REPUBLIC OF RWANDA

MINISTRY OF HEALTH
PO Box 84, Kigali

NATIONAL COMMUNITY HEALTH STRATEGIC PLAN

July 2013 - June 2018

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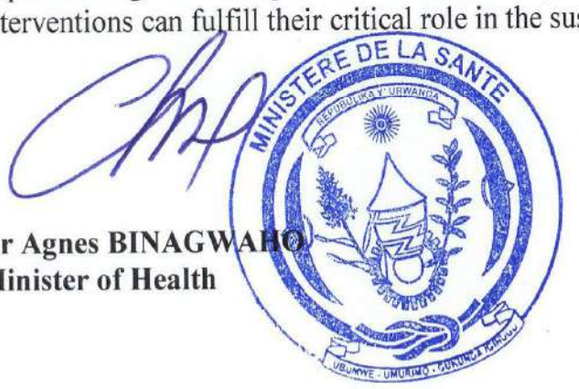
FOREWORD

The National Community Health Strategic Plan 2013-2018 has been informed by the experiences, challenges, and lessons learned from the previous community health strategic plan and other interventions implemented in an the effort to find solutions to existing limited access to Primary Health Care (PHC) in Rwanda. It builds upon the National Community Health Policy of 2009 and The Rwandan Health Sector Strategic Plan (HSSP III) of 2012-2018, which is aligned with the Rwandan Economic Development and Poverty Reduction Strategy (EDPRS).

The Government of Rwanda recognizes that the problem of access to primary health care is not only a health sector issue, but rather a multi-sectoral challenge that requires all sectors to work together in a synergistic manner to deliver a comprehensive community health package – ranging from preventive to curative interventions – with full community participation. Specifically, the community health package consists of the Community Case Management (CCM), Mother and Newborn Health Program (MNH), Reproductive Health (RH), Family Planning (FP), Community-Based Nutrition Program (CBNP), Community-Based Provision for Family Planning (CBP), Environmental Health and Hygiene (EH), Behavior Change Communication (BCC) and the Rwanda Community Health Management Information System (RCHMIS). These programs are primarily devoted to the reduction of maternal and child mortality. Additionally, the package includes the Community Performance-Based Funding (C-PBF) through Community Health Workers' (CHWs) cooperatives, both of which aim to augment the quality of health care, while at the same time improving the community by way of creating income-generating projects.

A key objective of this Strategic Plan is to significantly reduce the rate of maternal and child mortality by implementing the comprehensive community health package as defined by the 2009 National Community Health Policy, which will help us meet the Millennium Development Goals (MDGs) as well as those defined by HSSP III 2012-2018. The Community Health Strategic Plan was designed to be in alignment with the HSSP III 2012-2018 and all sectoral policies and strategies. Its objectives were developed based on existing community health policiesthat have been modified slightly to accommodate the implementation framework. Linked to each objective is a set of corresponding strategies that will help us achieve these goals, which will be done in partnership with many collaborators. This Strategic Plan also necessitates local engagement and community mobilization as we strengthen the capacity of decentralized health structures to enhance program design, implementation, monitoring and evaluation of community intervention, quality data collection, involving community members in decision-making and other community plans.

It is our hope that all partners of this Strategic Plan will rise to the great challenge before us and provide both technical support and the resources necessary to achieve its goals. The Government of Rwanda is committed to achieving the proposed objectives and ensures that the entire country is implementing the comprehensive community health package in order that community health interventions can fulfill their critical role in the sustainable development of Rwanda.



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Minister of Health

LIST OF ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
BCC	Behavior Change Communication
CAA	*Cellule d'appui à l'approche contractuelle* (within the MOH)
CBNP	Community-Based Nutrition Program
CBP	Community-Based Provision for Family Planning
CHAI	Clinton HIV/AIDS Initiative
CHD	Community Health Desk
CHW	Community Health Worker
CMNH	Community Maternal and Newborn Health
CHWC	Community Health Workers Cooperatives
CHIS	Community Health Information System
C-PBF	Community Performance-Based Funding
CSFVA	Comprehensive Food Security and Vulnerability Assessment
DH	District Hospitals
ECD	Early Childhood Development
EDPRS	Economic Development and Poverty Reduction Strategy
EH	Environmental Health
EIP	Expanded Impact (Child Survival) Program
FP	Family Planning
GF	Global Fund
GBV	Gender-Based Violence
HC	Health Center
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICCM	Integrated Community Case Management (formerly IMCI: Integrated Management of Childhood Illnesses
ITN	Insecticide-Treated Nets
LFA	Logical Framework Approach
MDG	Millennium Development Goals
MUAC	Mid-Upper Arm Circumference
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MSH	Management Sciences for Health
NCD	Non-Communicable Diseases
PHC	Primary Health Care
PLWA	People Living With AIDS
PNC	Post Natal Care
RBC	Rwanda Biomedical Center
RCHMIS	Rwanda Community Health Management Information System
RDHS	Rwanda Demographic and Health Survey
RH	Reproductive Health
SICCM	Supply for Care Community Management
TRAC+	Treatment and Research AIDS Center
PNILP	National Malaria Control Program
PNILT	National Tuberculosis and Leprosy Control Program
UNFPA	United Nations Population Fund Agency
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VPPD	Vaccine Preventable Disease Division
VUP	Vision 2020 *Umurenge* Project
WFP	World Food Program
WHO	World Health Organization

TRANSLATION OF KEY TERMS USED IN THE TEXT

Agent de santé binôme: Male or female community health worker
Animatrice de santé maternelle (ASM): Traditional birth attendant
Approche contractuelle: Contractual approach (Community-based financing)
Binômes: Pair of one male and one female community health worker
Cellule: Cell—An administrative unit comprised of various *imidugudu*
Comité de la mutuelle: Committee for the community-based mutual health insurance
Mutuelle de santé: Community-based mutual health insurance
m'Ubuzima: "Mobile in Health"—the application of mobile technology for health programs
Umudugudu: One village (one *umudugudu* is composed of 50 to 150 households)
Imidugudu: Many villages

1. INTRODUCTION TO COMMUNITY HEALTH

1.2 International Context

Over the last three decades following the 1978 Alma Ata Declaration on Primary Health Care (PHC), community health workers (CHWs) were promoted to become part of many developing countries' health systems (Walt 1988). In many of these countries, CHW programs were introduced in a top-down fashion with relatively limited capacity building and planning. Rather than being the leading edge of a transformed approach to health care, CHWs often ended up becoming a poorly resourced and undervalued extension of the existing health service—"just another pair of hands" (Walt 1990).

While there was considerable variation in the types of CHWs and the forms taken by CHW programs, CHWs' international experiences gave rise to debates on their role in health systems and highlighted the problems associated with their management. While successful experiments across a range of contexts provided inspiration for CHW programs, numerous challenges arose in the process of shifting from effective and small-scale local projects to national CHW schemes. Common problems cited included lack of community integration, unrealistic expectations, unsupportive environments, poor supervision, lack of appropriate incentives, high turnover, and ultimately poor quality services and cost-effectiveness (Berman et al. 1987; Walt 1988; Walt 1990; Gilson et al. 1989).

In the face of these difficulties coupled with economic crises, enthusiasm for national CHW programs declined internationally in the 1980s and 1990s (Abbott 2005). But although national governments tended to steer clear of CHW programs in the 1990s, CHWs did not disappear entirely from health systems.

Over the last decade, rapid expansion in HIV/AIDS funding and other health programs, such as for tuberculosis (TB) and malaria, and a renewed interest in child survival have propelled a shift in international thinking back towards large-scale deployment of CHWs (WHO 2006; Haines et al. 2007). The reasons for this appear to be more pragmatic than ideological: the need to address the crippling health worker shortages in many countries hampering "national scale-up" of new initiatives, such as access to antiretroviral therapy (ART) and maternal and child health (MCH) programming. Furthermore, there is significant evidence that CHWs can be used at the sub-national or the local level, even in developing countries (Witmer et al. 1995; Abbott 2005; Lewin et al. 2005; Haines et al. 2007; Lehmann and Sanders 2007).

Thus in 2006, the World Health Organization proposed "task shifting" and the training of CHWs as core ideas in its "AIDS and Health Workforce Plan" (WHO 2006). The "massive training of CHWs" was also identified as a quick win for achieving the Millennium Development Goals (MDGs) (UN Millennium Project 2005, cited in Abbott 2005).

More recent reviews of CHWs experiences suggest that under the right conditions, scaled-up community health programs are feasible, can lead to health gains, and produce wider range of social benefits over sustained periods of time (Haines et al. 2007; Lehmann and Sanders 2007). Examples of some successful contemporary programs include *Programa Agente Comunita´rio de Sa´ude* of Ceara´ State in Brazil, the *Mitanin program* of Chhattisgarh State in India (Sundararaman 2007), and the collective contribution of community health workers to the improvement of MCH conditions in Rwanda (External Evaluation of Health Sector Strategic Plan, MOH, November 2011 and DHS 2010). The right conditions needed for the CHWs programs to flourish include political support, community inclusiveness, training, strong supportive supervision, remuneration and incentive systems (Bhattacharyya et al. 2001; Lehmann and Sanders 2007).

1.3 Rwandan Context

With about 26,338 km², Rwanda is a mostly mountainous, landlocked country in the Great Lakes region of East Africa. With most of Rwanda's landscape classified as mountainous, not only does service delivery become a challenge, but also the use of CHWs becomes beneficial. The country consists of four provinces that are subdivided into 30 districts, plus Kigali City. Each district is divided into sectors, which are further divided into cells and finally into villages, *Imidugudu*. On average, a village can accommodate 50 to 150 households.

Rwanda is the most densely populated country in Africa, with an estimated population density of 416 people/km² (National Census 2012). The population growth currently stands at 2.6% per annum (National Census 2012). The high fertility rate is one factor fuelling rapid population growth – though all indications show that it has been declining over the last decade. The average fertility

rate for a Rwandan woman in her lifetime has been reduced from 6.1 in 2005 to 4.6 children (DHS 2008, 2010). Despite the reduction, Rwanda's total fertility rate is still high, taxing the country's scarce resources. Together, the high fertility rate and population density contribute to development and economic constraints and the depletion of Rwanda's natural resources.

The DHS 2010 data and several evaluations, such as HSSP II external evaluations and health situation analysis and main gaps done 2011, suggest that Rwanda is on track to achieve national health targets that include international commitments such as the United Nations Millennium Development Goals (MDGs). In fact, Rwanda has been widely praised regionally and internationally for being on track to achieve most health-related MDGs by the year 2015. Since inception, community-based interventions have been widely viewed to have significantly contributed towards current health achievements (DHS 2010). The Ministry of Health is committed to the implementation of a successful community health program and this has been reinforced by the strong collaboration with partners in various interventions. It is this strong partnership that has contributed towards achieving multiple MDGs and national targets.

CHWs' contributions have been felt in various ways. For example, Rwanda's Vaccine Preventable Disease Division (VPDD), which is the former Expanded Program on Immunization, has achieved the best immunization coverage levels in central Africa (see Table I). CHWs have also been commended for mobilizing the community population on the advantages of immunization; mobilizing men and women to utilize family planning services which are currently affordable and accessible to the majority of Rwandans (see Table I); and carrying out a nationwide community nutrition surveillance program with good results, such as kitchen gardens and under five growth monitoring. CHWs have likewise been heavily engaged in malaria prevention and treatment, where a significant impact at community level has been seen. TB and HIV/AIDS prevention have also shown impressive results (PBF TB Evaluation Report 2011). These examples show that CHWs, when used appropriately, can bring about positive changes in community health.

However, despite current health achievements, like many African countries the CHW program in Rwanda still faces significant challenges that hinder delivery of the quality of the comprehensive package of services. These challenges range from low capacity of CHWs, to insufficient resources to sustain routine community health activities including cooperatives, training, and refresher training, to reinforcing supply systems, to purchasing equipment, to upgrading infrastructures needed to deliver more health services to the community. Effectively addressing these challenges will significantly contribute to the achievement of the national health targets described in the HSSP III 2012-2018.

1.4 Profile of Community Health Workers in Rwanda

Rwanda started the community health program in 1995 after the genocide. At that time, there were no policy, strategy or operational guidelines on how to implement a community health program. The idea behind creating a community health program was mainly to improve access to health services by bringing services closer to the communities while also addressing the shortage of the health care provider work force.

Over time, the quantity of health care and promotional services provided by CHWs and the number of CHWs has been increasing. In 1995 when the MOH endorsed the program, the number of CHWs was approximately 12,000. By 2005, ten years later, the number had grown to 45,011. From 2005, after the decentralization policy was implemented countrywide, there were sustained capacity building of the CHWs through training, mainly in MCH service delivery and supplied materials. At present, each village has a male and female pair (*binomes*) of CHWs in charge of ICCM and one *Animatrice de santé maternelle* (ASM) in charge of maternal and newborn health.

In Rwanda, community health workers are a formal part of the national health strategy and are coordinated by the Community Health Desk of the Ministry of Health. Qualifications to become a CHW include the following: 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; and be elected by the village members. Each village should elect two women and one man.

In each village of approximately 100-150 households, there is one maternal health CHW, or ASM, who is responsible for:

1. Follow up of pregnant women and their newborns
2. Malnutrition screening
3. Community-based provision of contraceptives
4. Preventive NCDs

5. Preventive and behavior change activities
6. Household visits

Each village also has two multi-disciplinary CHWs (*binômes*: one man and one woman) who carry out:

1. Integrated community case management, or ICCM (assessment, classification and treatment or referral of diarrhea, pneumonia, malaria, and malnutrition in children under five years of age)
2. Malnutrition screening
3. Community-based provision of contraceptives
4. DOT for TB
5. Preventive NCDs
6. Prevention and behavior change activities
7. Household visits

There are two community health workers, called "cell coordinators", who are heads of all CHWs at the cell level, and whose aim is to follow up, and thereby strengthen, CHWs' activities. The specific roles and responsibilities of the cell coordinator at the cell level include the following:

1. Visiting of community health workers in order to monitor their activities on a monthly basis
2. Follow up and verify if CHW has patient registers, and if they are correctly filled out and well-kept
3. Monitor if drugs are distributed correctly and if these drugs are not expired and well-kept
4. Compilation of reports of drugs that have been used by CHW in that cell and requisition of drugs at health centers
5. Supervision of the *binome* and a household that was recently attended to by a CHW
6. Check if CHW does post-visit for children s/he recently treated
7. Supervise CHW on how well s/he is able to sensitize the community on family planning usage
8. Verification of reports brought for compilation if they have been sent by telephone (m'*Ubuzima*)

The cell coordinator is aided by an assistant cell coordinator, who is responsible for:

1. Monitor if the ASM has registers and these registers are filled correctly
2. Follow up and see if the ASM refers pregnant women for ANC visits at the HC
3. Follow up and verify if the ASM has sent RapidSMS reports for pregnant mothers confirmed by health provider
4. Verify if the ASM has Misoprostol drugs and the drugs are not expired

2. PLACE OF CHWs IN THE HEALTH SYSTEM

Health services are provided at different levels of the health care system – in communities, at health posts (HP), health centers (HC), district hospitals (DH), and referral hospitals – and by different types of providers – public, confessional, private-for-profit and NGO. At all levels, the sector is composed of administrative structures and implementing agencies.

At the lowest level, those in charge of community health activities at the health centers administratively supervise CHWs. The CHWs receive financial compensation through performance based financing, or PBF, for delivering a certain number of health services. Thirty percent of the total PBF funds are shared among CHW members while 70% is deposited in the collective funds of CHW cooperatives.

At the sector level, there are Health Center Committees that provide oversight on the work from various units in the health center, its outreach, supervision activities, and general financial controls.
At the district level, one finds district hospitals (DH), district pharmacies, community-based health insurance (CBHI) committees, and HIV/AIDS committees. For clinical services, they report to the Director of the district hospital. However, for administrative matters, the agencies are under the supervision of the staff responsible for Social Affairs at the district. Each district has a District Health Unit (DHU), being an administrative unit in charge of the provision of health services in the entire district and is responsible for planning, monitoring, and supervising implementing agencies and inter-sector collaboration and coordination with DPs operating in the district (through the Joint Action Development Forum, or JADF). The DHU is composed of two technical staff members, those responsible for planning and for M&E, and reports to the staff in charge of Social Affairs or to the District Council if applicable. The Director of the district hospital reports to the DHU on progressive performance of the DH.

At the national level, there are currently four recognized referral hospitals. The district hospitals transfer patients to the national referral hospitals for further care in cases of medical complications requiring advanced care.

In sum, Rwanda has four referral hospitals, 42 district hospitals, 438 health centers, and 45,011 CHWs operating in 14,873 villages. All CHWs are organized into cooperatives called Community Health Worker Cooperative, or CHWC. Each health center oversees one CHW cooperative.

3. CONTRIBUTION OF CHW TO THE SECTOR PERFORMANCE

The Government of Rwanda is highly committed to improving the health status of its population, as is evidenced by the fact that the Ministry of Health has achieved most health targets that were set over the last 10 years. The infant mortality ratio decreased from 86 per 1000 live births in 2004 to 50 per 1000 live births in 2010, and the under five mortality ratio declined from 152 to 76 per 1000 live births over the same period (RDHS 2010). The maternal mortality rate was last assessed in 2010 at 487 per 100,000 live births (RDHS 2010). With these figures, Rwanda will likely meet the maternal and child mortality MDGs targets by 2015. However, neonatal mortality remains of concern as it hardly decreased from 2007 (at 28 per 1000 live births) to 2010 (at 27 per 1000 live births).

DHS 2010 data indicate that Rwanda achieved a decline in malaria prevalence of almost half from 2007–08 data: from 2.6 percent to 1.4 percent among children age 6–59 months, and from 1.4 percent to 0.7 percent among women age 15–49. This improvement has been in part attributed to the wide coverage and use of mosquito nets, where CHWs have played a greater role in ensuring the nets are distributed to and used appropriately in every household in the community. DHS data indicates that 82% of households have at least one long lasting insecticide-treated mosquito net (LLIN) and 70% of children under five slept under the LLIN (DHS 2010). According to DHS 2010 results, the prevalence of acute respiratory infections, or ARI, also decreased significantly: the percentage of children with reported ARI in the last two weeks preceding the survey was 17% in 2005 and 4% in 2010. This can be attributed to the intensive scale up of the introduction and provision of the pneumococcal vaccine. However, diarrhea hardly decreased: the percentage of children who reported diarrhea in the last two weeks preceding the survey was 14% in 2005 and 13% in 2010.

Considerable progress has been registered in combating HIV/AIDS. The HIV prevalence was 3% in 2010 (DHS), one of the lowest in Sub-Saharan Africa. In a span of five years, the modern

contraceptive prevalence rate more than quadrupled from 10% in 2005 (DHS) to 45% (DHS) in 2010. The Total Fertility Rate decreased from 6.1% (DHS 2005) to 4.6% in 2010 (RDHS 2010), underlining the role of FP to addressing population growth. This increase has been due to government and partner commitment to FP as a top priority. However, CHWs have also done extensive mobilization in target places to ensure that the right messages reach targeted populations.

The implementation of different community health interventions has significantly contributed to improved access to health services. Examples of these interventions are Community-Based Health Insurance (CBHI), community PBF (stimulates demand and supply of health services), and RCHMIS (improves data collection and timely actions). CBHI coverage has attained more than 90% enrollment, which has resulted in increased care seeking by the population (DHS 2010).

Community-based health insurance (CBHI) covers primary health care services that are mainly delivered at the health center level. Patients with CBHI can be referred to secondary care delivered at the district hospitals and by qualified medical doctors; if patients cannot be managed at the district level, they are referred to national referral hospitals with specialized doctors. Therefore CHWs are part of the referral system right from the community levels. Between 2010-2011 a decrease in per capita visits for children under five in both the community and in health facilities was observed and might be attributed to the new tariff system of the CBHI introduced in 2011.

