experiences, 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 service utilization rate. 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; in 2006, MoH decided to roll out the PBF at national scale for quantitative and qualitative selected indicators.

After the introduction of clinical PBF, the Government of Rwanda introduced the PBF at community level (Community PBF) as a pilot in 2009; currently it is scaled up throughout the country. The national Community Performance-Based Financing (C-PBF) strategy is based on the significant achievements registered for rewarding health facilities for good performance, and C-PBF implemented during the last six years, which is defined as increased utilization and improved quality of services, and emphasizes output financing mechanisms rather than relying solely on input-based financing as well as community participation. It is critical for the MOH 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.

## 2.2 Community Performance Based Financing (C-PBF)

Community PBF is one of key incentives given to Community Health Workers to motivate them and ensure their retention. This has been revised to address challenges in the program such as reinforcement of CHWs Cooperatives income generating activities, mentorship, and supervision as well CHWs assessment, digitization to improve reporting, minimize data discrepancies, and speed up evaluation and PBF payment.

### Community Performance-Based Financing Principles

#### a) Definition of terms

- **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 on 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 the performance of health services delivery system.
- **Performance:** Optimal results that one can get in a particular field (bound by competitiveness, 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.

**Contract:** Covenant 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 – Community Health Workers). The PBF contract fitted 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.

- **Purchase:** Acquiring a good or a service after payment. PBF procurement entails a certain number of indicators for health facilities and community level benefits packages.
- **Purchaser:** The entity that buys the produced indicators according to terms /conditions of the contract between him/her and the provider. Like in a PBF contract, the buyer can be different depending on the level of the contract.
- **Provider/Vendor:** The entity that sells the produced indicators according to the terms/conditions of the contract between both parties. The PBF vendors also vary according to the level of the contract; the last vendor is the service provider.
- **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 of 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 intrinsic motivation and extrinsic motivation which are complementary to achieve a complete motivation and results
- **Quality:** A trait which attaches more or less value to a product or service. The quality of care provided to the population and purchased involves technical quality (compliance with norms and set standards for health care delivery). Technical quality control is achieved through quarterly quality supervision and evaluation.
- **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.
- **Indicator:** A performance measure which is objectively verifiable.
- **Evaluator:** an individual or entity which verifies if services are actually purchased.
- **Provider:** a person or entity that offers services (clinical or others – ex. administrative)
- **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.

## b) Community PBF Principles

The PBF approach is based on three principles: The separation of functions, contractual approach and indicators to be purchased.

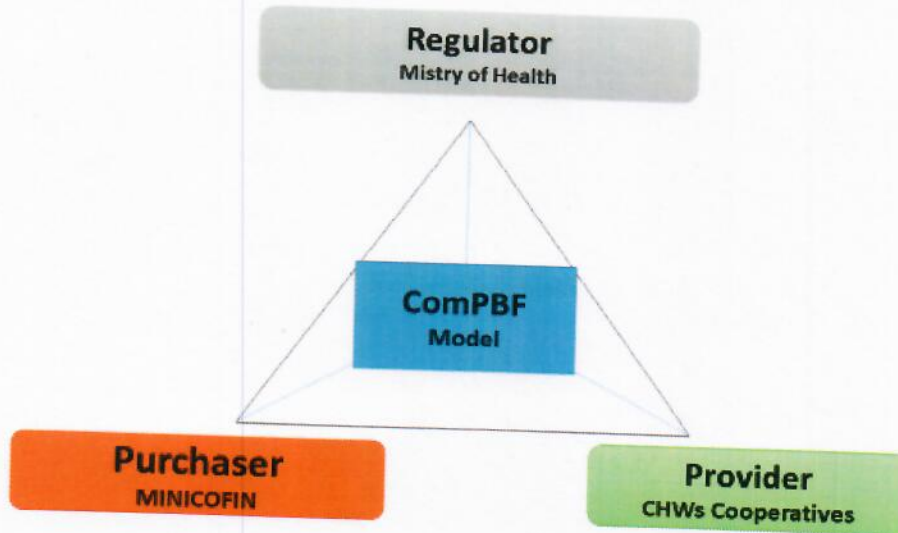
- **Separation of functions**

This section describes the institutional setup in PBF implementation ensuring separation of functions, roles and responsibilities. Separation of functions is paramount to effectively and

efficiently implement the PBF 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.

Figure below shows the functions and respective institutions involved in PBF implementation. MOH is the regulator and sets policies and procedures. The providers are CHWs Cooperatives delivering health services to the population whereas the purchasers are the Ministry of Finances and development Partners.

**Figure 2: Separation of functions in Community PBF**



### **Regulator**

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.

### **Purchaser**

The purchasers are the Government of Rwanda and development partners.