The government spending on health has increased since 2005: 8.2% in 2005, 9.1% in 2007, and 11.5% in 2010 (HSSP II Situation Analysis Report, MOH). The level of government spending on health in 2010 was within the reach of the Abuja declaration targets for national budget allocations to the health sector (15% by 2015). Therefore, as more health interventions shift to the community level, greater advocacy is needed to improve community health financing.

With regard to human resource for health, there was an absolute increase in the number of public health professionals (doctors, nurses, and paramedics) from 2008 to 2010. The total number increased from 11,604 in 2008 to 12,465 in 2010. The 2009 staff in-post numbers also showed an absolute growth of 12,288. During the same period, the number of doctors increased from 363 to 413 while nursing staff also increased from 6,154 to 6,462 (Human Resources for Health Country Profile, African Health Workforce Observatory, March 2010). The health system in Rwanda has greatly benefited from task shifting where CHWs are delivering primary health services at the community level. This has provided a relief of patient workload at the health center and reduced patient travel costs to the health center.

Table I. Main Rwandan Health Indicators

Population and Medical Personnel		
Total population:	10.5 million (Population Census 2012)	
Life expectancy:	55 years (HSSP III 2012-2017)	
Per capita utilization of health services:	85% (MOH 2011)	
Doctors:	1/17,240 inhabitants (HSSP III)	
Nurses:	1/1,294 inhabitants (HSSP III)	
Midwives:	1/66,749 inhabitants (HSSP III)	
Main Health Impact Indicators	**RDHS 2005**	**RDHS 2010**
Neonatal mortality/1,000 live births	37	27
Infant mortality/1,000 live births	86	50
U-5 Mortality/1,000 live births	152	76
Prevalence of stunting (Ht/Age)	51	44
Prevalence of wasting (Ht/Wt)	5	3
Children underweight prevalence	18	11
Maternal mortality/100,000 live births	750	487
Modern contraceptive prevalence among married women	10%	45%
Total fertility rate	6.1	4.6
Main Outcome Health Indicators		
HIV prevalence rate (15-49 years): 3% (DHS 2010) Malaria prevalence in children <5 yrs: 2.6% and 1.4% (DHS 2008 and 2010, respectively)		
Children <5 yrs sleeping under LLIN: 70% (DHS 2010)		
Births attended in health facilities: 69% (DHS 2010)		

Children <1 yr immunized for measles: 95% (DHS 2010)		
Modern contraceptive utilization rate: 45% (DHS 2010)		
Population covered by CBHI: 91% (HSSP III)		
GOR budget allocated to health: 11.5% (HSSP III, MTEF)		
Rates of CBHI Enrollment Over Time		
	Year	**Percentage**
	2006	44%
	2007	75%
	2008	85%
	2009	86%
	2010	91%

4. LEGAL AND POLICY FRAMEWORK

4.1 International commitments and goals

4.1.1 Millennium Development Goals (MDG)

Rwanda is committed to the international and regional agreements for which it is a signatory such as the Millennium Development Goals (MDGs). The MDGs commit the international community and each country to a renewed vision of development, one that vigorously promotes human development as the force that will sustain social and economic progress in all countries. In Rwanda, community health will contribute directly to achieving five of the eight goals, as shown in the table below.

Table II. The MDGs and the Role of the Community Health Sector

Eradicate extreme poverty and hunger	*By 2015…* *Target 1:* CH will contribute to the reduction of the number of persons in severe poverty by providing effective community health services that will keep the population of Rwanda healthy and productive, allowing for participation in the labor force, with reduced absenteeism due to poor health. *Target 2:* Enhance and expand nutrition surveillance and interventions to reduce by half the number of malnourished children. CH will strengthen community-based growth monitoring, nutrition education and support community-based supplementary nutrition projects, e.g., gardening and raising small livestock.
Reduce child mortality	***Target 5***: CH will contribute to reducing by two-thirds by 2015 the under-five mortality rate through the use of CHWs to enhance immunization services, to combat diarrhea through oral rehydration therapy (ORT), provide early treatment for key diseases such as malaria and childhood pneumonia, and strengthen community IMCI.
Improve maternal health	***Target 6***: CH will assist in reducing by three-fourths the maternal mortality ratio through overcoming access barriers to services, by education of parents, and by community involvement in maintaining access to health centers. Each pregnancy will be registered, the parents educated, and the couple urged to seek prenatal safe delivery and post natal care and family planning services in Rwanda.
Combat HIV/AIDS, malaria and other diseases	***Target 7***: CH will contribute to the national efforts to halt the spread of HIV and AIDS by 2015 through education of individuals and families in every village (*Umudugudu*) about HIV/AIDS, motivating for counseling, distributing condoms, and making sure all patients with HIV/AIDS or tuberculosis receive and adhere to treatment (via Directly Observed Therapy, or DOTS, for TB) and support. ***Target 8***: CH will assist the MOH to halt the spread of malaria by 2015 and begin to reverse the incidence of malaria and other major diseases. CH collaborates with the RBC and other programs by moving curative and preventive care to the periphery, including key IMCI services, to the level of the community health workers.
Ensure environmental Sustainability	***Target 10***: Reduce by half the proportion of people without access to safe drinking water. The Environmental Health department in CH has set targets in the *Health Strategic Plan (2012-2018)* to increase the proportion of people with access to a safe water supply.

According to international agencies for development, achieving the MDGs by 2015 will require more focus on development outcomes and inputs in order to effectively track national progress towards meeting these goals. Information for action will be necessary, from the community level to the central level. Rwanda's Community Health Information Management System (RCHIMS) will be targeted.

4.2 National Policies and Strategies

4.2.1 The Vision 2020

The major indicators for the Vision 2020 have been revised through EDPRS 2 to reflect Rwanda's current development situation. The Vision 2020 is Rwanda's leading planning framework that guides overall socioeconomic development efforts in Rwanda. Three goals constitute the pillars of Vision 2020:

1. Reduce Rwanda's aid dependency
2. Raise life expectancy to 55 years (already surpassed)
3. Become a middle-income country (halve the percentage of people living in poverty).

Population growth is the key component of the *Vision 2020*. Rwanda intended to reduce the total fertility rate (TFR) from 6.5 children per family to 4.5 within the next 20 years, but this target has already been attained. The MOH commits efforts and resources to shift primary health care interventions towards the community level. It has been observed that well planned and managed community-based interventions are paramount to improving access to preventive, health promoting, and curative health services. This is why the MOH advocated for high impact community health interventions targeting mainly maternal and child health services.

4.2.2 The Economic Development and Poverty Reduction Strategy (EDPRS 2)

The Rwanda Economic Development Strategy (EDPRS) was developed to provide a medium term framework for achieving the country's long-term development aspirations as embodied in Rwanda Vision 2020. The EDPRS used an analytical framework to identify four thematic areas where health is in the theme of the eight foundation areas. EDPRS' main objectives in the health sector are to maximize preventive health measures and build the capacity of CHWs to provide high quality and accessible health care services for the entire population in order to reduce malnutrition, infant and child mortality, and fertility, as well as the control of communicable diseases (EDPRS 2008-2012). EDPRS recognizes that the problem of access to primary health care is not only a health sector issue, rather a multi-sector challenge that proposes all sectors to work together in synergy to deliver a comprehensive community health package with full community participation through CHW cadres.

4.2.3 The Seven-Year Government Program 2010-2017

The Government Program 2010-2017 is a seven-year program developed in 2010 to guide all sectors and governmental institutions towards achieving the development targets by 2018 instead of 2020. This program has four major pillars: (I) Governance, (II) Justice, (III) Economic Development, and (IV) Social Welfare. Under social welfare, the program clearly emphasizes the need to "decentralize good health services up to the village level through a network of CHWs" throughout the country so that at least 90% of women aged between 15 and 49 use modern contraceptives and other community-based health services. The program particularly highlights other services such as HIV/AIDS, TB, and malaria, whose implementation at the community level has registered considerable progress. The program also singles out nutrition interventions to be implemented at the community level by the CHWs. The development of the Community Health Strategic Plan 2013-2018 will be aligned with the Government Program 2010-2017 in order to contribute to the realization of broader government program targets.

4.2.4 The National Health Policy

The National Health Policy outlines the roles of the central government and the decentralized structures: provincial and district structures, and emphasizes the norms established in 1998 for the minimum package of activities and services, as well as the complementary package of activities to be provided at hospital, health center, and community levels. This policy describes the role of community-based service delivery as contributing positively to the health status of the community. It also highlights the concept of partnerships as a key means of achieving integration, including inter-sector integration of health services.

The National Health Policy calls for greater health sector financing and urges initiatives that strengthen solidarity, such as mutual health insurance schemes, prepaid health insurance and health

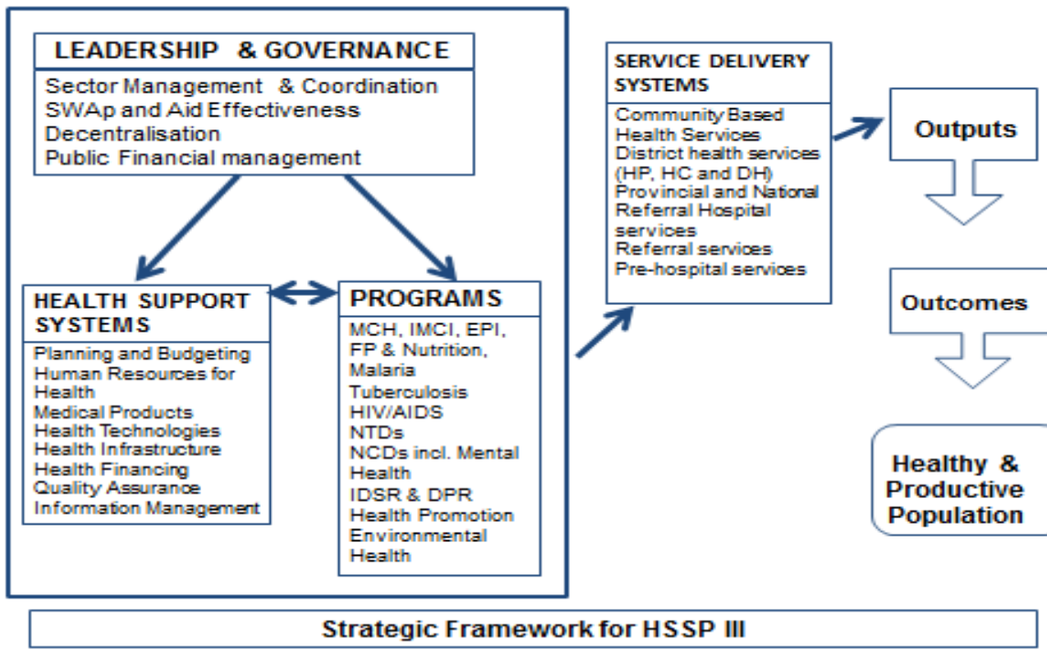
insurance. Specifically, the policy says that the functions of the health district include: (i) the organization of health services in health centers and the district hospital in terms of the minimum and complementary packages of activities, (ii) administrative functioning and logistics, including the management of resources and supply of drugs, under the responsibility of the district management team, and (iii) supervision of community health workers who operate at the village level (*umudugudu*). Other documents such as the National Reproductive Health Policy, the Strategic Plan to Accelerate the Reduction of Maternal and Neonatal Morbidity and Mortality, and national health policies on FP (VPDD), NSP-HIV, NSP-TB, and Community-based Health Insurance, are all policies with direct links to Community Health, where CHWs have important roles in their implementation.

4.2.5 The Health Sector Strategic Plan July 2012-June 2018

HSSP III 2012-2018 identifies the community health network as a key health infrastructure that contributes greatly to the delivery of health services to the majority of the population who lives and works in the community. HSSP III further affirms that introducing community health service delivery close to the population "fundamentally breaks barriers" for improved access to care and increased services utilization.

A developed network of public health facilities with defined service packages, guidelines, and protocols at each health facility level exists to meet the health needs of Rwanda's population. This network is structured as a pyramid with referral hospitals at the apex followed by district hospitals (among which five will soon be upgraded to Provincial Hospitals), and health centers. The health centers in turn supervise health posts and community health workers and other community-based associations for community outreach activities. HSSP III identifies the network of CHWs as an important component of the health system that will potentially contribute to the health system strengthening efforts. Figure I below shows where the community-based services lie in HSSP III.

Figure I. The Role of CHWs in the HSSP III Conceptual Strategic Framework



In August 2011, an external review of HSSP II was completed. The results of the review informed the development of HSSP III. This review also assessed the contribution of community health towards realizing national health targets, particularly those related to Maternal and Child Health. Recommendations drawn from mid-term review that are related to community health were taken into consideration during the development of the Community Health Strategic Plan 2012-2018. The main recommendations include building capacity of the community health workers and maintenance of the CHWs' incentives through community health workers' cooperatives.

4.2.6 The Community Health Policy

The Community Health Policy was developed mainly to guide and strengthen the provision of community health services in order to achieve the national and international health targets. The current Community Health Policy and proposed Community Health Strategic Plan 2013-2018 will be strongly linked to other important national policies. The Community Health Policy is oriented on a range of broader and specific policies and strategic plans in the wider health sector, and these include:

5. SITUATION ANALYSIS FOR COMMUNITY HEALTH

5.1 Objectives and Methodology of the Situational Analysis

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

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

The methodology for the assessment was guided by documentation reviews: quarterly and annual reports, the evaluation reports for specific interventions, HSSP II and HSSP III documents, and the DHS 2010. Specific interviews were conducted with the staff in charge of various interventions at the Community Health Desk and partners that support community health. Structured questionnaires were distributed by email to partners and responses were received via email as well.

Field visits were held in three districts, and in each district two health centers were selected (one rural and one urban). Interviewers were trained on the questionnaires and interviews were held with the staff in charge of community health at the district and health center levels, NGOs supporting the CHW cooperatives, and CHW cooperative presidents. Field visits generated additional information about the progress, the opportunities, and the challenges encountered in delivering community health services. A thorough analysis of the achievements will serve to showcase the best practices for what is working and what is not working, whereas the challenges will guide the desk to develop specific mechanisms to address shortcomings to maximize processes to achieve more health results. The opportunities from this analysis will guide the desk on where to capitalize efforts to improve the implementation efficiency.

5.2 Key Findings

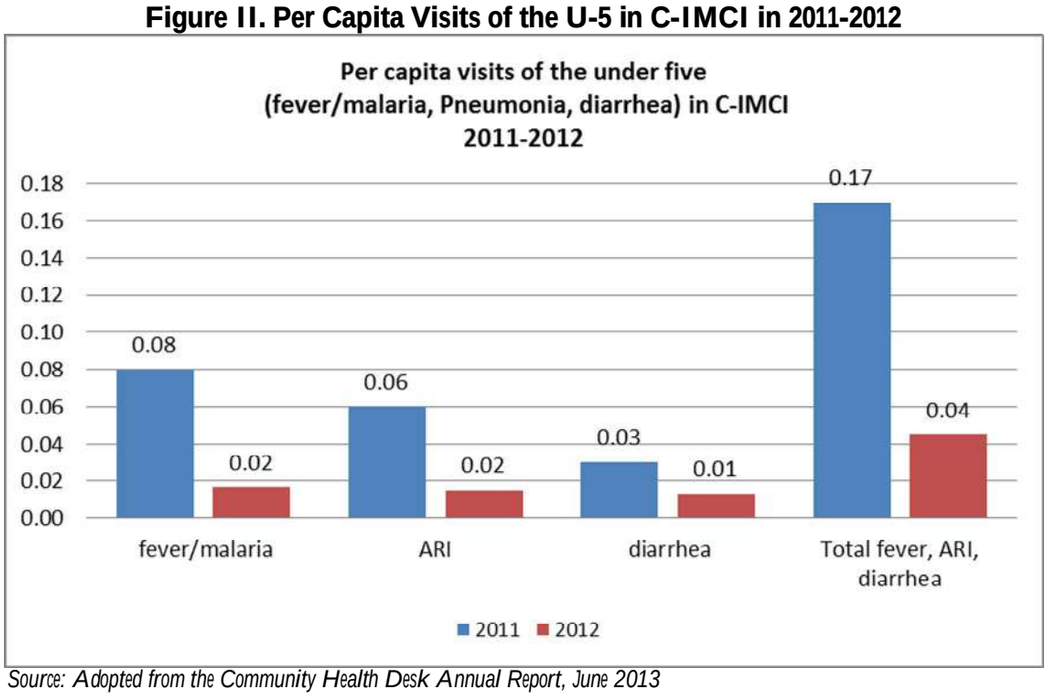
5.2.1 Integrated Community Case Management (IICCM)

The main objective of ICCM (also previously known as C-IMCI) is to: prevent, detect and provide early treatment for childhood illnesses (Community Health Desk, Annual Report 2012). To achieve this objective, ICCM employs the following strategies: institutional capacity building for health workers to gain knowledge, skills and attitudes in order to plan, implement, monitor and evaluate ICCM activities. The second strategy is mobilization of communities to implement ICCM, including 15 key family practices adopted by MOH out of the 16 elaborated in 1990 by WHO and UNICEF.

Based on the DHS 2010 results, the prevalence of ARI and Malaria has decreased significantly. However diarrhea hardly decreased (% of children who reported diarrhea in the last two weeks preceding the survey was 14 % in 2005 and 13% in 2010). Confirmed (microscopic) malaria prevalence among the under five has decreased from 2.6 in 2007/8 to 1.4 in 2010. The percentage of children under five who did seek treatment in case of fever, diarrhea and ARI increased since 2005 (63 % (ARI) 59 % (fever) and 50 % (diarrhea), DHS 2010). Health seeking behavior in case of diarrhea remains the lowest. According to DHS 2010, between 13-16 % of the U5 did seek care at CHW level. This percentage has increased according the RCHMIS data since C-IMCI was scaled up in 2009. In 2011, the percentage of clients who did seek care at CHW level increased mainly in cases of fever (75 % (fever), 10 % ARI and 25 % (diarrhea). Among children <5 years, the use of oral rehydration therapy increased, but remains low (37 % in 2010, of which 29 % is packaged ORS and 7 % recommended home made fluids).

Per capita visits of the U5 decreased considerably since 2010, especially for fever. Per capita visits of diarrhea also decreased and a possible reason for this could be due to the scale up of the environmental health program. The graph below indicates per capita visits for the U5 for fever/ malaria, pneumonia, and diarrhea in the ICCM program. These data were drawn from routine reports from the community.

Figure II. Per Capita Visits of the U-5 in C-IMCI in 2011-2012



Source: Adopted from the Community Health Desk Annual Report, June 2013

The Community Health Desk has recorded tremendous achievement in implementing the iCCM strategy. One of the main achievements was to rollout the iCCM strategy countrywide where the CHWs (the *binome*) treat all children with relevant conditions as described under the iCCM package of services (see annex 1). Development partners such as: World Vision, UNICEF, MCHIP, PIH, IRC and Lux Development who have supported the Community Health Desk to implement the C-iCCM program further re-affirm the achievements registered but also the challenges involved as well as opportunities. The main achievements include: improved overall coordination of iCCM activities, many tools such as: training modules, reporting and supervision template, and indicators for CHWs were elaborated and disseminated, rapid and supportive evaluations were conducted, and an increase in referrals for prenatal and deliveries to health centers. The challenges included: insufficient supervision to satisfy the supervision demands countrywide, supply of iCCM materials take long to reach the CHWs.

5.2.2 Supply Chain for Community Case Management

The problem of access to primary health care is not only a health sector issue, but rather a multi-sector challenge that needs a collective approach by all sectors to work together to deliver a comprehensive community health package (HSSP II 2009-2012, external evaluation report). The services in question are mainly curative, preventive, and health promoting interventions. Specifically, the community health package is made up of mainly: Community Case Management -ICCM), Community Mother and Newborn Health Program (C-MNH), Reproductive Health (RH), Family Planning (FP) such as the community-based distribution of family planning services (CBP), Community-Based Nutrition (CBN), Behavior Change Communication (BCC) and Community Health Management Information System (RCHMIS). The collective aim of these interventions is to improve service delivery and to reduce the number of maternal and child deaths.

Although the supply system between the central level and community has been developed, and procurement systems are in place at all levels with some limitations; the supply system needs to be strengthened to address frequent stock-outs of the essential materials and logistics. Development partners have been actively involved in the "supply chain of commodities for the community case management" in order to avoid shortages in the supply of community-based commodities. The partners supporting in this area think that, the ability to forecast most of these supplies to avoid stock-outs remains central to an effective supply system. Supply gaps do exist at all levels; the most profound gap is between the health center and the community, where more forecast tools need to be developed. The challenges affecting the supply chain commodities for community case management include: lack of integration of some community-based services like CBP into the essential community-based package. However, there are opportunities for improving these challenges, such as the presence of effective administrative structures from central to village level and availability of staff at each of these levels.

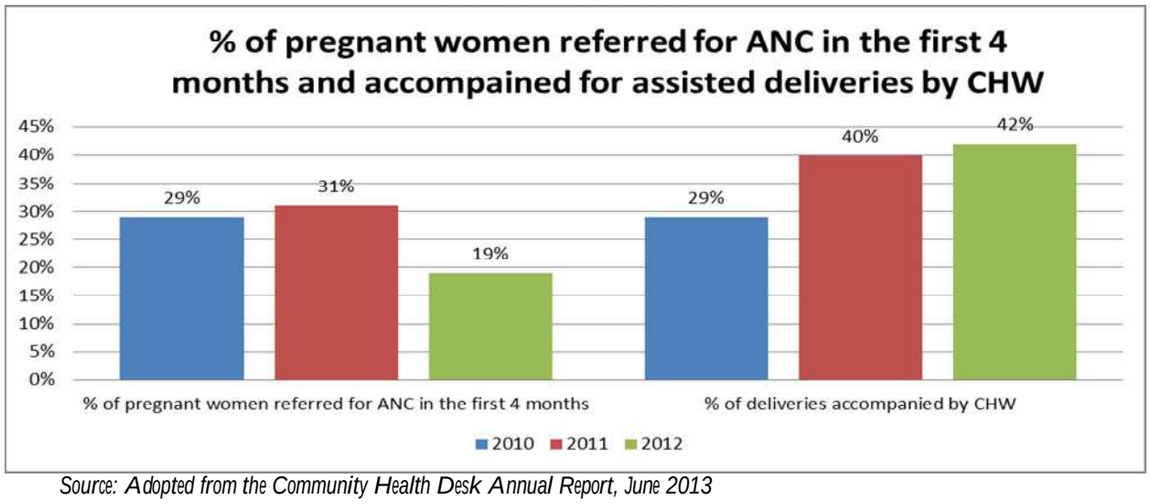
5.2.3 Community Maternal Newborn Health (C-MNH)

The CHD and partners support CHWs to identify and register women of reproductive age, to promote family planning service utilization by encouraging men and women of reproductive age to

adopt offered family planning methods. In addition, CHWs are responsible for identifying pregnant women in their community catchment areas and encouraging them to utilize Antenatal Care (ANC) services, and emphasize on birth preparedness so that mothers complete all the 4 ANC visits and deliver at the health facility.

The CHWs have succeeded in the identification of women and newborns in the community that have danger signs and refer them to health facilities for advanced care. The Community Health Desk has provided various tools to the CHWs to facilitate in identifying danger signs for children of different age groups and how to respond immediately whenever such signs are present. Where necessary, CHWs accompany women in labor to the health facilities to be delivered by qualified personnel. The graph below shows an increase of the proportion of pregnant women referred during the first 4 months of pregnancy and accompanied for assisted delivery (RCHMIS, 2009-2010). In reality the % is higher since it is calculated over expected pregnant women that are over estimated.

Figure III. Percentage of Pregnant Women <4 months Referred for ANC and Accompanied for Assisted Deliveries



Source: Adopted from the Community Health Desk Annual Report, June 2013

After delivery, CHWs mobilize mothers to attend early postnatal consultation at facility level to check the health status of both newborns and mothers. To facilitate the carrying out of some of these activities, CHWs countrywide have been supplied with mobile phones for *RapidSMS* reporting and monthly report form the village[1]. The Community Health Desk has registered achievements as well as challenges. Information from the district and health center staff in charge of community activities indicates that if MCH and C-MNH activities are incentivized through Community PBF, the CHWs can dedicate more efforts to provide health services and this would lead to optimal service delivery. The program has achieved a lot in a span of just 3 years, e.g. program implementation coverage is 75%, all tools, logistic materials, and service package revised and disseminated, supportive supervision conducted. The remaining districts will have the program by June 2013.

5.2.4 Behavior Communication and Change (BCC)

The Rwanda Health Communication Center (RHCC) was created to foster communication and penetration of health messages among policies, the implementers, and the population. The Community Health Desk BCC strategy uses various media on ICCM and CMNH to reach out to the target beneficiaries. Communities "Hygiene Clubs" (CHC) based at the village level have been established to fulfill this purpose. With the support from CHWs, these clubs address hygiene issues, such as clean water, sanitation and behavior change. So far, the program has been started in 9 out of 30 districts and there are plans to roll it out to the whole country. CHWs have played an important role of "MOH cadres" involved in mobilizing communities on disease preventive measures using BCC strategies, through:

1. Proper hygiene and sanitation,
2. Use of insecticide treated mosquito nets,
3. Early health care seeking behaviors,

[1] *RapidSMS* is a mobile based reporting that uses remote cell phones connected the server (for details see Community Health Information System)

4. Breast feeding, infant and young child feeding/nutrition
5. Disease surveillance, etc.

Despite these achievements, the Community Health Desk noted that some clubs are not yet fully operational in most parts of the country due to financial and technical constraints. The BCC strategic plan is still in development stages. However, the main tools for the BCC have been developed and disseminated to all CHWs. As this is a new strategy implemented by the Community Health Desk, the major challenge has been technical know-how especially in developing appropriate media messages for target populations and conducting regular monitoring to ascertain if the messages have reached target beneficiaries. As there has been no independent evaluation, there is a need to conduct regular process evaluations to assess if messages are making an impact on the peoples' behaviors, especially for CMNH. The staff in charge of community health activities at the district and health centers collectively affirms that CHWs activity demands in C-MNH did not match compensation levels.

5.2.5 Community-based Provision (CBP)

In 2009, the Community Health Desk in conjunction with the maternal and child health unit and partners developed a "Community-based Provision of FP" (CBP) program to increase the use of modern contraceptive methods in Rwanda. This was developed to provide evidence base in order to spearhead contraceptive supply, stimulate demand, create a supportive environment, and be easily scaled up. The initiative was piloted in 3 districts with the potential to be expanded gradually to at least 13 districts by the end of 2012, and subsequently be scaled up to the whole country.

The CHWs involved in the CBP pilot program deliver the following FP services:

1. Condoms
2. Oral contraceptive pills
3. Injectables
4. Cycle Beads
5. Standard Days Method

The pilot implementation began in October 2010, and 3,068 CHWs have been trained so far in CBP of family planning services. This number is expected to increase over time, as the MOH continues to gather evidence on how well CBP is implemented and as the program receives more funding (Community Health Desk Annual report). The CBP leveraged the already existing resources and CHW network providing services at the community level.

5.2.6 Community-based Nutrition Program (CBNP)

Nutrition is a crosscutting issue involving several sectors. Key sectors involved are Ministries of: Finance and Economic Planning, Agriculture, Education, and local Government, and finally that of Health. In the Ministry of Health, nutrition interventions are guided by the following main policy and strategy documents: National Emergency Plan to Eliminate Malnutrition (which includes active nutrition screening of children by CHWs since 2009), national protocol for the treatment of malnutrition, the National Strategy for the Elimination of Malnutrition and the district plan for the elimination of malnutrition (DPEM). These documents have driven a district based national scale up of nutrition interventions where children who are at risk of malnourishment have been referred to the nearest health facility for appropriate treatment, using therapeutic milks, ready-to-use therapeutic food for severe cases, and corn-soy blend for moderate cases. Other approaches have been initiated and include infant and young child feeding, community-based nutrition programs, behavior change communication--using media on the forefront, and home food fortification (using micronutrient powders).

CHD has strengthened and scaled-up the Community-Based Nutrition Interventions/Program (CBNP) to increase coverage in preventing and managing malnutrition in children under the age of 5 years, with particular focus on those aged less than two years, and in pregnant and lactating mothers (Annual Report on Community Health Desk, 2010-2012). The main objective of the National Nutrition Program is to eliminate all forms of malnutrition through implementation of the joint action plan to strengthen the multi-sector approach and community-lead interventions. To achieve this objective, the following policies, strategies, and interventions were developed:

1. Strengthen early identification and management of under-nutrition, including the response to their underlying causes.
2. Strengthen and scale-up community-based nutrition interventions/ programs (CBNP) to prevent and manage malnutrition in children under 5 years, with particular focus on (i) those

aged less than two years, and (ii) pregnant and lactating mothers.

3. Promote nutritional support and management of vulnerable groups
4. Promote food security at the household, community and national level
5. Promote nutrition in pre-school education and school environments.
6. Improve Monitoring and Evaluation for Nutrition innovations

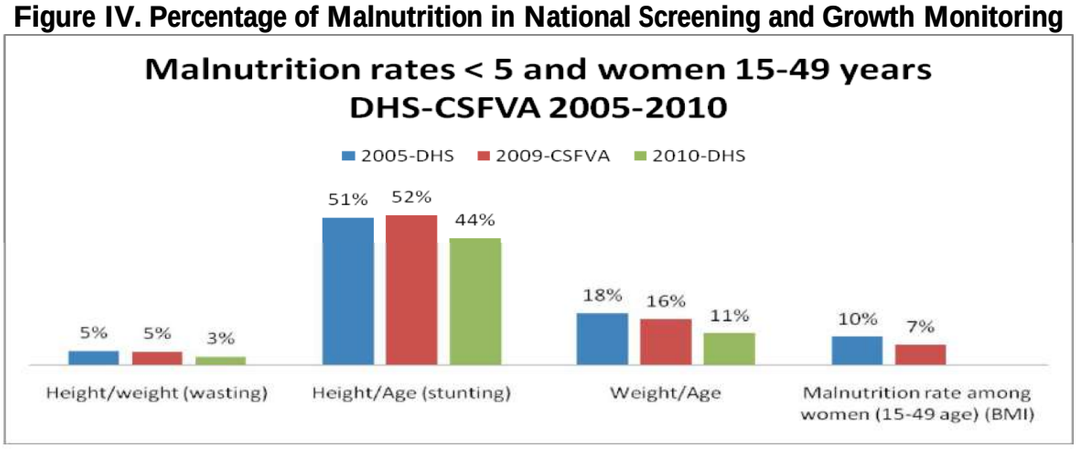
Table III. Rates of Malnutrition Over Time			
	2009-2010	**2010-2011**	**2011-2012**
Well nourished	94.00%	97.00%	99.00%
Moderately malnourished	5.40%	2.40%	1.20%
Severely malnourished	0.70%	0.30%	0.20%

Source: Community Health Desk Annual Report, July 2012

Routine data shown in the figure above indicate an important reduction in malnutrition rates since 2009, which was documented during annual MUAC screening, monthly growth monitoring by CHWs and health center malnutrition detection. However, some bias was noticed in the data on growth monitoring from the health centers and community because the data is not disaggregated between acute malnutrition, underweight, and stunting.

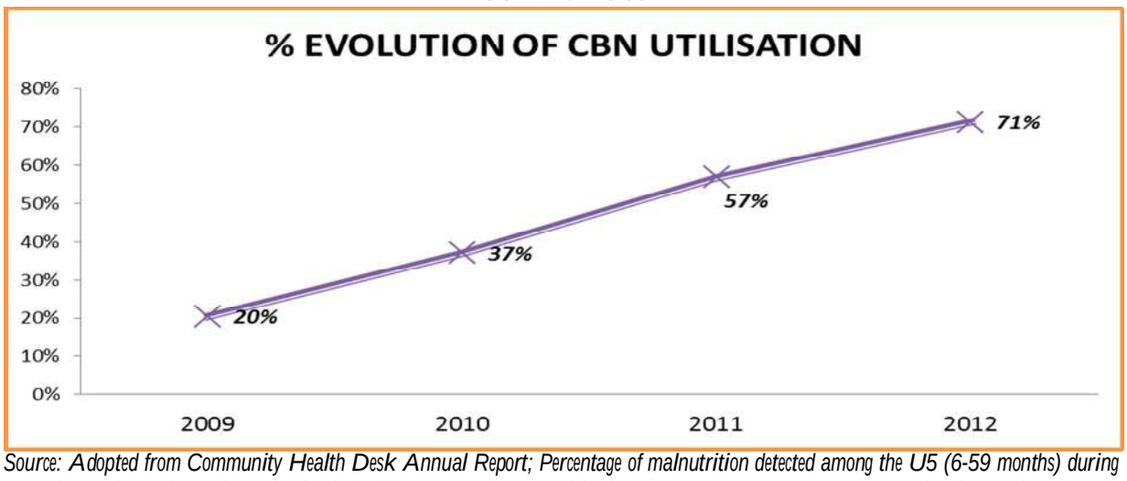
In an evaluation of Joint Supervision of DPEM, particular concern was also raised on coordination and planning on the DPEM implementation where about 30% of the districts report about inadequate coordination and planning of the activities towards implementing the DPEM strategy. The coordination and planning activities with challenges include: formation of multi-sector committees for DPEM implementation, convening meetings on DPEM implementation, availability of partners contributing towards the DPEM implementation, presence of specific village level action plans, and villages holding routine nutrition meeting. 30% of districts reported carrying out less than 50% of the coordination and planning activities they were supposed to carry out. This is a serious challenge of effective coordination, which can compromise reaching national targets set in HSSP III.

Figure IV. Percentage of Malnutrition in National Screening and Growth Monitoring



Source: DHS 2010

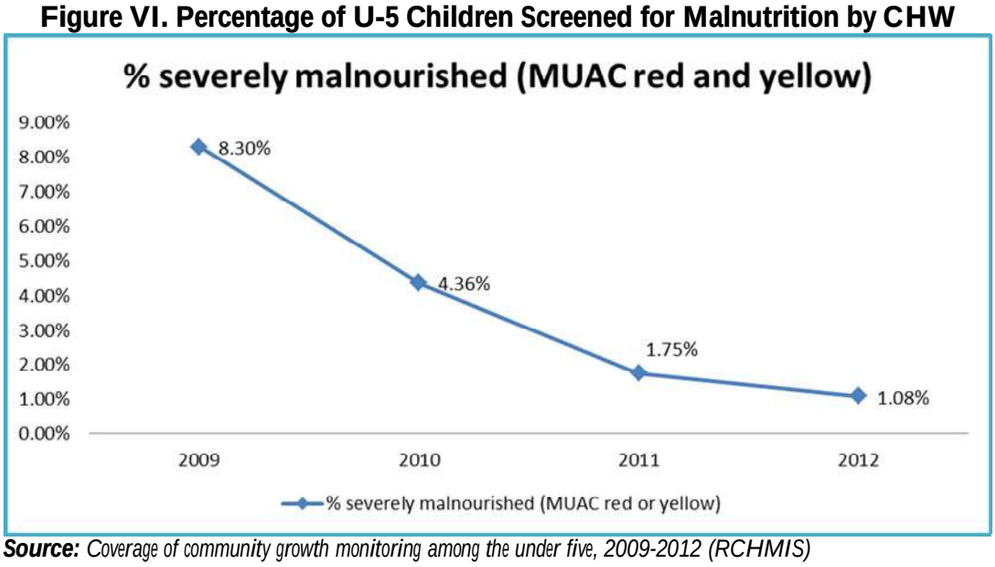
Figure V. Percentage of Malnutrition for Growth Monitoring in Health Centers and Communities



Source: Adopted from Community Health Desk Annual Report; Percentage of malnutrition detected among the U5 (6-59 months) during annual screening and growth monitoring in health centers and communities (2009-2012 RCHMIS, HMIS, National Screening Report)

The CHD has collaborated with the district and health center officials to build the capacity of the CHWs through the training of trainers (TOT). CHWs do monthly growth monitoring and promotion (record monthly data in RCHMIS, moderate and transfer severe cases), screen children for malnutrition using weight per age (Scale) and Mid-Upper Arm Circumference Measurement tape (MUAC). They also offer treatment of malnutrition with RUTF *(Plumpy'nut)* whenever necessary. CHWs also offer community demonstrations of kitchen cleanliness and gardens to prevent malnutrition and it's reoccurrence; they also conduct community level follow-up for malnutrition treatment effectiveness. Between 2009-2011, growth and monitoring coverage increased in the community (27% in 2009 to 51 %, 2012).

Figure VI. Percentage of U-5 Children Screened for Malnutrition by CHW



Source: *Coverage of community growth monitoring among the under five, 2009-2012 (RCHMIS)*

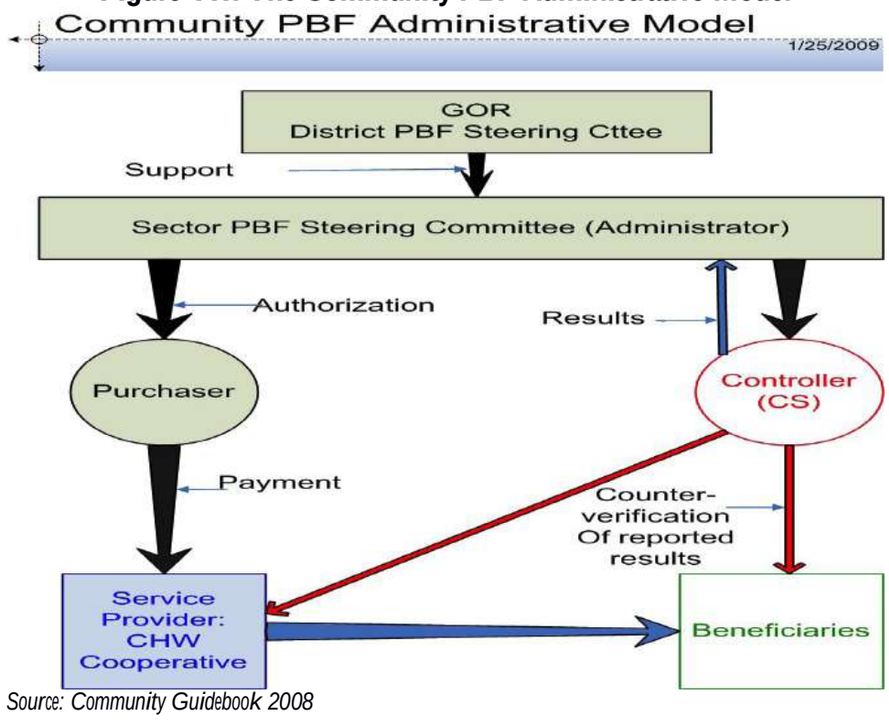
The achievements include: increased coverage in monitoring from 27% (2009) to 51% (2012) (CHD Annual Report 2012), all program documents and tools (prevention and promotion tools including brochures) were developed and disseminated to all CHWs, all planned training on nutrition was conducted, offering of "Home-Based Food Fortification (HF)" to all groups in need, sub TWG created to oversee nutrition related activities, nutrition messages passed on air and TVs as planned. There are opportunities such as high-level political commitment and partners to eliminate malnutrition. However there are still challenges related to insufficient funds to implement all the planned nutrition programs.