### **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.

- **PBF contracts**

### **Role of the contract**

The contract allows different parties in the separation of functions to be accountable for their responsibilities. In Rwandan model; contract is signed between the purchaser and the provider. Here the purchaser is MINECOFIN/Partners-DSC and the providers are cooperatives of the community health workers. The purchaser is responsible to pay 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 needs.

### **Type of Contracts**

In Rwandan community PBF model there are two types of contracts: Contract between the executive secretary of the sector and the sector steering committee and the contracts between the SSC of the sector and CHWs cooperatives

#### **a. Contract between the Executive secretary of the sector and the members of the SSC**

The district is the local government decentralized entity which functions under a district council. Every year the district mayor signs a performance contract with the president of the republic (imihigo). He also signs contracts with the structures under his authority to allow him achieve the required performance set into imihigo. It is in this regard that the district mayor signs the performance contracts with the executives' secretaries of the sectors. The sectors also sign the performance contracts with the steering committees to allow cooperatives of CHWs achieve their duties and responsibilities of delivering good services to the population. The sector steering committee is supported, monitored and evaluated by the district steering committee (DSC).  
(See Annex 2)

#### **b. Contract between the SSC of the sector 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 CHWs, they gather their reports at cell level and the cell combine all the reports at sector level, where there is one or more than one CHW cooperatives depending on the number of HCs. The president of the SSC of the sector signs a contract with the president of each cooperative operating in the sector. The members of the cooperative are all CHWs from the villages of 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 (Annex 3)

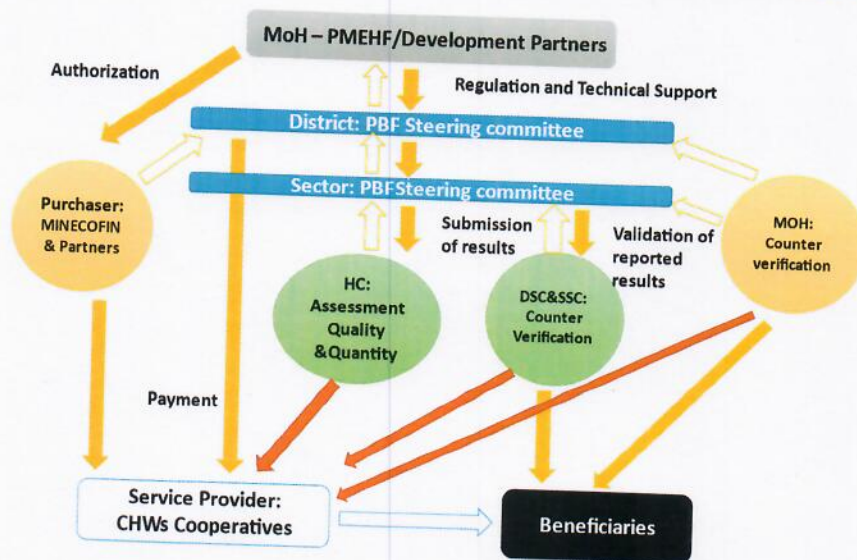
- **Indicators to be purchased**

Quantitative indicators from selected services packages including TB, HIV, MCCH, SPRP are purchased in the framework of motivating CHWs to increase the utilization of services. The incentives of CHWs are derived from their service package where payable indicators are formulated and CHWs work on an individual basis to fulfill the indicators.

## Community PBF design

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. Figure below, depicts the administrative model for the CPBF scheme in Rwanda.

**Figure 3 : Community PBF Administrative and Governance Model**



## Rationale of revising the Community PBF Procedure Manual

Despite the continued efforts and innovations in the health sector, there are challenges that have emerged in the implementation of C-PBF.

The key challenges include:

- Inadequate management skills of CHWs Cooperatives income generating activities yet these are part of the sustainable mechanisms and motivation of CHWs.
- Inadequate mentorship, supervision as well CHWs assessment especially from health center level and Cell Coordinators to CHWs.
- Paper based reporting which mostly leads to data discrepancies, delayed payments and impact on interpretation of indicators.
- Some additional service packages for CHWs such as maternal and neonatal and nutrition indicators that were not incorporated

It is against this background that there was need to revise the community PBF procedure manual to accommodate address challenges and adopt strategic change (especially technology) in the program.

### 3. Objectives of the C-PBF procedures manual

#### 3.1 Overall objective

The overall objective of the CPBF procedure manual is to increase the effectiveness of C-PBF by improving its governance and accountability at both central and decentralized levels

#### 3.2 Specific objectives

- To describe the planning and budgeting process for C-PBF
- To describe the monitoring, evaluation and reporting process for the C-PBF
- To describe the C-PBF remuneration process
- To describe the accountability mechanisms in the C-PBF

#### Objective 1: Planning and budgeting process for C-PBF

- **Earmarked transfers from ordinary budget**

The budget allocated to reimbursement of the cooperatives is distributed to districts by MINECOFIN according to a variety of criteria including the number of cooperatives and the number of CHWs.