5.2.7 Community Performance-based Financing (CPBF)

The performance based financing for Community Health is an innovational financing approach aimed at accelerating health results by focusing on high impact community level health interventions. This innovation is thought to be the first of its kind in the world. The CPBF was launched in an attempt to improve the health of the communities by raising selected health indicators to reach the national targets faster.

C-PBF improves performance of CHWs through motivation to rise agreed upon performance indicators (External Evaluation HSSP II 2009-2012, Report). An improved form of payments for CHW cooperatives is made when a proof of the agreed level of performance has been reached. A document about implementation of community PBF (management/regulation) was developed and provided to the system actors. Based on this document, the Sector Steering Committee at sector level oversees the implementation and approves payment to the CHW Cooperative after reviewing the levels performance. Data for different indicators are entered at district level through a web-based database (RCHMIS) after quarterly approval by committee with feedback.

Figure VII. The Community PBF Administrative Model



Source: Community Guidebook 2008

From 2008 when intensive community PBF started, an experimental design for the impact evaluation was nested into the community PBF program implementation. The evaluation started with baseline data collection before the program was implemented and a follow up data collection is planned to take place in early 2013. Data entry, analysis, and report writing will follow the end-line data collection. The comprehensive evaluation report will provide evidence on which strategy of community PBF is working among the four intervention arms (demand-side, supply-side, demand+ supply side, and control not taking the program) under the evaluation.

From the start of C-PBF, much has been achieved, such as: improvement of key indicators remunerated, source of staff motivation, improved quality of care, and improved quality data collection (TB PBF evaluation 2011). The challenges are: delay in transfer of funds (from central to CHW cooperatives, profound delays are seen at the level of HC to CHWs cooperatives), verification of data at the community and cell level before it reaches sector levels, data analysis difficult for generating payments orders and calculating payment for some indicators due to: data not always on time, funds not always on time, pressure to spend budget. Overall performance indicator: % of cooperative achieving >50% of all their targets (target population not always accurate, some targets unreasonably high), sustainability beyond 2013 when WB funds ends still an issue, there is a of challenge increasing ANC and deliveries: outputs have picked due to the success of FP program, so payment indicators for ANC might drop and those of FP rise.

5.2.8 Community Health Workers Cooperatives (CHWC)

The idea of putting CHWs together into cooperatives started in 2006 with the aim of organizing all the CHWs in each health sector under one umbrella. As of June 2012, there were 450 CHW cooperatives formed in all the health center catchment zones working closely with health centers. CHWs work under their cooperatives to generate revenue to sustain their work and ensure that they achieve certain levels of performance as determined through indicators. CHWs are also involved in income generating activities under the umbrella of their cooperatives. Therefore CHWs are accountable for two main activities: generating and investing funds from the cooperatives and working on health activities to achieve certain targets.

Guided by the CPBF regulations, the CHWs receive 30% from the total amount transferred by the central MOH while 70% goes to the CHWs Cooperatives to contribute to income generation activities. Profits generated by cooperatives are shared among cooperative members depending on the internal rules and regulations governing individual cooperatives. It is assumed that overtime, as CHW cooperatives receive income and invest in the cooperative activities, they will grow and later become self-sustaining over years. Extra caution is needed to avoid CHWs spending more of their time on income projects over their mandated health activities. There is thus a need to strike a balance as it not really known how much time CHWs spend on health and other activities.

The MOH in collaboration with partners, developed an on-line tool (web-based) called "Community Health Worker Cooperatives Financial tool (CHWCF)" whose primary function is to track financial flows within cooperatives in order to: advise the cooperative members, carry out financial audits, perform supervision based on the database information, monitor PBF fund flows to cooperatives, and legal registration.

The recording of the data in the tool starts at the health center after cooperative accountants have completed filling (manually) out financial information (from their cash and bank books with all transactions) on hard copy forms and submitted it to the health center every month. At the health center level, the in charge of community health activities assisted by the data clerk enters financial information from hard copies into the web-based interface (CHWCF). At this level, the corrections can be made before submission to the district hospital. At the district level, the community health supervisor at DH who has access to all cooperatives in his catchment area then verifies and approves data in the CHWCF. Local NGOs working in districts have access to the tools data but do not have the ability to change anything. CHD supervisors and data managers will have access to information on all cooperatives country-wide, data manager who is also the administrator will be able to make changes or corrections where necessary.

The role of CHW cooperatives is to mainly encourage and facilitate coordination of planning meetings for health interventions. This in turn avoids duplication of interventions targeting the same groups in the same area and ensures a good coverage of the population by those interventions. In so doing, the CHW have faced also the challenges related to coordination such as:

1. Insufficient resources to coordinate meetings related to implementation of the community health activities.
2. Poor coordination often lead to delayed collecting and compiling of health data;
3. Ineffective documentation of the best practices due to poor coordination,
4. There are no dissemination meetings amongst members and external partners due to lack of coordination;
5. Lack of knowledge also hinders CHW to represent their constituencies in local decision-making bodies especially those related income related cooperatives.

The main achievements include: creation of CHW cooperatives in all health centers (87% with legal agreements); successful reforms such as: creating income projects, training on management and accountability; creation of cooperative sub-TWG; training targets attained: all CHWs were trained on cooperative policy and management techniques, forecasting profits. The 450 financial agreements were signed with MOH, 5 NGO were selected to build CHW cooperatives capacity, development of tracking tool "Community Health Worker Cooperatives Financial tool (CHWCF)"; and hosting radio shows.

The challenges include: insufficient staff from central to village level (including the NGOs), insufficient remuneration of the CHWs (need to increase from 30% to at least40%), some CHWs cooperatives take too long to generate profits which is a disincentive to the CHWs, tracking tool can not function when internet is weak, sustainability, accountability, and management needs to be tackled as well.

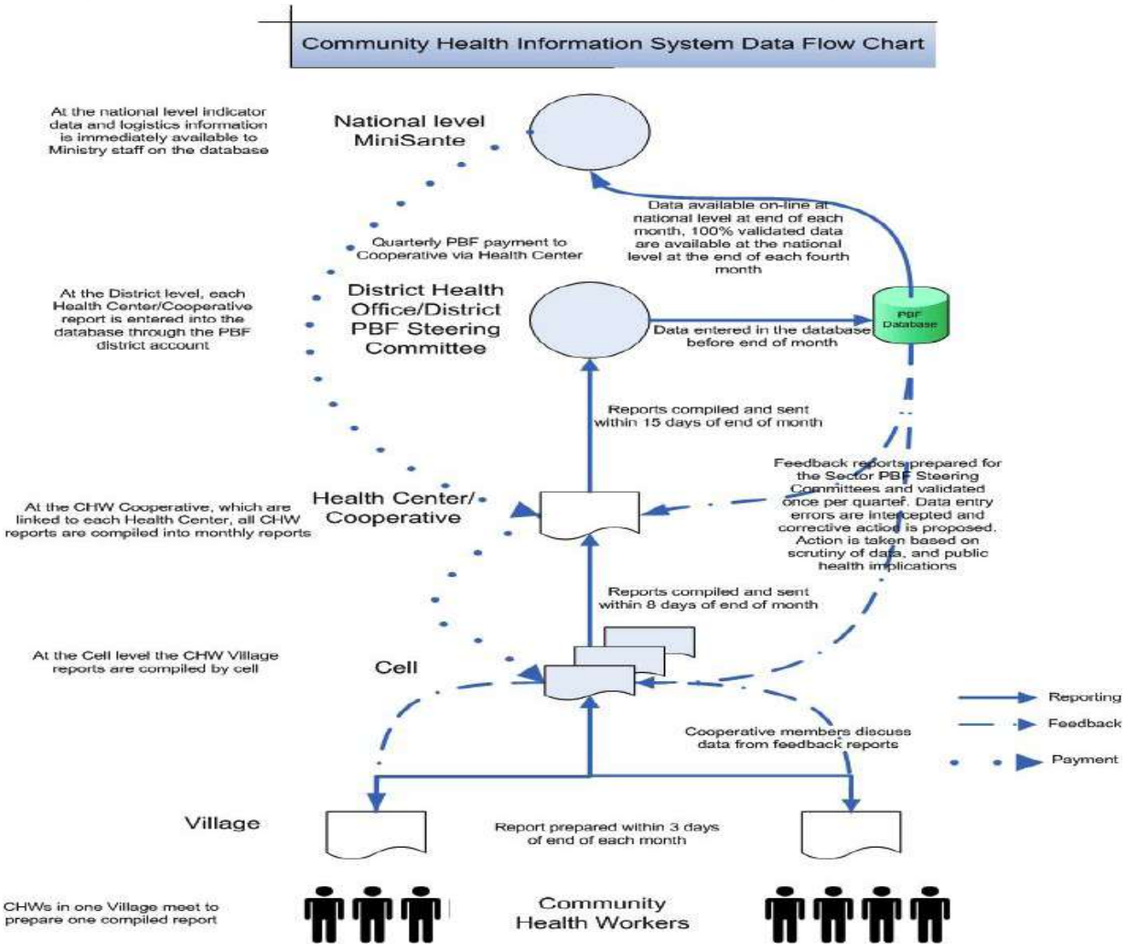
5.2.9 Rwanda Community Health Information System (RCHMIS)

A Community Health Information System was established to gather and collect health information from the community level to supplement HMIS. RCHMIS, which also includes HIV/AIDS and general health related data, was developed to support the HMIS system in gathering the data generated by CHW health activities at the community level. As described above, all CHWs currently possess mobile phones to facilitate in transmitting information on health emergencies or seek advice for appropriate service. As will be clarified in the next sub-chapter, the m'*Ubuzima* strategy uses mobile phones for community health data reporting for each village, such as: new pregnancy, birth, maternal death and other indicators related to maternal and child health from community to the central level. The system has the potential to include more indicators, and could serve as an important tool for effective community health program monitoring. The C-HMIS is a growing system as community health implementers learn more about the system and how it can be improved through addition of more indicators and improving its technological efficiency for the users.

The MOH/Community Health Desk is the lead institution for coordination of C-HMIS and its M&E framework. Often, the system of data collection uses registers and data is transmitted through RCHMIS. CHWs are currently providing services to the community members and collect data on population, vital events, sanitation, HIV, immunization, and family planning service coverage. At the

end of each month, the CHWs who work together in the same village, meet to consolidate data from their individual registers and fill out a village level CHW monthly report form. The CHWs' supervisor at the health center compiles all villages and cell reports together and sends district facility-level monthly report forms to the District Hospital. The chart below shows how information flows from lower levels (village) to district level and how feedback loops functions for rapid response by the policy makers at central level.

Figure VIII. Administrative Information Flow from Community to the Central Level



Source: Diagram showing health data flows from the village to central level, from the Community PBF Guidebook 2009

The challenges include: inaccurate maternal and under-five deaths; death audits not yet scaled up, insufficient use of data at all levels, takes time to get data system in place to collect and validate data. On the other hand, there is a big achievement related improve reporting compliance to 97% due to combining PBF incentive with Community HMIS and avoiding parallel reporting system.

RapidSMS

The RapidSMS system is a new innovation for rapid reporting on maternal emergencies to central level. The MOH Community Health Desk, in collaboration with partners, developed the RapidSMS system to contribute to the improvement of community reporting on life threatening maternal indicators.

The RapidSMS system works on the principle that a phone transmits information into a computerized recording and response system. The data from the pilot indicates that this innovation is tremendously improving referral system through contact tracing thereby facilitating emergency services. However, some challenges have been noted in this innovation, which need to be addressed in the new Community Health Desk strategic plan. According to MOH staff using the tool, the main challenge is the lack of trained staff to work with the new RapidSMS technology. Therefore there is a need to recruit local RapidSMS system facilitators and managers to enable sustainable application, regular data reviews and generation of reliable information, additionally, there is a need to recruit RapidSMS system administrators that will upgrade and maintain system for the system maintenance and sustainability. The field staff at district and health centers, where the Rapid SMS is piloted say that the innovation is good but there are often challenges related to network coverage. Most challenges are the same as those of m'*Ubuzima* and will be listed together.

*m'*Ubuzima
Like in the Rapid SMS, the CHWs use cell phones to report data from community level (RCHMIS) to the central level i.e. Community---HC---District----Central level. The m'*Ubuzima* innovation is now being applied in all 30 districts for reporting purposes. The CHW enters their data for the list of community health indicators that feeds into national HMIS. There are in total 22 indicators that mainly relate to: ICCM, MCH, deaths in community, vaccinations, visits, delivery complications needing ambulances, and number of infants in the village with age up to 9 months. Each of these indicators is coded (for example if a baby in neonatal dies, at what age, due to what, etc.).

All the CHWs across the country have received mobile phones to use in the m'*Ubuzima* reporting strategy. The implementation of the m'*Ubuzima* strategy is being piloted for CHWs to report on HMIS indicators. The m'*Ubuzima* is not yet fully functional. However, training has been completed. The following achievement and challenges are crosscutting across the community health information system. The achievements include: timely reporting (data goes in real time to the MOH and a response immediately effected); plans underway to scale up; all districts now trained; and some CHWs have started reporting.

The following achievements and challenges are crosscutting across the community health information system. The achievements include: improved community level data tracking; error minimization (traditional paper based had long processes that lead to possible errors due to aggregation of data from village to cell and sector levels) where data is reported directly from the community, decrease in the waste of materials like papers and pens, environmentally friendly, training for m'*Ubuzima* and RapidSMS completed. The challenges include: cost of innovation; phone lines busy during reporting; manipulation and navigation through the phone functions in order to report is too long and unfriendly; network coverage is an issue for some CHWs; training becoming costly every time there is an innovation; length of data to report for m'*Ubuzima*, such as national ID number, telephone number, and personal details like physical address; inability to analyze data at community level; charging phones at community level an issue; stolen phones without replacement; and CHWs failing to manipulate phones.

5.2.10 Non Communicable Diseases and HIV/AIDS (NCD and HIV/AIDS)

Started in January 2012, the NCD program is a new program in the Community Health Desk. There are currently few program documents (policy and strategic plan but not yet officially endorsed). NCD has a concept note that describes the program overview, the objectives, and the rationale. Currently, there is no official budget for the NCD program, but plans are underway to develop one once the strategy is made official by the Rwanda Biomedical center that is working hand in hand with the Community Health Desk to implement NCDs in the community at national level. The policy and strategic plan will be available at the Rwanda Biomedical center and includes the following:

1. Harmonization and integration with the TWG on NCD with RBC and MOH/CHD
2. Workshop to finalize the integrated CH module on NCD- HIV/AIDS
3. Minister's preliminary concurrency with the proposed strategy
4. Develop tools for NCD- HIV/Chronic illness-CHW and implementation follow-up
5. TOT and CHW training in NCD-HIV and other chronic illness in 15 District
6. Registration of people born with cleft lips and palates in all districts
7. Registration of women with fistulae

5.2.11 Sexual and Gender-Based Violence (SGBV)

Over 4,405 cases of sexual violence were reported by district hospitals and one-third of these cases had objective symptoms of sexual violence (HSSP III). 95% of the cases investigated were among females. The largest group of victims was females between 5-18 years (57%). Males represented about 5% of the cases investigated in 2010, being the same as in 2009 (HSSP III). The CHWs have the responsibility to fight against the SGBV at the community level, where most gender-based crimes take place. The role of the CHWs (including the Community GBV volunteers) in the fight against sexual and gender-based violence at the community level will entail the following:

1. Using mass media campaign, mobilize communities, local leaders on SGBV
2. Define and create guidelines for community and CHWs for SGBV
3. Build capacity of local leaders and CHWs on SGBV
4. Adopt specific targeted planning and management of SGBV vulnerable groups, including children and people with disabilities
5. Expand one stop centers from districts to community level with a standardized PMA

Although this was not found to be a major issue in the during the situation analysis, CHD will need to work with SGBV also under the MCH to identify tools and materials to address this problem.

The table below proposes an indicator to track the SGBV and targets.

Table IV. Tracking SGBV			
Outputs	**Baseline 2011**	**Target 2015**	**Target 2018**
Number of SGBV cases referred to HC by CHW	TBD	TBD	TBD

5.2.12 Coordination and Monitoring and Evaluation

Coordination

Implementing various competing priorities coupled with a sense of urgency to make tangible progress can be jeopardized if activities are not well coordinated. Poorly coordinated interventions results not only in the inefficiencies, but also duplication of efforts due to the development of parallel and competing systems, in settings where resources are already limited.

Coordination with other sectors at the local government level is critical and for the Community Health Desk, it is an on-going process though not without facing some challenges. The Joint Action Development Forum (JADF) that takes place quarterly often needs time to work out their agendas and become fully functional and useful across all sectors and stakeholders. The JADF at district level is used as the entry point for planning and action in health, in particular community health, to avoid duplication and parallelism.

The coordination of activities such as: training and meetings are managed under the newly created NCD/HIV/AIDS program. The coordination constitutes a wide range of activities with support of partners providing various levels of technical assistance. Trainings are primarily organized by the Community Health Desk under health program such as: NCD and HIV/AIDS, FP, TB, etc. by setting the agenda while the partners will come in to provided their technical inputs as necessary. In addition to partners, the coordination meetings also involve: Director of health at district hospital, all partners in the district, supervisor of community health at the district hospital, the *titulaire*, often chosen by the supervisor of community health at district hospital. The main activities involved in the coordination meetings are to develop action plans (central and decentralized levels together), perform joint supervisions; assess progress made against what was planned and reporting. The meetings are conducted on a quarterly basis and are chaired by the Community Health Desk. The coordination meetings are based on the region: North, South, East, and West. Given the shortage of time, these meetings take only 2 days per region. Given 5 regions, Kigali city inclusive; it therefore takes 10 days to complete these coordination meetings countrywide.

5.2.13 Monitoring and Evaluation

Monitoring and evaluation is a strong integral part of any program implementation. It essentially provides progress measurements against results both during and after the period of the implementation. In addition to tracking and measuring performance, M&E should inform the policy makers and implementers on the implementation. The success should be followed with continuous capacity building efforts to keep the momentum of the lower structures. Improvements are required in data collection and reporting systems especially from the community level to the sector levels. The challenges and achievements are captured under HMIS and Community PBF sections above.

The challenge with M&E is that the MOH and stakeholders staff has supporting the community health program defers in the definition of some indicators. In some cases, this has often led to collecting different data. In addition, parallel data collection by some partners and the MOH often takes place. However, this challenge has been solved through enhanced national and decentralized coordination. The respondents at the district and health center levels revealed that there are a lot of data collection demands from the community health workers and this leads to implementation fatigue for the CHWs who largely remain volunteers. The other challenge appear to be limited feedback loop where information from the MOH is provided back to the CHWs in form of capacity building and how to better improved quality data collection. This strategic plan will strive to ensure that there are no parallel data collection systems and all indicators have the same definitions and are collected by the MOH. More information on the M&E on how data is collected from the community level to the central and feedback loop are provided under the chapter on the support systems, specifically, under HMIS. The challenges affecting the M&E component are cited under individual intervention and overall challenges in the annexes below.

5.2.14 General Challenges, Mitigation Plans, and Opportunities

During the situation analysis, it was observed that most challenges that affected the implementation of community health activities were crosscutting. A list of these challenges and how they can be mitigated is included in the annexes below.