After reception of earmarked budget from MINECOFIN by district, fund distribution is done according to the number of cooperatives in district. The payment is calculated by applying qualitative score to quantities of each CHWs cooperative.

In case invoiced amount is over or under quarterly budget available, the total amount to be obtained by cooperative is calculated using proportional distribution by multiplying the billed amount from each cooperative by total earmarked budget at district level and divide by total amount billed by all cooperative in district.

**Eg.1:** If CHW cooperative A billed 5.000.000 Frw, Cooperative B billed 4.800.000 Frw with total of 9.800.000 Frw when quarterly budget available is 8.200.200 Frw. The final amount for each cooperative will be calculated as follow:

❖ Cooperative A:  $5.000.000 * 8.200.000 / 9.800.000 = 4.183.673$  Frw

❖ Cooperative B:  $4.800.000 * 8.200.000 / 9.800.000 = 4.016.327$  Frw

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**8 200 000 Frw**

**Eg.2:** If CHW cooperative A billed 3 211.000 Frw, Cooperative B billed 4.380.000 Frw with total of 7 591 000 Frw when quarterly budget available is 16.000.000 Frw. The final amount for each cooperative will be calculated as follow:

❖ Cooperative A:  $3\ 211.000 * 16.000.000 / 7\ 591\ 000$  Frw = 6 768 015 Frw

❖ Cooperative B:  $4.380.000 * 16.000.000 / 7\ 591\ 000$  Frw = 9 231 985 Frw

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**16 00 000 Frw**

- **External funding from Development partners**

Funding from different external Partners is used to finance CHWs PBF. The current system gives CHWs the total of development partners fund whereby is distributed according to individual performance.

## **Objective 2: Monitoring, evaluation and reporting process for the C-PBF**

### **Roles of different actors in the operationalization of CPBF**

Different actors in CPBF are as follow:

#### **Ministry of Health (MOH)**

The Ministry of Health is responsible of:

- Defining the policies related to the community health and community performance-based financing;
- Supporting Districts in the implementation of the health policy which includes Community health;
- Mobilizing resources (technical and financial) to support the implementation of C-PBF
- Evaluating the progress and make changes on the policy or capitalize on the success.
- Managing the PBF database
- Arranging the payment of PBF indicators
- Elaborate and reviewing CPBF documents
- Elaborate and reviewing CPBF indicators and determine the unit cost in collaboration with CHWs and Districts
- Following up to make sure beneficiaries (CHWs) received their rightful PBF funds
- Conducting data analysis and counter verification to ensure implementation of C-PBF and accountability

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. At district level there is a steering committee in charge of PBF matters which is composed by the following members:

1. Director or in charge of health at District; (Chairperson)
2. Hospital Director General; (Co-Chair)
3. PBF focal person at the hospital (Secretary);
4. Planning and M&E officer at the hospital;
5. RSSB Branch Manager at district level;
6. Community health focal person at hospital level;
7. Director of Pharmacy at district level;
8. Representative of health centers in each hospital catchment area;

9. Representative of Community PBF sector steering committees
10. Representative of development partners supporting health activities in the district;
11. Representative of CHWs cooperatives in the district.

DSC is responsible:

- To operationalize the PBF strategy at the decentralized level
- To ensure that PBF data entry in PBF Database is timely completed
- To ensure that the preparatory meeting of DSC was held and PBF Data verified;
- To hold a quarterly or ad hoc meeting to discuss and address health issues within the district and validate PBF data from database with comparison to PBF evaluation cooperative results;
- Daily management of the PBF database;
- To submit on time, the report including minutes and PBF invoices to the central level;
- To ensure that all PBF transfers to Community Health cooperatives from central level have been received;
- Formulate and review the strategies for improving the quality of care in community;
- Supporting and supervising the sector steering committee
- Ensuring the coordination between the central level and the peripheral level
- Developing capacity of the Sector Steering Committee
- Monitoring the progress of the C-PBF indicators
- Organizing quarterly counter-verification of C-PBF indicators at Health Center level and at cell and village levels
- Propose administrative measures including penalties for Health Center, CHWs Cooperative, Staff or CHW in case there is a fraud
- Resolving conflicts occurring between SSC and CHWs cooperatives
- Providing a quarterly report on C-PBF funds received by the cooperatives
- Give overview on Income Generating Activities of the cooperatives in catchment

**NB: District notify to MOH the date of DSC quarterly meeting before five days**

### **Sector Steering Committee**

The SSC coordinates PBF implementation at sector level representing the Executive Secretary of the sector for all health-related matters.