6 THE STRATEGIES AND RESULTS FRAMEWORK

6.1 Vision, Mission, and Objectives

6.1.1 Vision

The vision of the Community Health Program is provided within the framework of the National Community Health Policy of 2009, which is to ensure the provision of holistic community health care services for all, for the betterment of the entire Rwandan population. The community health policy, which embraces the values of equity in service delivery and solidarity with the disadvantaged, also embraces standards ethics in service provision, where gender, age and positive cultural norms in relation to healthy lifestyles are respected. Additionally, the Community Health Policy capitalizes on active participation by communities in planning processes, implementation, monitoring and evaluation of community health programs geared at improving their health status with greater emphasis on improved feedback.

6.1.2 Mission

The main mission is to engender conditions for achieving good health for the entire population to enable them to contribute to sustainable development in Rwanda.

The strategic plan will contribute to those community health activities and processes outlined in the Health Sector Policy and HSSP III that will reduce child, infant, and maternal mortality rates, improve the general health of the population, and contribute to the improvement of the Millennium Development Goals indicators. The strategic plan will seek to guide the implementation of the community activities through enhanced capacity of community health workers to provide quality services. The strategy further seeks to reinforce linkages between the community and the entire country's health system.

6.1.3 Objectives

General Objective:

To provide guidance for provision of holistic and sustainable quality and quantity health care services to communities with their full participation.

Specific Objectives:

The Community Health Strategic Plan outlines the steps and priorities that will ensure the timely operationalization of the National Community health policy. The plan will also contribute efforts to meet the objectives of HSSP III 2012-2018, as well as operationalize the community health policy objectives. As such it will draw and expand from the policy objectives with alignment to the HSSP III and EDPRS 2. Below are specific objectives drawn from the community health policy.

Figure IX. Community Health Objectives

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.

6.1.4 The Strategies to Achieve the Objectives

The strategies for the Community Health Strategic Plan will be aligned with those of the Health Sector Strategic Plan (HSSP III) 2012-2018 and EDPRS 2, whose overall aim is to improve the health of the Rwandan people through their full involvement and participation. The current Community Health Strategic Plan will be developed based on what has worked in the previous years while addressing the challenges and gaps identified during the situation analysis.

To achieve the aforementioned objectives, major outcomes with several outputs have been developed through various consultative processes. The outcomes will guide the Community Health Desk, stakeholders, including major line ministries in refining and implementing the proposed interventions and strategies. The plan achieves this through a multi-sector and multi-disciplinary approach that emphasizes coordination, collaboration, prioritization, efficiency and sustainability in terms of funding, programming and research. The following section outlines objectives, outcomes,

and key outputs and strategies to achieve outputs. The details including additional outputs and key strategic activities are presented in the logical framework section in the annexes.

***Objective 1*:**
Strengthen the capacity of decentralized structures in community health service delivery

***Outcome 1*:**
Improved knowledge and skills for CHWs to deliver quality integrated community health package

Guidelines and management tools are critical to ensure that programs are implemented. In this strategic plan, a key set of operational plans and management tools for integrated CHP will be developed and disseminated to all who implement community health activities. District-level community-based implementers will develop annual action plans linked to the strategies and specific objectives that are outlined in this strategic plan. These action plans will be consolidated at the district level and submitted to the MOH for review and approval during the first quarter of each calendar year. The community-based operational and management tools will be elaborated in line with district-level community-based action plans and operational tools. The annual planning exercise for both district and community levels will also encompass general community level monitoring tools to ensure that district and community-level interventions are on track to achieve the overall health targets set in the HSSP III 2012-2018. This objective will be achieved through CHWs' capacity building efforts.

Building the capacities of CHWs at decentralized levels is critical to ensure that quality and continuity of services are provided to the population in the community. Part of the capacity building involves mobilization of communities for their full participation in community health care provision and is also in part linked to the structural support through strengthening the community social cohesions. Strengthening the capacity of CHWs in service delivery would significantly enhance the quality of the services they will provide at the community level.

Integration of services is important for both the providers and beneficiaries. Once services are integrated, service delivery becomes efficient (takes less time, and minimal resources, uses same infrastructure); and not only benefits the providers but also the beneficiaries as it reduces the need for separate additional appointments at the health facility for other health services. The process of integration also benefits central and district level supervisors because during supervision (integrated supervision), all activities are supervised in one supervision visit. It should however, be noted that integration should match similar activities and relevant products to be supplied. For example, MCH activities tend to revolve around the same activities and products that can be integrated and delivered once.

Interaction and regular communication between health centers and the community health workers is an important channel for the continuing integration of community health services and training of the CHW, and has to continue with even more emphasis in this strategic plan. Other members of the Community-based organizations involved in the provision of services at the community level also need to receive standard training on integration processes to ensure harmonization of their interventions. Below the community health intervention is provided under the umbrella of maternal and child health.

***Outcome 1 Indicator*:**
Proportion of CHW Cooperatives with improved knowledge and skills to deliver quality CHP

Output 1.1: Operational plans, Guidelines, and supervision tools developed and disseminated to all CHWs
Key strategies:

1. Community Health Desk to lead in developing the operational plans and tools
2. Community Health Desk and partners to validate the tools through TWGs
3. Disseminate validated guidelines and management tools to all levels (District, HC, and community)

Output 1.2: TOT (District and HC staff in charge of community health) trained on Community Health Package
Key strategies:

1. Planning and budgeting (training inputs)
2. Identify Trainers of Trainers to be trained

3. Effective coordination with donors and districts for the training
4. Effective coordination by central level (Community Health Desk)

Output 1.3: CHWs trained in delivery of Community Health Package (CHP)
Key strategies:
1. Planning and budgeting (training inputs)
2. Effective coordination with donors and partners
3. Elaboration and Dissemination of the new CHW training strategy

Output 1.4: Supply chain of community essential commodities and materials for community health reinforced
Key strategies:
1. Supply chain system in place is strengthened through training on forecasts to ensure quick supplies and avoid stock-outs
2. Train personnel involved in the supply chain (especially districts) to ensure a match between demand and supply of commodities (forecast)

Maternal and Neonatal Health
Output 1.5: CHW capacity to deliver MNH services strengthened
Key strategies:
1. CHD and partners prepare mobilization tools (pamphlets, media messages) for CHWs
2. CHD disseminates the messages packages
3. CHW identifies best forum (*umuganda*, church) to disseminate messages
4. CHW disseminates messages to the beneficiaries (women) and men

Child Health ICCM (IMCI)
Output 1.6: CHWs capacity to deliver ICCM services strengthened
Key strategies:
1. CHD and partners prepare training materials and logistics
2. Identifies trainers and TOT from districts and health centers
3. Plan training with all stakeholders
4. Rollout training

Community-based Nutrition Promotion (CBNP)
Output 1.7: Good nutrition practices (including under fives, school children, pregnant and lactating women) promoted
Key strategies:
1. Preparation of nutritional training materials by CHD and partners (Planning and roll out of trainings CHWs on good nutritional practices)
2. Provision of promotion materials for good nutritional practices
3. Nutrition surveillance and education
4. Management of acute malnutrition
5. Promotion of food security activities

Community-Based Provision (CBP)
Output 1.8: Delivery of quality CBP services strengthened through its integration in the CHP
Key strategies:
1. Integrate existing CBD services into those of CHP
2. Supervision to ensure quality care for CBP

Non-Communicable Diseases (NCDs)
The HSSP III provides two overview indicators related to: establishing NCD laws, and collecting baseline data. The output and outcome indicators to address non-communicable diseases have been developed based on the NCD policy and strategic plan. Below are key outputs for the NCDs. Also below we provide key non-communicable diseases and anticipated output.

Output 1.9: NCDs and Chronic illnesses are integrated into CHP by all districts
Key strategies:
1. Prepare tools (program document, supervision tools, etc.)
2. Plan training
3. Routine supervision as this will be new activity for CHWs (including a random sample evaluation of the program to see where remaining challenges are)

Output 1.10: CHWs capacity to deliver NCD services and other chronic illnesses strengthened
A. *Tuberculosis (TB)*: See output indicators for TB in the LFA
Key strategies:

1. Mobilize the community members on TB prevention
2. CHW identify cases of adult with cough > 2weeks, to ensure screening for early detection
3. Administer INH (IPT) to children under five
4. Identify children (< 5years) in close contact with TB patients (same household)
5. Follow-up and referral, tracking of defaulters, and ensure DOT for TB patients

B. *HIV and AIDS*: See output indicators for HIV/AIDS in the LFA

Key strategies:

1. Mobilize community members on advantages of testing and knowing their HIV status
2. Screening/early detection and ensure follow-up and referral
3. Ensure the follow-up of mother – child couple HIV+ after birth early infant diagnosis
4. Provide care and support for pre-ART and patients on ART at community level who voluntarily disclosed their sero-status
5. Reinforce the psychosocial and adherence support for PLWHIV who voluntarily disclosed their sero-status, and ensure home visits
6. Equip family members with basic skills to provide basic support to patients with HIV

C. *Cancers, chronic obstructive respiratory, metabolic, renal and cardiovascular disorders*: See output indicators in LFA

Key strategies:

1. Mobilize communities to reduce tobacco use, salt and fat intake, and harmful use of alcohol
2. Encourage physical activity to greatly reduce risk of above conditions
3. Train CHWs essentials of these conditions and to refer anyone with symptoms of chronic obstructive respiratory, metabolic, renal and cardiovascular disorders
4. Mobilize families to always seek advice and/or report to CHWs in case of symptoms of the above condition present and also on health status of the patient under the treatment
5. CHWs mobilize population to identify and report on people living with chronic illnesses
6. CHWS to refer all cases accordingly and support home based care whenever possible

D. *Neuropsychiatric diseases and psychological disorders*: See output indicators in LFA

Key strategies:

1. CHD to prepare training of CHWs on basic neuropsychiatric and psychological disorders
2. CHWs mobilize the population to report any neuropsychiatric or psychological disorders for referral and management
3. CHWs conduct home visits for mental health promotion for early detection & referral
4. Specifically, detect children with learning difficulties referred for evaluation and make effective follow ups
5. Train CHWs on how they can provide psycho-social support
6. Introduce support groups in the community to assist the mentally ill individuals

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

Outcome 2:
Communities (in all *imidugudu*) fully participate in all community-based health programs

Mobilization of the community members is essential to ensure that they actively participate in the processes leading to their health care provision. Not only does this improve their understanding of the advantages of using these services, but they also take ownership of these activities. Mobilization mainly focuses on the promotional, prevention, and curative health activities, which are the 3 pillars of CHW activities. We expect that, with mass mobilization, more men and women will actively participate in the main process leading to utilization of the community health services, as the majority may not even know of some health benefits that they are entitled to. The strategy to mobilize communities will be through radios, local leaders, mass communication during big gatherings e.g. *umuganda,* church, CHC, etc.

The progress towards achieving outcome 4 will be tracked by the following outputs:

Output 2.1: Community mobilized in community health programs through community gatherings, e.g. Umuganda
Key strategies:

1. Identify days when there are community gatherings
2. Design relevant messages to be disseminated via community gatherings
3. Use radio Rwanda and TV mostly watched by the targeted population
4. Disseminate IEC materials via channels like community works, *umuganda* and CHWs
5. Strongly involve local and opinion leaders

Output 2.2: Community members involved in the process of analyzing local health needs and propose solutions
Key strategies:

1. CHD to develop guidelines on how health needs can be assessed and given to CHWs
2. Local authorities to involve population during the community gatherings
3. Involve district local authorities in the identification of community health needs
4. Involve men and women but use more women in women sensitive programs
5. Use strategic days like monthly *Umuganda* program and national vaccine campaigns

Output 2.3: Community health service utilization increased
Key strategies:

1. Mobilization of citizens
2. Improving supply of services
3. Removal of remain financial and cultural barriers

Objective 3:
Motivate CHWs and clients to improve health service delivery and access in the community

***Outcome 3*:**
CHW cooperatives and health service delivery strengthened and utilization increased through monetary and non-monetary incentives

The CHWs cooperatives form the umbrella of all CHWs in the country. Currently, CHWs are motivated through CPBF and a bigger share of financial incentives (70%) goes straight to their cooperatives, while 30% is divided among the CHWs based on their internal regulations. These have been efforts lead by MOH to strengthen the CHW motivations. It is also important that the current efforts to strengthen the CHWs be maintained so as to maintain current health benefits achieved through this financing strategy. During the situation analysis, it was observed that despite impressive progress over previous years, challenges have remained, such as: workload for CHWs that do not match level of incentives, transports means for some, cooperative management issues, etc. It is thus critical that these challenges be addressed in this strategic plan to contribute to achieving national targets.

In furtherance of the above outcome, the following outputs have been formulated:

Output 3.1: CHW cooperatives subsidized for achieving high coverage indicators through CPBF
Key strategies:

1. Advocate for additional funding for the CPBF
2. Increase Government funding in the scheme
3. Regular assessment of financial needs/gaps for the implementation and sustainability of CPBF

Main activities:

1. Conduct needs assessment for the implementation and sustainability of CPBF

Output 3.2: CHW performance indicators updated and reviewed to respond to national priorities
Key strategies:

1. Regular review of CPBF assessment framework
2. Refine PBF quality performance indicators and assessment process to reflect CHW activities
3. Monitor performance indicators trends
4. Institute CPBF counter verification measure and data audit
5. Link CPBF incentives to community data quality audit assessment

Main activities:

1. Annual review of community PBF indicators and assessment tools
2. Refresher training to update all community PBF stakeholders
3. Disseminate reviewed tools to all community PBF stakeholders
4. Quarterly CPBF indicators analysis and feedback meetings to stakeholders
5. Conduct annual CPBF system audit

Output 3.3: Local structures capacities enhanced to effectively participate in the CHW PBF activities
Key strategies:
1. Functional analysis of different CPBF structures
2. Reinforce the M&E system to local structures involved in CPBF
3. Continuous refreshment based on needs.

Main activities:
1. Conduct functional analysis of the roles and responsibilities of different CPBF structures
2. Review the CPBF institutional set up and TOR of different structures
3. Conduct integrated supervision on CPBF
4. Participate in the joint supervision (with partners) on CPBF

Output 3.4: CHW cooperatives business activities strengthened
Key strategies:
1. Public private community partnership for business orientation
2. Capacity transfer on business management
3. Advocate for financial audits of CHW cooperatives
4. Assess time CHWs take for cooperatives and health activities
5. Regular assessment of the CHW cooperative performance
6. Best practices documentation and dissemination
7. Exchanges and study tours between cooperatives
8. Assess individual and cooperative benefit from the PBF generated incomes

Main activities:
1. Subcontract private companies to support the management and business orientation of CHW cooperatives
2. Develop procedures manual of CHW cooperatives
3. Training of CHW cooperatives on business plan elaboration
4. Quarterly assessment of CHW cooperatives' performance
5. Document and disseminate best practices on CHW cooperatives' business
6. Facilitate exchanges and study tours between CHW cooperatives
7. Conduct integrated supervision on CHW cooperatives' activities
8. Collaborate with specialized organizations to facilitate financial audits of CHW cooperatives
9. Institutionalize financial management software of CHW cooperatives
10. Conduct assessment of individual and cooperative benefit through their income generation activities

Output 3.5: Community demand in health activities increased through non-monetary incentives (in-kind incentives)
Key strategies:
1. Advocate for funds for demand side activities
2. Allocate incentives to high risk populations/areas
3. Impact evaluation of demand side activities

Main activities:
1. Document the administrative process for delivering in-kind incentives
2. Reformulate CH policy based on impact evaluation results of demand side

Objective 4:
Strengthen M&E and coordination of community health activities at the central, district, health center and community levels

Outcome 4:
Quarterly integrated meeting (especially evidence-based planning, resource mobilization, and M&E) with partners is strengthened

Monitoring and Evaluation

Monitoring and Evaluation is the backbone of any program being implemented. Monitoring informs implementing agents if they are on track while evaluation is performed to ascertain if intended results were obtained. For the community health strategic plan to be implemented well, a functioning M&E system that has been in place will be strengthened to track the implementation processes. Data sources for each level indicator will be identified and agreed upon by all the stakeholders. In furtherance to this, there is a major category of data sources: routine data sources and output monitoring indicators. Routine output monitoring data sources include program data from community health implementers and community-based organizations. Under the new strategic plan, an annual costed national M&E work plan will be jointly developed by the Community Health Desk and its stakeholders, including activities, implementers, timelines, and activity costs for all M&E activities in the country. The developed M&E operational plans will be regularly reviewed by all of stakeholders. Each year, the work plan will be assessed in participatory workshops with all stakeholders. Based on assessment results, the next work plan will be developed. To progress towards achieving outcome 5, the following output (s) have been proposed:

Output 4.1: M&E for community-based health activities developed and disseminated
Key strategies:

1. Develop community-based M&E through consultative meetings with stakeholders
2. Regularly review indicators for consistency and reporting purposes
3. Implement the M&E plan
4. Incorporate performance-based financing in priority indicators

Output 4.2: M&E staff at districts and Health Centers trained on the new M&E plan
Key strategies:

1. Identify trainers from central level
2. Identify and TOT from district and health centers to be trained
3. Identify training inputs (logistics and venues) and mobilize resources
4. Execute training plan for the TOT and later to train the M&E staff from respective facilities

Output 4.3: M&E used to strengthen data quality to inform policy
Key strategies:

1. Data and M&E managers at CHD check on the data consistency and quality to ensure quality is maintained
2. Identify any inconsistency in data collection and report it for mitigation
3. Train the data collectors at district, health center and community level on quality data collection (first with TOT and then with CHWs)
4. Inform policy and implementers on the progress

Coordination
Coordination of community health activities with all partners at different levels is critical to foster community health implementation. Effective coordination will ensure that all partners involved in the community health activities are brought on board to review the various community health interventions and how well they are doing. Coordination meetings not only focus on the review of the program updates, but also can increase efficiency by preventing implementation of the parallel activities. Coordination meetings can further contribute to the capacity building of various MOH staff through interaction with more competent personnel from the implementing partners. During the situation analysis, program specific coordination challenges were identified, with more coordination challenges being faced by district staff. This strategic plan will ensure that more coordination is done to ensure that community health programs are better implemented in a well coordinated and managed manner.