### **Sector Steering Committee members**

- The staff in charge of Health or Social affairs at sector (President)
- The Head of the health center (Vice-President)
- The staff in charge of CHWs at Health center level (CEHO) (Secretary)
- The president of the cooperative
- The data manager of health center

- In charge of cooperatives at sector level

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

### **Roles of the Sector Steering Committee (SSC)**

The Sector Steering Committee has the following roles and responsibilities:

- Supervises, trains and evaluates community health workers Cooperative;
- Analyses and corrects monthly reports of the CHWs sent by CEHO of the health centers;
- Manages archives of all community health PBF documents (reports, Invoices, payment orders);
- Validated Community PBF data and counter-verifies all level (Health center –Cell level-Village and client) if need be. It approves the data for payment after all verifications are accomplished.
- Submit to District Steering Committee and Copy to the hospital the following documents (*This must be done not later than the 25<sup>th</sup> day of the following the month of evaluated quarter*):
  - ✓ Sector steering committee minute and attendance list attached,
  - ✓ Quarterly PBF invoice for all Community PBF packages,
  - ✓ Feedback report on PBF received by Cooperative,
- Provides a quarterly report on C-PBF funds received by CHWs cooperative
- Overview on Income Generating Activities of the CHWs cooperative

### **Sector Steering Committee Functionality**

Instructions for sector steering committee meetings are:

#### **Participants' quorum**

The number of the members of the sector steering committee is defined in the SCC 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 Head of the Health center or his/her delegate
- The Representative of the cooperatives
- One person among the technicians of the health center (Data manager or CEHO)

## Meeting proceedings

- **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 (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 district, the minutes with PBF invoices and others annex required must be approved and signed by the Executive secretary of the sector within **two days after the meeting**. All SSC files must be kept by the Secretary of the committee.

## Community Health Workers Cooperatives Organization

Community health workers from the catchment area of each Health center (HC) are gathered into a single cooperative. The CHW cooperatives have the following main role:

- They deliver health services to the community in order to achieve the desired performance for the selected community health indicators
- They manage 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.

- Compilation of monthly data at village, cell and cooperative level.
- Check quality of data reported by CHWs Cooperative members on monthly basis.
- Follow up the performance of CHWs in the cooperative.
- Ensure proper filing and storage of all reports on primary health care and report related to indicators payment
- Ensure proper maintenance of all tools and kits given to CHWs like mobile phones, storage boxes, flashlights, registers, etc.
- Ensure that CHWs receive their quarterly PBF incentives based on individual performance. This must be done within 30 days of receiving the incentives on the cooperative's bank account.
- Ensure proper management of Earmarked transfer funds for income generation in the cooperative.
- Submit to the health center the quarterly feedback on PBF received and paid to CHWs.

**This must be done not later than the 15<sup>th</sup> day of the following month after the quarter.**

**(Annex 4)** with following document:

- ✓ *Distribution report of PBF incentives to CHWs (payroll list of CHWs signed) in the previous quarter*
- ✓ *Bank statement for the previous quarter*
- ✓ *Copies of Payment Order.*
- Prepare and also ensure implementation of business and action plans for income generating activities in the cooperative.
- Overview report on Income Generating Activities of the cooperative (**Annex 5**)

CHWs perform multiple roles to improve community health performance in their respective catchment area; These include:

- Increasing awareness of population in diseases prevention through sensitization.
- Managing the health care problems included in the CHW package
- Collecting, consolidating and verifying data from the catchment area of the health center.
- Sending the monthly report to the health center
- Monitoring the performance of indicators at their level and recommending measures for improvement if necessary.
- Participate in elaboration of revenue generating projects and implementing income generating activities
- Monitoring the management of their cooperatives and sharing monthly report of the cooperative through general assemblies and other mechanisms.

### **CHWs Reporting system**

#### **RHIMS SIS Com Data Flow**

Unlike the Hospital and HC PBF models which have their own parallel reporting tools, the CPBF model relies on data collected from CHWs at village level, on monthly basis reports are generated by CHWs at every village then compiled at different levels until utilized by MoH for payment. The SISCom which is a health information system that is both paper-based and web-based plays a greater critical role in data management. CHWs maintain a variety of registers (Household, Maternal, Child & Stock) during their day-to-day work.

Figure 4: SISCom Monthly Report



**Community Health Workers' Monthly HMIS Report/ Rapport Mensuel SISCom**

I. Identification / Identification			
1. Facility Name/Nom de la formation sanitaire		5. Year/ Année	
2. District/ District		6. Month/ Mois	
3. Sector/ Secteur		7. Cell/ Cellule	
4. Cooperative name		8. Village	

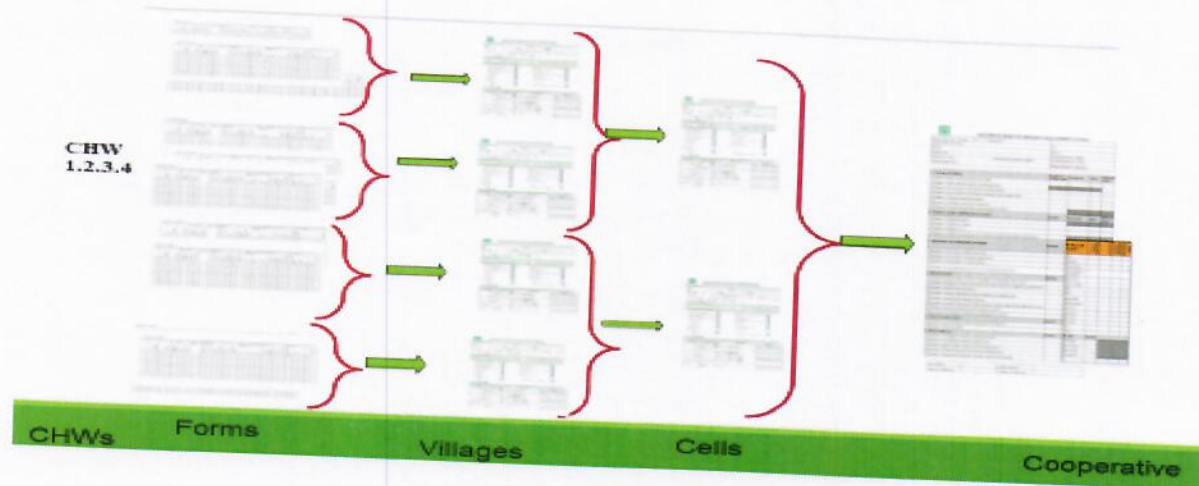
II. Population and CHW					
Population		Number	CHW	Number	Those who produced (submitted) reports
1	Number of residents:		1	Binome	
2	Village residents(monthly):		2	ASM	
3	Number of households		3	Health Promotion	
4	Number of children under 28 Days:				
5	Number of children under 1 year:				
6	Number of children between 6 to 59 month:				
7	Number of children under Five years:				
8	Women aged 15 to 49 of age:				

A. Treatment of sick children (Integrated Community Case Management_ICCM)		Total cases received	Treated	Referred	
				Before treatment	After treatment
1	Number of sick children under 5 years old seen by the CHW				
2	Cases seen by CHWs 6-59 months with fever_malaria presenting within 24 hrs				
3	Cases seen by CHWs 6-59 months with fever_malaria presenting after 24 hrs				
4	Cases seen by CHWs 6-72 months with severe malaria				

At the end of each month, the data from each village are tallied by the 4 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 the catchment area into another version of the same report. 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 cooperative president. At Cooperative level, the president verifies the completion and accuracy of all data coming from the different cells into one CHW Cooperative report and sends a signed consolidated report to the health center.

**Figure 5 : Compilation and data flow from village up to Cooperative**



At health center level, the in charge of CHWs (C-EHO) and HC Data Manager analyze data in the compiled report of all villages sent by CHWs Cooperative President, they then verify the completion and accuracy of the report and organize a feedback session to CHWs at the end of the month as part of their monthly meetings. The SISCom report is entered into the SISCom website on the HMIS servers at the national level ([www.hmis.gov.rw/healthfinancing](http://www.hmis.gov.rw/healthfinancing)) by the data manager at health center level before the 5<sup>th</sup> of the following month. At hospital level, a signed hard copy of the monthly SISCom report sent by HC is analyzed and verified then entered in the SISCom database, then after; a feedback is sent to the health centers.

### **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. 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
- Monthly Coordination meeting with all CHWs and HC where CHWs data are analyzed
- Monthly counter-verification by the sector steering committee members before submitting PBF invoices
- Quarterly counter- verification by the district steering Committee
- Data evaluation and counter-verification by the PBF team from the MoH bi-annually

## Responsibilities in Community data assessment

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.

### a. Cell Coordinators

The CRDQA1 tool helps the cell coordinator to identify discrepancies between the register and the monthly reports maintained by CHWs at the village level. (*Annex 6*)

### b. Sector Steering Committee

The counter-verification of the performance of the SSC is made on quarterly basis by a team composed of two people minimum from the District steering committee

## RHIMS PBF Database in DHIS-2

The national PBF scheme uses the following web site: [hmis.moh.gov.rw/pbfrwanda/dhis2](http://hmis.moh.gov.rw/pbfrwanda/dhis2) database accessible via the internet. The main purpose of the PBF database is to improve data management, data analysis and smooth invoicing system.

### RHIMS PBF Database structure

- Organization Unit structure:
- Rwanda
  - Province
    - District
      - Sub District (catchment area of a hospital)
        - Sector
          - Health Facilities (Hospitals, HC/CHWs Cooperative)















### PBF database role

The PBF database [www.hmis.moh.gov.rw/pbfrwanda/dhis](http://www.hmis.moh.gov.rw/pbfrwanda/dhis) is a component of health management information system (HMIS) managed by the Ministry of Health with the following main responsibilities:

- Designing new report formats
- Adding or modifying indicators,
- Adding or modifying tariffs,
- Adding or modifying account number,
- Adding health facilities or CHWs Cooperatives that need to be paid
- Changing and adding users.