To achieve the above outcome, the following outputs have been proposed:

Output 4.4: Quarterly coordination meeting conducted
Key strategies:

1. Community Health Desk assumes the leading role to coordinate community health partners
2. Community Health Desk and partners draw up a clear quarterly coordination work-plan
3. Ensure that districts and health centers are included during the planning of the work-plan
4. Conduct quarterly coordination meeting

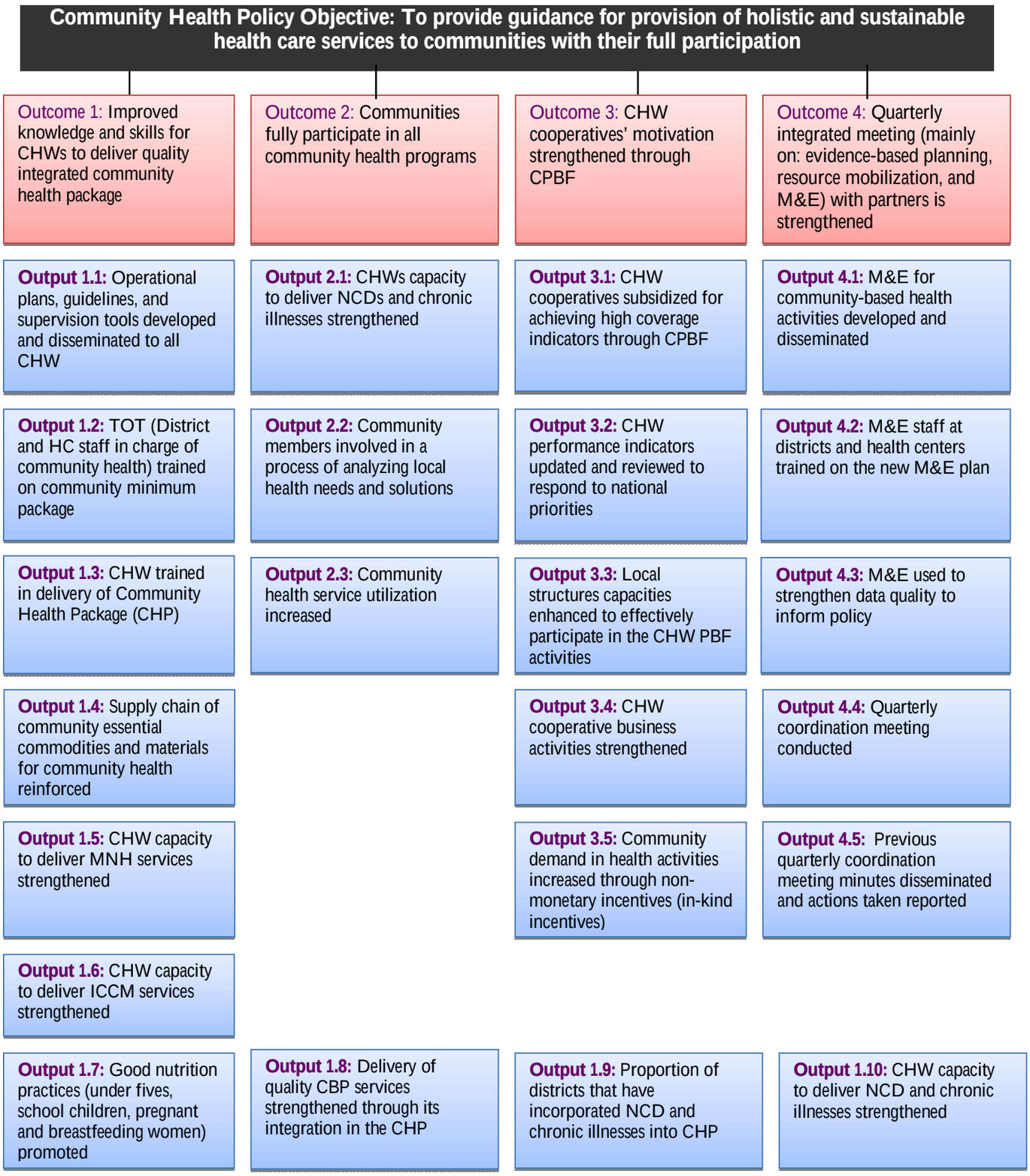
Output 4.5: Previous quarterly coordination meeting minutes disseminated and actions taken reported.
Key strategies:

1. The leader of the coordination meeting disseminates the meeting minutes

2. The CHD and partners in charge of the coordination report provide actions taken as a result of previous coordination meeting

6.1.5 The Framework for Community Health Strategy

Figure X. Community Health Strategy Framework



The Logical Framework with Proposed Impact, Outcomes and Outputs

7 THE SUPPORT SYSTEMS

The support system for the community health strategy is divided into three broader support areas: clinical, logistical and management support.

7.1 Clinical Support

The term "clinical" is defined in the medical dictionary as "the observation and treatment of patients rather than relying on theoretical or laboratory studies". The health activities for the CHWs falls under three main categories: curative, preventive, and health promoting. Based on the above clinical definition, the clinical support system includes all capacity building assistance to the CHWs related to curative and to some extent preventive, and referral system for advanced cases that are beyond the CHWs' scope. The key clinical support will come from interventions such as:

1. Community Case Management of malaria, ARI, diarrhea, vaccination, malnutrition (e.g. Community Integrated Management of Childhood Illnesses/Community IMCI)
2. Provision of family planning services including FP products
3. Engage in community DOTS for tuberculosis

Although CHWs have guidelines on all current interventions, they are also trained on how the clinical symptoms present and are given written materials about clinical presentations, including groups of indications that points to when a person should be referred to the health post or health center. The central level is responsible for ensuring that these materials are well developed and disseminated in time.

7.2 Logistical Support

Planning and Budgeting

The community health strategic plan has been developed after the HSSP III has been completed. The development of the HSSP III was aligned with the EDPRS 2, which will start in July 2013. After the completion of the community health strategic plan, several operational plans will be developed with budgets to expand on the main activities provided in the HSSP III. These operational plans will be composed of the detailed activities and M&E plan that the central and decentralized levels will use for the implementation of this strategy. The planning and budgeting processes will be discussed mostly in the TWGs and with the district teams.

Commodity Supply

There is a need to recognize CHWs as able cadres that have significantly contributed to the strengthening of the health system. The materials supplied at the community level are provided in the annex 1. These materials are supplied to community level through the health system (from central level to district, and from district to the health center, and from health center to the community). The health center receives the supplies such as tools, and some materials direct from the central level, while consumable and medical supplies are supplied via the district pharmacy. In this strategic plan, more capacity will be built in the supply system to ensure that gaps in the supply system are minimized. During the situation analysis, it was found that challenges in the supply of commodities were mostly noticed between health centers and the community. Thus more training emphasis will be focused at this point to ensure that cadres involved at this delivery point have skills and knowledge on planning to forecast commodities to avoid community stock-outs. The capacity building will also target all those cadres up to district levels.

Other supplies such as: consumables and non-consumables, materials and equipment, etc. will always be supplied based on specific interventions and will be disseminated by those responsible for providing support.

7.3 Management Support

Human Resources

To achieve the health targets set in the HSSP III and community health strategic plan; the MOH will need sufficient human resources both in quantity and quality. Currently, Community Health has insufficient staff at the central, district, health center and community levels. At the central level, the prevailing scarcity of staff has been for a short term solved by using partners in a wide range of activities including supervision and TWG (planning, M&E, and approval of several program documents). At district level, there is only one staff in charge community health activities, and is often involved in other activities because the district itself does not have enough staff. As the scarcity of medical staff also looms at referral and district levels, it can be an opportunity to use CHWs to deliver basic curative, preventive, and promotion services. But as more tasks are being shifted to the community level, additional training and capacity building is critical and this of course will have budget implications. Through this task shifting, the use of community health workers can solve the challenge of the human resource scarcity.

At the health center where almost all community health activities are coordinated from, there is one staff in charge of community health, which is also overworked because he/she has to supervise all the CHWs in the health center catchment zone, and conduct verifications, etc. at the community level. The external evaluation of the HSSP II found that for all the current community health activities to be implemented effectively, there is a need to have at least six CHWs per village. Until recently there were four CHWs per village but one was removed, increasing the workload further for the three CHWs per village. The staffing will be addressed through the Human Resource for Health Strategy. However, the capacity building for the existing staff will continue and hiring where through project staff, wherever possible. For details, please strategic plan for human resource for health.

Regulation

As the health sector continues its efforts to strengthen and support professional bodies, professional regulatory bodies have played an important role in the health system by controlling the practice of health professionals and protecting the public from unsafe practices. Currently the Medical and Nurses & Midwifery professional councils have been established with the mandate to regulate professional practice and professional education through credentialing, accreditation of professionals, registration and licensing. Different health professionals are still encouraged to establish councils, as this is paramount to maintaining a functioning health system. As the CHWs become more and more involved in the delivery of the health services they need to be accountable in some way. Due to a lack of formal accountability and professionalism (CHWs are still counted as volunteers) it is difficult to reinforce professionalism. However, through the training institutions and professional bodies, the main community-based packages of services may be integrated into quality assurance programs. The performance of CHWs needs to be formally recognized and professionalism should continue to be encouraged by the sector, with the help of existing professional bodies.

Financial Management and Advocacy

There has been relatively satisfactory coordination of available financing mechanism at the central level mainly in the identification of priorities, but it is important to acknowledge that there has been challenges related to control of CHWs cooperatives members on actual expenditures versus revenues. With successful decentralization of most central roles and responsibilities to the local agents, it is expected that a larger share of funds will progressively be mobilized and disbursed directly to local governments agents working directly or indirectly on the community health programs and of course with the CHWs cooperatives.

In addition to the above, as more and more health interventions move towards community level, more financial resources will be required to implement this strategy. Therefore the MOH will be required to mobilize adequate finances if the intended results are to be attained. The MOH thus has the role of mobilizing funding in order to implement this strategic plan. In short term, implementation of community health activities is foreseen to continue to rely on donor support. However, in the medium and long term, more sustainable financing mechanisms will need to be thought about and considered. Much as we have to acknowledge the Governments' increasing financial support to community health interventions through general increase in budget allocation in the health sector, the government will have to explore other funding options such as insurance coverage, user fees, income generation by the CHW cooperatives, and involvement of the national insurance companies as the population improves its income and enters wage sectors.

It will be the responsibility of the MOH to persistently continue advocating with pertinent ministries, like those of: Finance, Local Government, Agriculture, Gender, Commerce, etc. for resource allocation for various interventions in the community health strategic plan. The MOH will further advocate through other partners, such as the international agencies to mobilize external resources and to help build a strong and sustainable community-based system by providing technical and financial support. Advocacy should also involve local and international NGOs and FBOs that can implement components of the community health strategy using their own resources. It should be noted thus, in the process of this advocacy, effective partnerships with different organizations in accordance to their comparative advantage should be developed and managed effectively by the MOH.

Ensuring Quality Assurance and Standard

The Ministry of Health has defined the quality assurance policy and strategy and the Essential Health Care Package (EHCP) for the different levels of care alongside their norms and standards, including the community level. A quality assurance task team was established in the MOH to review existing services the health care system is providing, including the CHWs. Consequent to these reviews, updates will be made and norms and standards will be revised and introduced in the health care delivery system, from the central level to the community level. New instruments and tools for self-assessment and external assessment of quality of care, based on clear and measurable indicators, will be developed and health providers will be oriented on the use of these tools.

Specifically, for the community level, the existing CHP will be continuously reviewed as time goes by to ensure that regular updates are made. These will be followed with CHWs training and capacity building after each update. Conducting integrated supervision to ascertain that services are provided in the best quality possible will further ensure quality assurance and standards at the community

level. Quality indicators in the community PBF will be further encouraged as a way to improve quality of the services. Norms and standards will be adapted from internationally recognized norms and standards. District TOT training will be conducted to ensure that there is continuous training of CHWs on quality related topics using quality modules available.
The HSSP III plan to build on the achievements included the establishment of a fully-fledged national accreditation body that will be responsible for assessing each health facility (from health center to the national referral hospital), the staff in the quality assurance will have to work with the Community Health Desk to develop internal accreditation plans to also assess community health interventions.

The process will not be difficult; tools will be developed to support community health following what is being done at the health center, district and referral hospitals. As in the health facilities, the overarching goal will be to recognize and reward those CHW cooperatives that demonstrate quality improvement and safe health care services delivery. Aside from community health client surveys and/or feedback, regular community/client satisfaction surveys may be undertaken to inform the quality assurance program and guarantee Continuous Quality Improvement (CQI). To support and strengthen institutionalization of continuous quality improvements, community PBF will continue to be linked to quality assessments through accreditation.

8 IMPLEMENTATION FRAMEWORK

8.1 Implementation of Community Health Strategy

The MOH will implement the community health strategy through the Community Health Desk. The health sector is led by the MOH, whose overall function is to: support, coordinate and regulate all interventions whose primary objective is to improve the health of the population (HSSP III, 2012-2018). Therefore, MOH is responsible for the overall coordination and implementation of all health activities and programs in the country and will thus be the primary implementer of the Community Health Desk Strategic Plan, through Maternal and Child Health, Community Health Desk.

8.2 Roles and Responsibilities of Ministry of Health

Central Level

MOH is the lead implementer of the community health strategy. As such, it will be responsible for advocacy for all policies that have links to community health programs and services at the national, district, sector, cell and community levels; ensuring that there are periodic reviews of programs of ministries, departments and agencies and engagements with non-governmental organizations and other institutions involved in the implementation of the community health Policy and Strategic Plan; advocate, promote and coordinate the implementation of the strategic plan at both national and sub-national levels; and advocate for CHWs' empowerment through capacity building in policy and management of their cooperatives. In addition, the MOH will be responsible for actively leading resource mobilization for the community health strategy especially financing of the cooperatives and staff working to deliver community health activities; provision of effective leadership in monitoring the utilization of inputs during implementation of the Policy and strategic plan; continuous capacity building of providers (through TOT) at district and health center level in order to ensure that CHWs provide services that conform with the standards and quality of care set by the Ministry of Health's minimum packages; support community health related research, document best practices and disseminate results; strengthen linkages with relevant ministries, Partners, and NGOs involved in community health; and support development of standards of care at the community level, through the development of appropriate tools and operational plans.

Community Health Desk:

Under MCH, CHD is responsible for coordinating and managing routine community health activities, including planning processes, implementation, and monitoring and evaluation. The accountant within the administrative structure is responsible for overseeing finance-related activities. The MOH organization chart includes a health-financing expert who will be responsible for providing technical assistance during the implementation CPBF (see CHD organization chart). The performance-based financing expert will support the management and coordination of CPBF program activities, including follow-up to ensure that performance-based payments are made in the right amount, at the right time, for the right CHW cooperatives.

District Level

Under the Ministry of Local Government, the district is the unit of decentralization. This level provides administrative support to the district hospitals and health centers. A district health expert is in charge of community health and will work closely with district and health center health facilities in the district catchment zone to coordinate and manage community health-related activities. The

district hospital will continue to coordinate and directly oversee the implementation of the community health activities, including the CPBF program. The district focal point person is also responsible for implementing community activities including analyzing and entering the data into the RCHMIS and for verifying the data reported and submitted from the health center. This staff will also be responsible for ensuring that the CPBF program is implemented in the community through the coordination and management of the health center staff also in charge of community health activities.

Sector Level and Health Center

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

Sector PBF Steering Committee:

The CPBF program establishes the rules that govern the Sector PBF Steering Committee. This committee includes:

1. The sector staff member in charge of health and social affairs (chairperson)
2. The staff member in charge of the health center (vice chairperson)
3. The president of the community health worker cooperative (non-voting member)
4. The focal person at the health center in charge of community health (secretary)
5. One community member (not a member of one of the above institutions)

Health Center Level:

The health center staff in charge of community health activities oversees all community health activities including the ongoing demand-side incentive strategy aimed at increasing the number of women utilizing the maternal and child services. This intervention is among the World Bank and School of Public Health Impact evaluation study. This staff also offers among other services, monitoring the demand-side incentives and provides regular advice. Under the CPBF program, the health center will continue to work with the health sector and district administrations to implement the CPBF program. The responsibilities of the staff in charge of community health include:

1. Managing a sub-account with funds from the central level to pay the CHW cooperatives
2. Validate CHW cooperative quarterly reports with referrals records from CHWs to health center
3. Supporting review and assessment of the aggregated CHW cooperative data
4. Coordinating related community promotional activities
5. Coordinating monthly CHW meetings at the health center
6. Conducting field visits to confirm correct referrals by CHWs
7. Monthly supervision visits to CHWs

Community Level

The CHWs are the MOH cadres that deliver the community-based interventions, including the community performance indicators. Each village has three CHWs. The CHWs implement and

collects data on the population in the community and aggregates it at cell level before transmission to the health center, at sector level. As seen from the situation analysis, there are challenges related to the quality of data collected and compiled at the cell level. The challenge is that there are no control mechanisms at these levels (between health center and community) to ensure that quality data is collected. A mechanism will be required to tackle this challenge—this can be discussed in the TWGs. Also to improve on their performance in implementing and collecting the data, CHWs need to be further trained on various indicators especially the high performance indicators and the importance of reporting correct data.

8.3 Coordination and Role of Partners in Implementation

The involvement of partners in the implementation of this strategy will be critical in order to contribute in achieving the desirable targets set by HSSP III 2012-2018 and EDPRS 2. Thus, the need for harnessing the shared roles and responsibilities of all partners will be paramount in the realization of the intended results of this strategic plan. As the leader implementer, the MOH will ensure that complementarities of the roles and responsibilities of all ministries and agencies, Development Partners, Religious Organizations and Faith-Based Institutions, Research Institutions, CBOs and NGOs are identified in line with their mandates. Linkages will be further strengthened through effective coordination mechanisms to ensure joint formulation, implementation, monitoring and evaluation of community health strategy.

The Community Health Desk under MCH occupies greater part in the wider sector coordination. The coordination of Development partner in Rwanda is well organized, and inclusive of all partners (bilateral and multilateral donors, international and local NGOs, private sector). The key entities in the coordination include Development Partners Coordination Group (DPCG), Budget Support Harmonization Group (BSHG), Sector Working Groups, and Technical Working Groups (TWGs). TWGs (such as Community Health Technical Working Group: CH-TWG, inclusive) serve as sector entities for technical experts to review and discuss program planning, implementation, and joint supervisions.

At the sector level, the Health Sector Working Group (HSWG) is the main coordination body, and is co-chaired by the Ministry of Health and a rotating lead Development Partner. In 2010, the MOH updated TWGs into a consolidated list of 7 overall groups, with associated sub-groups. Each group and sub-group has official GOR and development partner co-chairs.

The coordinating entity for the community health program is the CH-TWG, which coordinates and provides leadership with regards to policy implementation and strategic orientation. Once every quarter the group convenes a meeting bringing together government and partners supporting the community health program. The head of the Community Health Desk chairs the group and the co-chair rotates between partner members.

During the situation analysis and elaboration of the strategic plan, the Community Health Desk nominated core committee members to keep in constant liaison with the consultant and to provide all the requisite support. The TWG members were updated regularly on the progress in order to provide their input. During the course of implementation of this strategic plan, the process of involving partners will be strengthened further and expanded to include other relevant institutions. The TWG shall develop an annual national community health operational plan and ensure that this plan is jointly executed. This group shall further continue to be the community health coordination body at the national and sub-national levels.

The creation of the Joint Action Forums (JAF) at the district level was inspired by the central level development partner coordination mechanism that needs to be strengthened. Lessons drawn from successful central level coordination approaches need to be extended to the district and community levels where many health interventions are being shifted. At the district level, coordination is under

the responsibility of the district authority in charge of community health with guidance and support from the central level.

At the community level, coordination of the community health activities is done through the health center with guidance and support from the district authority (staff in charge of community health). This will continue with necessary adjustments for improvement. With the expansion of community health packages, the need for community participation is of paramount importance. Normally, all community health activities are organized and coordinated from the health center. Therefore, the health center will need to further develop a stronger collaboration and linkages with partners that support the provision of community health services as well as with the community members, local and opinion leaders to ensure greater ownership of the community health activities. That said, the health center would be the coordination unit at the sector or health center level.

9 COSTING OF STRATEGY

9.1 Costing Methodology

The community health strategic plan costing exercise was conducted using "ingredient costing methodology". In this methodology, each intervention is described with resources needed to deliver corresponding sets of outputs. UNICEF, through Professor Kara Hanson and Lucy Gilson, recommended this methodology for application and use in basic health service provision in lower delivery levels of developing countries. The two professors propose costing the "package of services" for different interventions while identifying the resource gap and determining "the value of these gaps" (additional resources required to produce desirable quality of services). The approach considers identifying the level of inputs to produce required services.

The costing exercise was planned for two days and carried out by all the members of the community health TWG. Four groups were identified corresponding to the four outcomes levels. Each group was tasked to first review all the outcome and output indicators previously developed by consultant and reviewed by the core team appointed by the MOH. The group then developed indicators and activities based on the outcomes. The two-day workshop was highly participatory and in the end, the groups made presentations in the plenary while the audience asked questions for clarification.

The estimation cost for each activity was done guided by a standardized framework involving three sets of assumptions: quantity, frequency, and unit cost variables.