**Figure 6: PBF database data element**

**PBF Management**

-  **PBF Data Entry**  
Manage performance of PBF indicators
-  **Quality Max Score**  
Manage quality max scores for quality related indicators
-  **Partner Management**  
Manage partners for PBF indicators
-  **Utilization Rule Management**  
Manage utilization rules and associate tariffs with utilization rates
-  **Aggregation Query List**  
Create new aggregation queries for aggregate data analysis
-  **Report Management**  
Manage PBF reports
-  **Lookup**  
Configure and manage Look up combinations
-  **Quality Score Entry**  
Manage quality scores for quality related ind
-  **Data Element Tariff and Target Manag**  
Manage tariffs for PBF indicators
-  **Bank Details Management**  
Manage bank details
-  **Quality Score Payment**  
Manage quality score ranges for additional c
-  **Manual Aggregation**  
Run the aggregation queries to aggregate fa
-  **PBF Report**  
Generate PBF Reports
-  **Payment Adjustment**  
Manage PBF payments based on availability

**PBF Data entry**

Data validation and evaluation process activities are done prior to data entry, once the tariffs are set, the users can start with PBF data entry that will include the reporting of the quantities/qualities reported by each Hospital. For doing data entry for PBF the facility user needs to select 'PBF Data Entry' option from the menu.

**Figure 6 : PBF data entry**

Organisation unit: Gashora CS

Dataset: CHWs\_H I V\_Data Set\_2019

Period: December 2020

DataElement	Partner	Quantity Reported	Quantity Validated	Quantity External Verification	Tariff Amount	Total
Nber_news_borns_received home visits_3dayafter b	Ministry of Health	74	74		100	7400
Nber of women_4 months_pregnancy referred by ASM	Ministry of Health	47	47		50	2350
Nber_childrens sick under 5 yrs old seen_CHWs	Ministry of Health	223	223		50	11150
Nber_Children u 5 yrs monitored_CHWs_MUAC 6-59	Ministry of Health	4501	4501		50	225050
Nber_Pregnant women_Accompanied_HC by CHWs_deliv	Ministry of Health	70	70		100	7000
						252950

### PBF Invoice generation

Once the data are entered into the database, the system produces a variety of outputs:

- District quarterly PBF invoices for different packages
- Health Facilities/CHW Cooperative specific reports for a given period.
- Table of indicator values to be used in pivot tables for ad hoc analysis, etc.

The user name and password are given to every district steering committee focal person to enable him access to the PBF database

Figure 7 : District quarterly PBF invoice



**PBF CHWs HIV Quartery Invoice**

Open in Acrobat

Calendar period 2020Q4 Fiscal period Q2 2020-2021

#	Facility Name	Bank	Account	Account name	Oct	Nov	Dec	Total
1	Bethsaida CS	BP	407212250810174	UMWEZI WITERAMBERE	38,200	37,050	27,400	102,650
2	Busanza CS	BP	426224590210172	ABAHUJE INKINDI	164,250	161,400	172,350	498,000
3	Gahanga CS	BP	407211907510177	DUKUNDE	313,300	350,500	343,300	1,007,100
4	Gatenga CS	BP	407213014310175	ABAHUJE URUGWIRO	236,250	235,800	229,850	701,900
5	Gikondo CS	BP	402119170710162	INDATWA ZA GIKONDO	236,300	251,650	264,050	752,000
6	Kabuga	BP	415370629210137	TWITEKUBUZIMA GAKO	60,900	78,950	71,300	211,150
7	Kairos CS	BP	426224590210172	ABAHUJE INKINDI	77,250	92,850	97,450	267,550
8	Kicukiro CS	BP	407212233610234	TERIMBERE	62,100	75,000	88,150	225,250
9	Masaka CS	BP	415235272410138	INDAKEMWA ZA	186,300	176,800	175,200	538,300
10	Nyarugunga CS	BP	426223994110183	TERIMBERE	138,100	130,800	127,250	396,150



**PBF CHWs HIV Quartery Invoice**

Open in Acrobat

Calendar period 2020Q4 Fiscal period Q2 2020-2021

#	Facility Name	Bank	Account	Account name	Oct	Nov	Dec	Total
					Total payment amount:			4,700,050

Date: \_\_\_\_\_

President du Comite de Pilotage \_\_\_\_\_

Secretaire Executif du District \_\_\_\_\_

**Determination of unit cost for quantitative indicators**

The quantitative indicators unit cost allocated to each indicator varies from one to another. The MoH in collaboration with Districts determines the indicator weight considering key criteria, such as health sector priorities, target achievement but also available budget.