The above two authors considers the application of five guidance frameworks for costing exercises:

1. Identify resources used to produce the services being costed
2. Estimate the quantity of each input used
3. Assign monitory value to each unit of input and compute the total cost of the input
4. Allocate the costs to activities in which they are used
5. Use measures of service output to calculate average costs

These were used as guidance to cost the activities in the community health strategic plan.
Where possible, personnel involved in implementing community activities and budgets experts for community health activities have been consulted in order to have more realistic assumptions. The whole costing exercise was based on the budget and real expenditures as well as national standards.

9.2 Major Costing Assumptions

Before embarking on the costing exercise, the team that worked on costing developed a range of assumptions. The following are the key assumption that guided the costing of the community health strategic plan.

1. More than 70% of the resources used to implement the community health activities were provided by donors (MTEF 2013)
2. The costing exercise also considered the current commitment by the GVT to increase its resource allocation to the health sector (currently standing at (11.5%)
3. The considered assumed continuous financial support by both GVT and donors

4. The costing did not go into details of investment and recurrent costs as this is done at higher levels
5. The unit costs were derived from the current prices while target were set based on HSSP III 2012-2017
6. The cost projection were reflected in the inflation rate
7. At some point, the costing assumed continuous growth in domestic GDP and income per capita.
8. The costing exercise applied 5% inflation rate

9.3 Findings

The CHD TWG carried full range of costing for all the activities. The costing relied heavily on the assumptions that large share of the funds used to implement community health activities comes from donors. After considering the all the activities that that have been implemented by the CHD over the last 5 years, and the need to keep the gains, while also scaling up others; to implement the all community health activities from the fiscal years 2013 to 2018, and as outlined in the HSSP III 2012-2017 to attain some community health targets, the community health strategic plan will require a total estimated amount of RWF 57,510,266,704.

Table V. Total Cost by Outcome Level

	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2013-2018
Total Cost Outcome 1	9,128,324,300	3,735,154,500	6,512,013,680	5,363,315,536	7,136,674,735	30,531,781,331
Total Cost Outcome 2	939,148,595	8,560,440	1,033,083,837	9,437,885	9,909,779	2,000,140,536
Total Cost Outcome 3	994,144,980	632,094,900	841,327,798	919,974,014	917,954,177	22,106,925,868
Total Cost Outcome 4	444,652,750	463,787,888	490,074,782	511,326,146	540,144,828	2,781,524,269
Total Cost Outcomes	12,945,068,355	5,935,480,515	10,207,902,676	8,235,353,740	10,062,782,523	**57,420,372,004**

9.4 Resource Gap Analysis

The CHD TWG carried full range of costing for all the activities. Then, the gap analysis was carried out once the full costing exercise was completed. The analysis was carried out at output level. Estimates of total available resources were derived from two sources: the budgets for currently GVT allocation to the Community Health Desk, and the available funding from the Global Fund, which

funds more than 75% of the community health activities. By the time of costing, we were not able to identify other potential sources of funding. The WB funding to the CHW intervention was considered as the GVT of Rwanda budget, since it is direct budget support. These available funds were analyzed in detail to estimate funding gaps with regard to the proposed community health strategic plan.

To implement CHD activities, it will require a total estimated amount of RWF 57,510,266,704. The available funds totals to 10,937,622,345 and the resource gap stands at 46,572,644,359. The fiscal year 2013/14 carried a huge budget because of the initial activities involving capacity building (training), which is often done once. We applied 5% inflation rate for subsequent years during costing. The resource gap shows that about 20% of the resources required to implement the 5-year strategic plan is available. The MOH thus has the responsibility of mobilizing for the remaining 80% of the required resources if it is to implement all the strategic activities included in the strategic plan.

Table VI. Summary of Resource Gap

	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	Total
Needed Resources	11,549,077,625	4,839,597,728	8,923,587,796	6,804,053,581	8,604,683,519	57,510,266,704
Available Resources	2,914,848,132	3,253,075,321	2,403,072,352	1,183,313,270	1,183,313,270	10,937,622,345
Resources Gap	8,634,229,493	1,586,522,407	6,520,515,444	5,620,740,311	7,421,370,249	46,572,644,359

10 MONITORING AND EVALUATION FRAMEWORK

Monitoring is the continuous process of collecting and analyzing data for performance indicators, to compare how well a development intervention; partnership or policy reform is being implemented against expected results (achievements of outputs and progress towards outcomes).

The existence of the Community Health Management Information System (CHMIS) is critical for the CHD to collect data for policy use and then provide feedback to the decentralized levels where data originated. Tools and data will provide the basis for performance monitoring and evaluation of this strategy. The CHWs use the tools and guidelines prepared by the Community Health Desk to collect the population level data. The following are the main steps involved in the community level data collection:

Service Delivery Points
Records, cards, registers and tickler file systems for the management of individual patients and clients. Community deaths are also recorded. Immediate reports to communicate information about particular events, such as diseases or conditions that require immediate action, also take place at the community level.

Village, Sector, District, and MOH Levels
Periodic reports (monthly, quarterly, semi-annually, and annually) are transmitted between all these levels

Central Level
Results of periodic surveys (e.g. Household Survey, National Health Survey), record reviews and evaluations conducted by MOH and its partners

In the course of the implementation of this strategic plan, periodic progress reports will be produced detailing the progress and resource consumption, as indicated in the Strategic plan and its operational plan. The report should detail what has been accomplished compared to what was proposed, identifies constraints, and suggests necessary modifications where gaps are identified.

The role of community health data management and reporting is complementary at different levels up to central level. Feedback will occur at all levels, starting from CHWs. The feedback will be provided not only through structured reports, but also through periodic meetings, reviews and supervision. The CHMIS will be utilized to identify the progress, gaps, lessons learnt and to ensure that best practices are disseminated across different levels and shared within and outside the health sector. Below are detailed processes of the data collection from lower to central levels.

Village and Cell Level
At the end of each month, the CHWs produce the progress report from which data/information are aggregated to a Cell level report, which is submitted to the Health Center by the 8th day following end of the month.

Health Center Level

The CHWs supervisor at the HC compiles all the cell level reports together and sends a monthly report form to the District Hospital.

District Level
Before the end of each month, the data manager at the district Hospital enters each HC-level consolidated monthly report form to allow electronic data submission to the central MOH level.

National Level
The Health Information System Unit merges the data from all districts and maintains a national database of health statistics. From the database, the unit prepares the ad hoc reports to inform different MOH departments, programs and donor partners, and, the Annual Health Bulletin. Staff within the Health Department use this data to monitor disease trends and for planning purposes. Analysis of all data from the previous year must be ready by the 1st of May, so that key trends can be presented and discussed at the Annual Health Conference. The use of data for decision-making is the central component of the framework and reflects the ultimate purpose of M&E in general: using data to answer fundamental questions about a program.

The data collection from the community health activities will heavily feed into routine data generated through RCHMIS and HMIS reporting systems. To harmonize community level implementers' efforts, joint operational annual plans will be developed by the community health TWG in collaboration with partners, as it has been the practice, which needs to be strengthened further. District Health Directorates and District Hospitals will be consulted during planning in a participatory planning process to ensure that district's needs as those reflected in the district action plans are captured. The Community Health Desk and partners will base these operational plans on quarterly work plans and process evaluations will be carried out bi-annually.

It is worthwhile noting that the community health TWG will undertake periodic review of key community data sources and reports to ensure that needed information is being obtained. Integrated quarterly formative supervision of health facilities by MOH officials shall continue to be a reliable means of verification of the reported information.

10.1 Research

Research in Rwanda benefits from strong political commitment within MOH and in the country at large. In the MOH there is the position of 'medical education and research', responsible for policy development. There are several high-level research institutions with wide international networks, such as the Institute of HIV/AIDS, Disease Prevention and Control (IHDPC) within the Rwanda Biomedical Center (RBC), (with its mission to promote treatment and research in HIV/AIDS, Malaria, Tuberculosis and other diseases), the School of Public Health and the two academic hospitals (CHUK and CHUB) (HSSPIII). Within RBC, the Division of Medical Research has been established to coordinate the various research activities. There is also a TWG specifically for health sector research and so the Community Health Desk must be well represented. The MOH fully understands the importance of evidence-based policy-making and program implementation and therefore takes research as a critical tool to inform policy and implementation. As community health is still evolving and as more health interventions are shifting towards the community, there is a need to conduct more research on the community to capture the rich information available at the community level. This will not only allow the health sectors to assess the progress made, but will

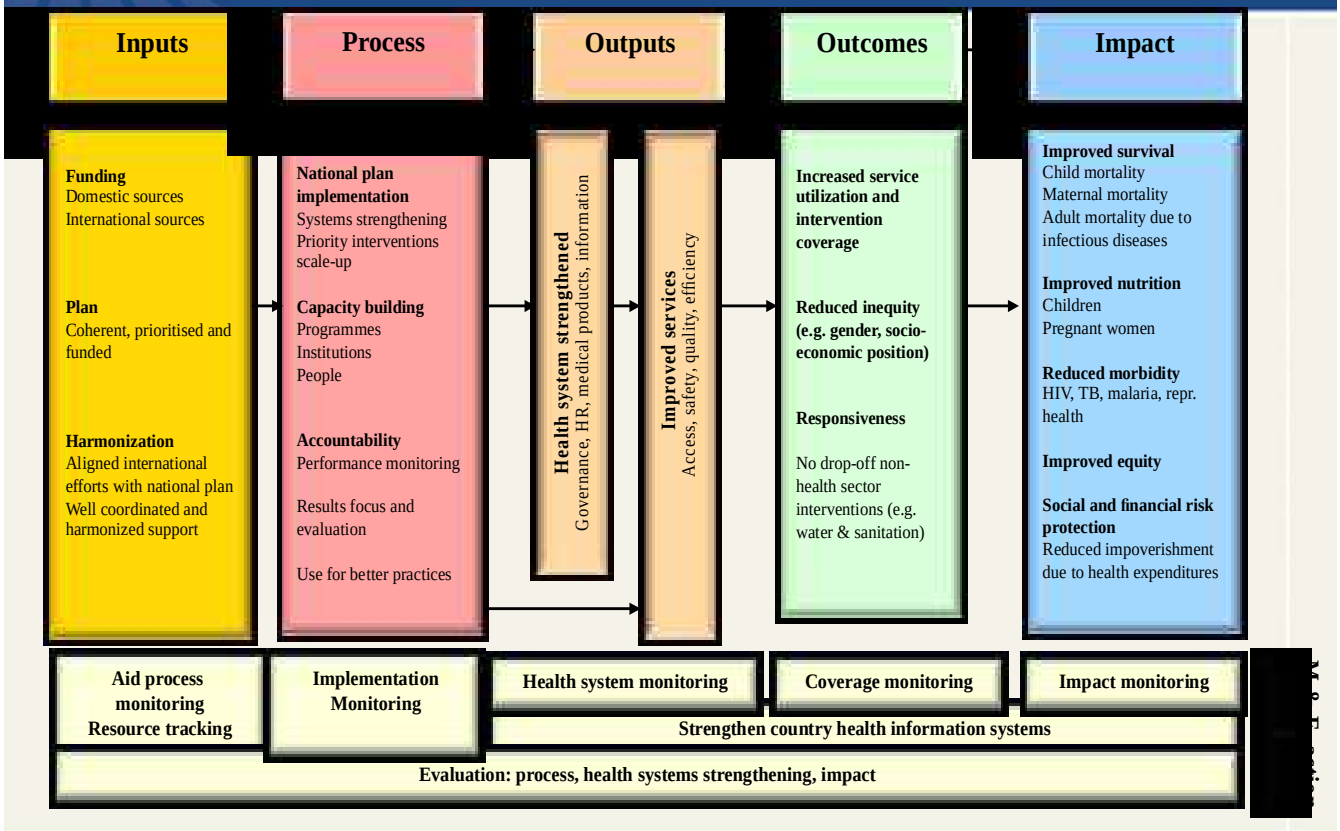
also other countries wishing to replicate the model to use the data from this research to inform their programs.

Despite interest in this research, there are several constraints impeding rapid expansion of research, such as limited research capacity and limited numbers of qualified and experienced researchers within the MOH; insufficient research infrastructure, including limited effective coordination mechanisms; and insufficient funding[2] to carry out all necessary and desirable research. There is a need to increase publications in international peer-reviewed journals. Importantly, a research agenda for the country has not (yet) been defined, resulting in insufficient priority setting on the issues that are most pressing to address to improve the health of all people in Rwanda. Another limitation is the insufficient use of much of the available information. Specifically, for community health, the area is still new and most of the data and information generated from the community level activities needs to be analyzed on multiple fronts.

Figure XI. The Common Results Framework

[2] The WHO recommends that Ministries of Health allocate two percent (2%) of their annual budgets for funding health research.

Common Results Framework



Adapted from Boerma T, Bos E, Walford V et al. International Health Partnership+. A common framework for monitoring performance and evaluation of the scale up for better health. Draft 4, February 2008.

Source: Adapted from Boerma T, Bos E, Walford V et al; International Health Partnership

11 ANNEXES

11.1 Annex 1. General Challenges, Proposed Solutions, and Opportunities for Community Health

General Challenges
1. ***CHW work load***: A real risk that three CHWs per village is not enough to cover tasks that are remunerated and those that is not. Also, there is no clear information of how many hours CHW spend on health related activities, on their cooperatives. As CHW are still volunteer except some PBF based on some activities.
2. ***Movement***: Trained CHWs movement out of the cooperatives is a challenge as replacement is costly and often not done.
3. ***Transport means***: The technical supervisor (nurse at the HC) and/or the controller of the cooperative often get stack with transport means to supervise and support CHWs.
4. ***Motivation***: All those interviewed think motivational benefits for the CHW need to be increase to match level of their efforts. The respondents in the field reaffirm this and add that, most cooperative take time to generate profits and CHW feel disincentivized. It is important that, as a CHW workload increases, their labor days are compensated. The Community Health Desk through GoR and partners support compensation of CHWs through newly created cooperatives at every health centers; the MOH strongly supports this strategy.
5. ***Cooperative management***: There are reports of mismanagement of cooperatives' leadership. There is not qualified accountant to manage the finances, some cooperative have just kept money are risk averse to use the capital, etc. the respondents at district level recommend that audits needs to be done in many cooperatives.
6. ***Misunderstandings among some local leaders***: There are reports of lack of good will to assist in development of cooperatives by some local leaders both at sector and district. At district, leaders do not take extra care to the CHW cooperatives the way they do for other cooperatives. They think it's the work of the MOH. Local leaders at sector, cell, and village, say it is the CHW since they are remunerated.
7. ***Accountability and professionalism***: Quality assurance due to lack of accountability and professionalism: Through training institutions and professional bodies, the main community-based packages of services should be integrated into quality assurance programs. The performance of CHWs needs to be promoted and professionalism should be encouraged by the MOH, with the help of existing professional bodies.
8. ***Replacing CHWs***: In some districts, some CHW/ASM have low level of knowledge often required to provide services at the community level and the replacement is a challenge because of the previous program that they have been trained in. Can the financial tracking tool recently developed to track CHWs be used track CHW and then plan for a timely replacement?
9. ***Logistical management skills***: Gaps are mainly seen in the forecast of the supplies between health center and community. The partners supporting in logistics supply systems should institute a well-run logistics system that ensures that supplies are in good condition and delivered in a timely manner. The system should control costs by eliminating overstock, spoilage, and proper waste disposal.
10. ***Long walking distances***: Most CHW expressed their challenge as long distance walk and

the geographical inaccessibility for some health facilities (PBF TB external evaluation report 2012). A section of CHWs believe that provision of transportation means such as bicycles was best way to solve this problem because some CHW in some parts of the country have been given bicycles and this has improved on service delivery significantly. Financing this can improve the service delivery as well.

11. ***Sustainability***: Sustainability of the community health program, especially cooperatives, is a big challenge. It would be ideal to conduct a study on the cost of the program and efficiency so that community health actor understand where funding goes and how best use the community health resources to maximize the benefits. Alternatively, the MOH can think of using CBHI premiums to support components of the CHW activities.
12. ***CHW materials***: In the same evaluation (PBF TB external evaluation report 2012), CHW expressed lack of training materials for educational. Insufficient sensitization campaigns at the community level, insufficient knowledge on new interventions. There is also a challenge related to culture and stigma whereby some community members have tendency to keep private their conditions, for example, if someone or a relative is suffering from HIV/AIDS or TB. There is therefore a need to improve on the levels of sensitization and counseling within community to increase knowledge on some stigma-linked diseases and intervention at community level.

Proposed Solutions

Over the next implementation of new community strategic plan, the desk should devise innovative strategic and operational approaches in order to overcome the above challenges, some of which are outlined below:

1. ***Focus on capacity building of the health staff involved in the community health program, both at central, district and decentralized levels***:
   a. Program design, implementation, M&E and coordination of community health activities at all levels
   b. Developing curriculum and training plan for CHWs to provide quality community health services in the areas of Nutrition, FP, ICCM, MNH and in disease prevention (HIV and TB) and Training of Trainers (TOT) of HC staff to train and supervise the CHWs
   c. Early childhood development and family approaches needs to be strengthened
   d. Rapid SMS and m'*Ubuzima* refresher training ensuring efficient use mobile phones to submit real time quality data
   e. Evaluation of CHWs cooperatives especially for community health care (ICCM, MNH, FP, CBNP etc.)
   f. Hands on application of RapidSMS and m'*Ubuzima* to (i) better inform providers and decision makers (ii) generate quick evidence based actions and decisions, and (iii) Cost and sustainability of RapidSMS system needs critical analysis
   g. Supportive supervision of community health activities (especially the pilots) needs more reinforcement

2. ***Strengthen the coordination of community health services at the local and***

national levels:

a. Mobilize communities for their full participation in healthcare provision through dialogue with religious leaders on the use of contraceptive methods, involvement of husbands /partners in birth control / FP, bringing pregnant women to the HC for ante-natal consultations and delivery, home visits to ensure adherence and improve their KAP of healthy practices, personal and environmental hygiene
b. Reinforce integration of holistic community services delivery to offer comprehensive and coordinated community health interventions
c. Reinforce sustainable community drug supply chain and storage (via improved drug forecast and effective supply channel)
d. Advocate/mobilize resources to support implementation of the community health programs
e. Improve the support for legal registration of CHW Cooperatives; train co-operative members on financial management and accountability
f. Ensure timely quarterly payment through C-PBF, based on data reported by CHWs
g. Strengthen existing partnerships between local leaders, government services, development partners operating in the area, civil society and private sector organizations for a joint effort to improve community health at local and national levels
h. Expand the existing monitoring system to all capture community health activities and provide real time feedback and guidance to targeted formative supervisions and audits
i. Some partner think that there are still few partners at the community level compared with the current levels of activities
j. Recruit local RapidSMS system facilitators and managers to enable sustainable application, regular data reviews and generation of reliable information: Recruit RapidSMS system administrators that will upgrade and maintain the system for its sustainability and continuous improvement

Opportunities

The community health program has presented various opportunities. For the program to continue to post even more impressive results, these opportunities will have to be seriously pursued. In this strategy, lists of some of the existing opportunities are outlined but new ones must be continuously sought out during implementation and new approaches identified. Below we provide some of the existing key opportunities:

1. ***Political commitment***: Political will to improve population health provides an opportunity for resource leveraging, and as such CHWs have gained strength.
2. ***Willingness to collaborate among partners***: There is an increased collaboration among partners, (local and international), CBOs, Faith Based Organizations (FBOs), and local associations that provide services, financial and technical support.
3. ***The presence of well structured local government from the district to the***

village level

4. ***Existence of CHW structures***: The presence of CHW elected at community level, now offering various health services at the community level, has become an important component of the health systems' strengthening force. Continuous harnessing this human resource efficiently can make big difference in the overall health outcomes.
5. ***Presence of well-organized and incentivized CHW cooperatives*** can be more to deliver more services, with of course additional remuneration.
6. ***Partners and civil society organizations*** are willing to live and work with community at the community level.
7. ***CHWs have improved confidence as time goes by***. Investing in them can be more productive in terms of service delivery.