### **Objective 3: Community PBF remuneration process**

#### **Determination of unit cost for quantitative indicators**

The quantitative indicators unit cost allocated to each indicator varies from one to another. The Ministry of Health in collaboration with Districts determines the indicator weight considering key criteria, such as health sector priorities, target achievement but also available budget.

#### **Performance Assessment Process**

The PBF evaluation tools are available at sector, health center and CHWs Cooperative level both in soft and hard copies. This procedures manual describes the way different evaluators will be done.

#### **CHWs Individual Performance Assessment**

The individual performance evaluation is done on monthly basis. This assessment is executed in accordance to the procedures below:

- CHW brings different sources of data (Register, file...)
- CHW brings data (SISCom reports) of quarter being evaluated;
- CHWs compares data from sources of data and SIS com;
- Evaluation of CHW is conducted by cell coordinator in collaboration with CHWs Cooperative President and submit evaluation report to HC not later than 15<sup>th</sup> day of month following the evaluated quarter **Annex 7**

#### **Monthly Quantitative Assessment of CHWs Cooperative**

The quantitative performance assessment of cooperative is done by HC on monthly basis. Quantitative evaluating will mainly be focusing on quality of data reported from village up to Cooperative level. Health center consolidate and analyses report then prepares invoice to be submitted to SSC not later than 20<sup>th</sup> day of month following the evaluated quarter (**Annex 8**).

#### **Quarterly Qualitative Assessment of CHWs Cooperative**

The qualitative performance assessment of cooperative is done quarterly by HC. Quality evaluation focuses on functionality of cooperative not later than 15<sup>th</sup> day of month following the evaluated quarter Annex 9

**Feedback on data quality:** The term agrees on the finding with health facility and Cooperative that has been assessed. Then after the whole exercises, the MOH team analyses data and make a comprehensive report and after which official management letters are written individually to Health facilities giving them the feedback which may include deductions that will be made on

case of overpayment and advise on the way to improve data quality through deeper evaluations and analysis of the reports before submitting their invoices for payment

### **Community PBF Payment Process**

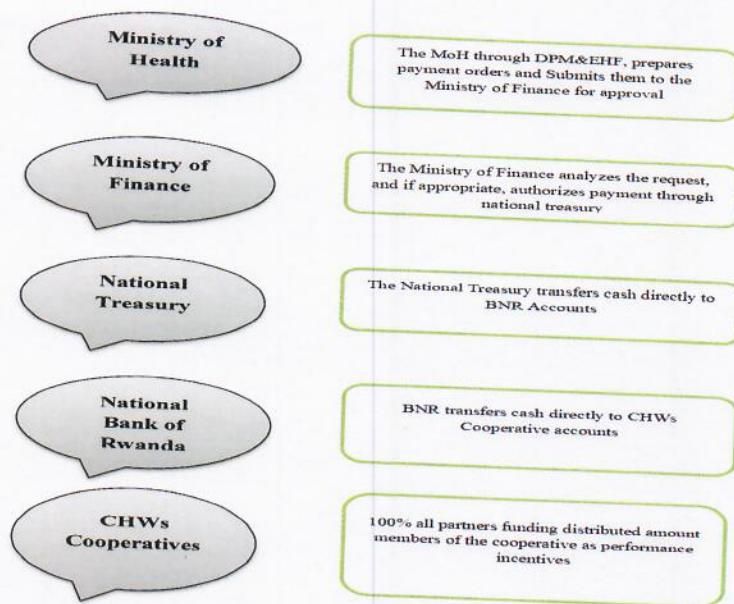
A report is generated by CHWs at every village then compiled at different levels until used by MoH for payment.

- Data are generated on monthly basis by 4 CHWs at each village then consolidated by every Coordinators of cells a.
- Data from cells are also analyzed then consolidated at cooperative level.
- Aggregated data from Cooperative are analyzed and approved by Sector Steering Committee the; sent to District Steering committee through HC
- District Steering Committee delegate do data entry in the database
- District Steering Committee analyses and approves the synthetized CHWS PBF data
- Synthetized Quarterly PBF invoice is approved by District then sent to MoH for payment
- MoH analyses and compiles PBF invoices from all District (all packages) then send them to MINECOFIN for fund transfer to CHWs Cooperatives
- After receiving PBF funds from central level, Every CHWs Cooperative pays individual incentives according to their performance. **Note that cashless system is to be encouraged when distributing PBF to CHWs**

Referring to Payment orders (OP) as payment proof, Cooperatives that didn't receive money notify in writing to the MoH within 30 days for follow up.

Earmarked funds are dedicated to fund income generation activities to sustain CHWs cooperative

**Figure 8: Diagram showing cash flow from the central level to the final beneficiaries**



The earmarked funds from MINICOFIN via Districts is directly transferred to CHWs Cooperatives accounts to be invested in CHWs cooperatives Income generating activities.

#### Objective 4: Accountability mechanisms in the C-PBF

##### CPBF Counter Verification

The counter verification is conducted to ensure accuracy of C-PBF data verified by SSC and DSC, comparing with SIS Com reports and other different reports, registers and files. MoH conducts bi-annually the counter verification exercise of C-PBF data. The exercise is done by selecting HCs with outliers identified during the data analysis and targeted CHWs cooperatives with doubtful data/information in their report. The counter verification exercise covers at least 15% of CHWs Cooperatives that received PBF funds.

The purpose of this exercise is:

- To verify whether the data reported in PBF database are similar to data from PBF evaluation form, SIS Com and registers.
- To identify the root cause of data discrepancy
- To formulate recommendations in the framework of improving data quality

**N.B for any data discrepancy identified during the PBF counter verification exercise, the feedback is given in writing to the concerned CHWs cooperatives and the extra amount received by CHWs cooperatives due to data discrepancy is deducted for the next C-PBF payment transfers and other corrective measures are taken by MoH.**

##### Community PBF System assessment

The main objective for conducting PBF system assessment is to determine the level of compliance with the implementation of PBF conceptual framework and to provide recommendations to improve PBF System. The specific objectives are as follows:

- To ensure the existence of updated PBF contracts and other PBF documents
- To assess effective implementation of clauses stipulated in the contracts;
- To monitor the CHWs Cooperative evaluations process
- To ensure that PBF transfers have been received to the Cooperative accounts;
- To ensure that PBF received were paid to CHWs on time according to PBF principles.

### **Community PBF Audit**

The audit aims at reinforcing the compliance with the community PBF model according to established procedures. The audit should be conducted by an independent body, partner or other governmental agency this will help to guarantee the transparency and efficiency of the community PBF model. Selection of cooperatives to be audited 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 audit of the C-PBF system will specifically focus on the following procedures:

- Implementation modalities
- Implementation procedures
- Improvements in the social status of CHWs due to the benefits from the revenue of their cooperatives.

The Monitoring process is mainly done by giving management letters to the concerned Health facilities and CHWs Cooperatives and if any overpayment; informing them on the deduction to be done during the following payments. The concerned CHWs cooperatives provide feedback in writing to MOH on the corrective measures they have undertaken to ensure the issues are fixed in a long term perspective.

#### **4. Governance framework:**

To describe key responsibilities of the below mentioned actors in the implementation of this procedures manual.

#### **Ministry of Finance and Economic Planning (MINECOFIN)**

- To provide the budget for C-PBF
- To conduct audit to ensure proper utilization of C-PBF funds by both central and decentralized levels
- Capacity building on proper financial management

### **Ministry of Health (MOH)**

- To provide policy guidance on the implementation of this manual
- To plan the budget of C-PBF
- To provide capacity building (supervision, Mentorship.) to the decentralized levels on the compliance of this manual
- To Monitor, Evaluate and conduct data quality assessments

### **Districts:**

- To ensure proper implementation of the C-PBF procedures manual at the decentralized levels
- To ensure timely transfer of C-PBF funds to the CHWS cooperatives
- To ensure timely submission of C-PBF invoices to the central level
- To monitor the utilization of C-PBF or proper accountability
- To Evaluate of sector steering committees

### **Hospitals and health centers:**

- To provide technical support to the CHW cooperatives on data quality and reporting
- To Supervise and Mentor of HC and CHWs Cooperatives

### **CHW cooperatives:**

- Compiler CHWs monthly report
- To submit timely the C-PBF invoices for payment
- Report on income generating activities
- Distribute and give report on individual distribution of Community PBF
- Supervision of CHWs in villages

## ANNEX

- Annex 1 : Services package of Community Health Workers
- Annex 2 : Contract between the Executive Secretary of Sector and SSC Members
- Annex 3 : Contract between the SSC and the CHWs (in Kinyarwanda)
- Annex 4: : Feedback format report on community PBF funds received and distributed
- Annex 5 : CHW Cooperative Income Generating Activities report format
- Annex 6 : Community Routine data quality assessment tool (Village and Cell level)
- Annex 7 : CHWs Individual Performance Assessment tool
- Annex 8 : Monthly Quantitative CHW Cooperative Assessment Tool
- Annex 9 : Qualitative CHW Cooperative Assessment Tool

#### **4. References**

- a. Community Performance -Based Financing (PBF) Procedure Manual, Supplemental for the Stunting Prevention and Reduction Program (SPRP)
- b. Community Performance -Based Financing User Guide 2009
- c. Performance Based Financing Procedures Manual for Health Facilities (Hospitals and Health Centers), Dec 2020.
- d. Rwanda Fourth Health Sector Strategic Plan (July 2018-June 2024)
- e. 7 Years Government Program: National Strategy for Transformation (NST1) 2017–2024.