11.2 Annex 2. TOR for Community Health Workers

Prevention

1. Provision of family planning services and products like injectables, pills, and condoms
2. NCDs packages
3. Community sensitization on prevention of common diseases like malaria, diarrhea, ARIs, etc.
4. Education on the prevention of sexually transmitted diseases and infections
5. Maternal and newborn health package
6. Nutrition education

Primary Care

1. Maternal and newborn health package
2. Community Case Management of malaria, ARI, diarrhea, vaccinations, malnutrition, etc. (e.g. Community Integrated Management of Childhood Illnesses/Community IMCI)
3. Engage in community DOTS for tuberculosis and HIV
4. Misoprostol to mothers who delivered home and on their way to health center

Promotion

1. Education to communities on nutrition
2. Growth monitoring, particularly among children under five years old
3. Nutrition surveillance
4. Routine home visits for active case-finding
5. Health campaigns on hygiene and sanitation, immunization etc.

11.3 Annex 3. Minimum Package for Community Health Workers

Integrated Community Case Management, ICCM (Binomes)
Printed tools and registers
Sick child recording form
CCM register
Referral and count referral recording form
Monthly report register for CHW
Counseling card/BCC
Poster CCM/BCC
Algorithm for CHW on the fever, diarrhea, pneumonia
Stock card
GDP (Good Dispensing Practice)
Job aid for re-supply chain
Procurement card for medicines for the cell coordinator
Calculator for the cell coordinator
Plastic file
Bag for registers
Pen, pencil, eraser, pencil sharpener
Notebook
Calculator for cell coordinator
Health care management tools
Cupboard
MUAC tape
Timer
Boots
Jerry can
Cup
Spoon
Rain coat
Torch with capacity to recharge the phone
Bag
Biodegradable bag in plastic
Safety boxes
Umbrella
Phone
Thermometer
Gloves
Medications
Amoxicillin (cp 125 mg)

Primo Tuku
Primo Hondo
Kit for RDT
Zinc (cp 10mg)
ORS
Sur eau
Condoms
Pills
Misoprostol
Gloves
Training, Supervision, and Evaluation
Training materials
CCM trainer's guide
Supply chain trainer's guide
Training guide for the cell coordinator on supervision, reporting, and procurement of medicines (being elaborated)
Facilitator guide on BCC
Cassette video, timer, MUAC tape, etc.
Supervision tools
Integrated supervision recording form of health facilities at the community level
Supervision recording form of health facilities at the cell level
Individual performance assessment/evaluation
Terms of reference for formative evaluation
Database of individual performance assessment of CHW
Monitoring and Evaluation Fees
Individual evaluation
3000Frws of per diem (*insimburamubyizi*) for every CHW
500Frws for every mother/child pair during individual evaluation practice
5000Frws of per diem for evaluator
Monthly supervision at health center by hospital
5000Frws/month/per health center/per day for the supervisor
4000Frws/month/per health center/per day for the driver
20 L of fuel/per month/per health center
Monthly supervision at the community level by health center
5000Frws for transport/trimester/village
CHW monthly meeting

3000Frws as ticket per CHW/month
Other
Contribution to the rapid evaluation by partners

Maternal and Newborn Health, MNH (ASM)
Registers
Register of pregnant women of childbearing age
Follow up recording form for pregnant women
Referral and counter referral recording form
Counseling card (MNH)
Monthly report
Materials
Timer
Thermometer
Weighing scales for babies
Torch
Plastic file
Notebook
Bag
Super net
Umbrella
Boots
Kit for delivery (box)
Mobile phone
Algorithm for RapidSMS
Medicines
Misoprostol (pilot phase)

Community Based Provision, CBP (Binomes)
Registers
CHW register (for uses of FP in the community)
Referral form of CHW clients in CBP/PF
Monthly report form of consumption and requisition
Monthly report form for activities transmitted to health centers
Monthly report form for activities transmitted to local leaders at cell and village level
Individual card for PF for health center
Guide for CHW
Training guide
Materials
Squeeze bottle
Chlorexidine

Syringe
Gloves
Cotton
Security boxes (03)
Artificial penis
Anatomical model during the training for injection
Cupboards
Sanitary towel
Stock book
Calendar
Bag
Boots
Umbrella
Torch
Protective coat
Medications
Microlyt
Microgynon
Depo-Provera
String of beads
Male condom

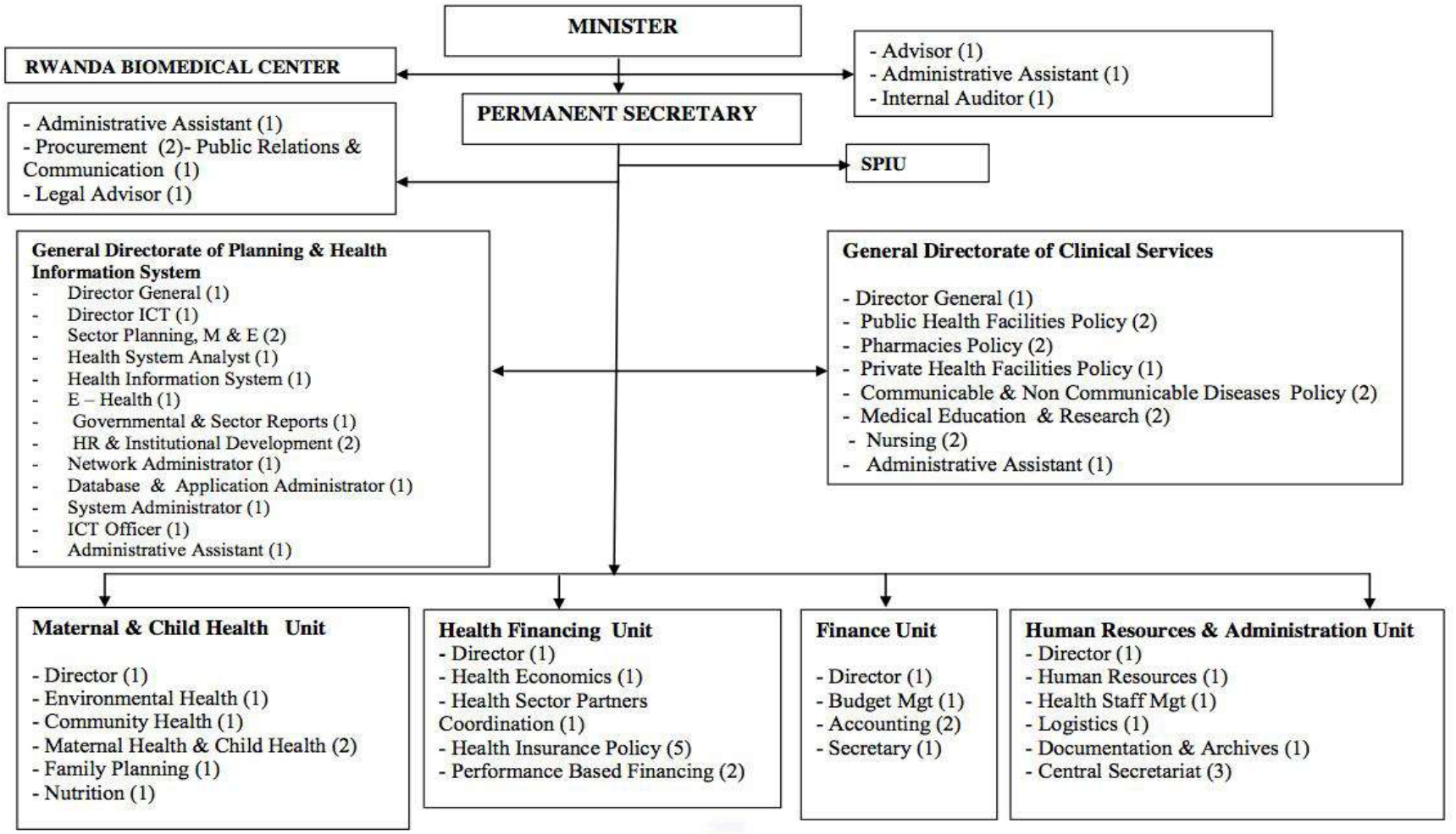
Community Based Nutrition Program, CBNP
Registers
Register for activities for CBNP at community level
Community register used for growth monitoring for under-five children at village level
Referral form
Supervision guide at cell level
Supervision guide at health center level
Supervision guide for the activities
Stock card for Mebendazole, Vitamin A and Ongera
Diagnostic tools
MUAC tape
Weighing scale
Protective baby clothes
Length scale (height)
Community register used for growth monitoring
Markers
Kitchen utensils for cooking demonstrations: big sauce pans
Training materials and IEC
Training guide for CHW

Participation model
Counseling card
Brochures
Cooking demonstration and recipes booklet
Kitchen garden booklet
Community growth chart

m'*Ubuzima* (Binomes) and RapidSMS
Registers
Card codes
Monthly report
Materials
Telephones
Health facility training tools
Training modules
Supervision tools
Narrative report template for compilation of quarterly activities at DH
Supervision guide for HC by DH
Supervision guide for supervision and reporting by central level
Supervision guide by HC to community

Non Communicable Diseases
Training guide for all parties (TOT and CHW)
Supervision tool

11.4 Annex 4. Location of CHD in MOH Organigram



Source: HSSP III 2012-2018

11.5 Annex 5. Logical Framework Approach (LFA)

This logical framework has been developed to demonstrate links between objectives for the community health policy and strategic plan with outcomes, outputs, and targets. It also shows how the outcomes will contribute to the overall sector policy objectives for universal accessibility of quality health services to all Rwandans.

Community Health Policy Objective: To provide guidance for provision of holistic and sustainable health care services to communities with their full participation.

Outcome: Medium term effect towards achieving the policy objective

Output: Service delivery (direct result of activities)

Indicator: Measure to assess result: indicator can be for impact, outcome, or output

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

Outcome 1: Improved knowledge and skills for CHWs to deliver quality integrated community health package	**Outcome 1 indicator**: Proportion of CHW cooperatives with improved knowledge and skills in delivering quality CHP

Output 1.1: Operational plans, guidelines, and supervision tools developed and disseminated to all CHW					
Key Activities to deliver output	**Output 1.1 indicator**	**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
See Activities under Costing for achieving Output 1.1	Proportion of districts that have disseminated these tools to CHWs				
	Proportion of health centers and cooperatives utilizing operation tools				
Output 1.2: TOT (District and HC staff in charge of community health) trained on community minimum package					
Key Activities to deliver output	**Output 1.1 indicator**	**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
See Activities under Costing for achieving Output 1.2	% of district and HC TOT trained				
Output 1.3: CHW trained in delivery of Community Health Package (CHP)					
See Activities under Costing for achieving Output 1.3	Proportion of CHW trained by TOT				
Output 1.4: Supply chain of community essential commodities and materials for community health reinforced					
See Activities under Costing for achieving Output 1.4	Proportion of CHWs trained in supply and forecast				
	% of HC reporting community stock-outs			TBD	TBD

Output 1.5 CHW capacity to deliver MNH services strengthened					
Key Activities to deliver output	**Output 2.1 indicator**	**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
See Activities under Costing for achieving Output 1.5	% of deliveries with one PN visit within the first week	79			
	% of pregnant women referred by CHWs to deliver at health facilities	78			
	% of pregnant women receiving 4 ANC standard visits	34			
Output 1.6: [Child Health (ICCM or IMCI)]: CHW capacity to deliver ICCM services strengthened					

	Per capita U5 visits seeking treatment for ARI+ Malaria +Diarrhea at HC and C-IMCI	0.6 / 0.2			
	Average # of U5 children seen by CHW/Month	1.1			
Output 1.7: [Community-based Nutrition Promotion (CBNP)]: Good nutrition practices (under fives, school children, pregnant and breastfeeding women) promoted					
	% of children < 5 years screened in CBNP	56			
	% of children in nutrition rehabilitation program (/total children malnourished)				
	% of households with kitchen gardens				
Output 1.8: ***[Community-Based Provision (CBP)]:*** *Delivery of quality CBP services strengthened through its integration in the CHP*					
	% of CHWs delivering CBP integrated in CHP in districts implementing CBP			00	
Non-Communicable Diseases (NCDs): ***General Indicator for NCD***					
Output 1.9: Proportion of districts that have incorporated NCD and chronic illnesses into Community-Health Package					
Key Activities to deliver output					
See Activities under Costing for achieving Output 1.9					
Output 1.10: CHW capacity to deliver NCD and chronic illnesses strengthened					
Key Activities to deliver output					
See Activities under Costing for achieving Output 1.10	*A. Indicators for TB:*				
	# of people screened for TB				
	# of people referred to HC				
	# of people treated in community				
	B. Indicators for HIV and AIDS:				
	# of households referred for HIV testing.				
	# of HIV positive patients missed appointments and brought back into care and treatment program at health center				
	# of exposed infants missed appointments and brought back into care and treatment program at health center				
	C. Indicators for cancers, chronic obstructive respiratory, metabolic, renal and cardiovascular disorders				
	# of IEC sessions conducted.				
	# of patients attended to by health workers				
	# of people referred by CHWs				
	# of home visits				
	D. Indicators for Neuropsychiatric diseases & psychological disorders				

	# of adult patients with mental health disorders referred for mental health care				
	# of children with mental health problems referred for mental health care				
	# of messages given during home visits on mental health promotion and advocacy.				
	E. Indicator for Sexual Gender Based Violence (SGBV)				
	# of SGBV cases referred to HC by CHW				

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

Outcome 2: Communities fully participate in all community health programs	**Outcome 4 indicator**: Per capita utilization of maternal health services at community level

Output 2.1: Community mobilized in community health programs through community gatherings, e.g., Umuganda					
Key Activities to deliver output	**Output indicator**	**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
See Activities under Costing for achieving Output 2.1	Proportion of spots and emissions broadcasted according to plan	40%			
	Proportion of IEC materials distributed by CHWs to community	70%			
	Proportion of local and opinions leaders sensitized	65%			
Output 2.2: Community members involved in a process of analyzing local health needs and solutions					
	Proportion of villages participating in problem analysis	65%	100%	100%	
See Activities under Costing for achieving Output 2.2	Proportion of CHW receiving feedback from upper levels on issues they identify by community				

Output 2.3: Community health service utilization increased					
Key Activities to deliver output	**Output indicator**	**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
See Activities under Costing for achieving Output 2.3		40%	TBD	TBD	TBD
		70%	TBD	TBD	TBD

Objective 3: Strengthen CHW motivation through CPBF to improve health service delivery

Outcome 3: CHW cooperatives and health service delivery strengthened and utilization increased through monetary and non-	**Outcome 3 indicator**:
	% age of CHW cooperatives reaching 80% of targeted annual profits
	% age of CHW cooperatives that improved at least five main community health performance indicators

monetary incentives	Proportion of autonomous CHW cooperatives with fully functioning

Output 3.1: CHW cooperatives subsidized for achieving high coverage indicators through CPBF					
Key Activities to deliver output	**Output indicator**	**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
See Activities under Costing for achieving Output 3.1	*Per-capita spending on community PBF (GoR, Donors) (HRT)*				
Output 3.2: CHW performance indicators updated and reviewed to respond to national priorities					
See Activities under Costing for achieving Output 3.2	*Updated procedures manual (annual report)* *Data accuracy rate (SISCom)*			TBD	TBD
Output 3.3: Local structures capacities enhanced to effectively participate in the CHW PBF activities					
See Activities under Costing for achieving Output 3.3	Proportion of sectors trained in CPBF approach			TBD	TBD
Output 3.4 CHW cooperatives' business activities strengthened					
See Activities under Costing for achieving Output 3.4	*% of CHW cooperative fully supported on business orientation (survey data)*				
	% of CHs cooperatives which generate benefit (survey data)				
Output 3.5: Community demand in health activities increased through non-monetary incentives (in-kind incentives)					
See Activities under Costing for achieving Output 3.4	Proportion of HCs implementing non-monetary incentive program				

Objective 4: Strengthen M&E and coordination of community health services at the central, districts, health centers and community levels

Outcome 4: Quarterly integrated meeting (mainly on evidence-based planning, resource mobilization, and M&E) with partners is strengthened	**Outcome 4 indicator**: Number of coordination meeting conducted and M&E strengthened at all levels

Output 4.1: M&E for community-based health activities developed and disseminated					
Key Activities to deliver output	**Output indicator**	**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
See Activities under Costing for achieving Output 4.1	Proportion of districts and HCs using new M&E to collect data			65%	TBD
Output 4.2: Train M&E staff at districts and Health Centers on the new M&E plan					
See Activities under Costing for achieving Output 4.2	Proportion of districts and HC trained on new M&E plan	65%			TBD

Output 4.3: Quarterly coordination meeting conducted					
Key Activities to deliver output	**Output indicator**	**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
See Activities under Costing for achieving Output 4.3	# of quarterly coordination meeting conducted annually	100%	100%		TBD
	Proportion of stakeholders (partners, MOH, and district staff) attending coordination meeting annually	100%:	100%		TBD
	# of inter-coordination meeting held within CHD to harmonize various CH programs	100%	100%	TBD	TBD

11.6 Annex 6. M&E Framework

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

Outcome 1: Improved knowledge and skills for CHWs to deliver quality integrated community health package	**Outcome 1 indicator**: Proportion of CHW cooperatives with improved knowledge and skills in delivering quality CHP

Output 1.1: Operational plans, guidelines, and supervision tools developed and disseminated						
Key Activities to deliver output	**Output 1.1 indicator**	**Source of data**	**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
See Activities under Costing for achieving Output 1.1	Proportion of districts that have disseminated guidelines to CHWs	Survey	100%	100%	100%	Annually

	Proportion of health centers and cooperatives utilizing guidelines	Survey	100%	100%	100%	Quarter

Output 1.2: TOT (District and HC staff trained on community health package						
Key Activities to deliver output	**Output 1.1 indicator**		**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
See Activities under Costing for achieving Output 1.2	% age of districts staff trained in CHP	Training reports	78%	100%	100%	Annually
	% age of HC staff trained in CHP	Training reports	78%	100%	100%	Annually
Output 1.3: CHW trained in delivery of Community Health Package (CHP)						
See Activities under Costing for achieving Output 1.3	Proportion of CHW trained by TOT	Training Reports	75%	90%	100%	Annually
Output 1.4: Supply chain of community essential commodities and materials for community health reinforced						
See Activities under Costing for achieving Output 1.4	Proportion of CHWs trained in supply and forecast	Quarterly reports	25%	80 %	90 %	Annually
	% age of HC without community stock-outs	SISCom	30%	95%	98 %	Quarterly

Output 1.5: CHW capacity to deliver MNH services strengthened						
Key Activities to deliver output	**Output 2.1 indicator**		**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
See Activities under Costing for achieving Output 1.5	% of newborns receiving a post natal check from CHW within 48 hours of birth	RapidSMS	15%	75	85	Quarterly
	% of pregnant women referred by CHW to deliver at health facilities	SISCom	69 k	75	80	TBD
	% of pregnant women attending 4 ANC standard visits	RapidSMS/SISCom	34	50	TBD	TBD
Output 1.6: [Child Health (ICCM or IMCI)]: CHW capacity to deliver ICCM services strengthened						
	Average # of U5 children seen by CHW/month	SISCom	1.1	2.2	2.7	Quarterly
Output 1.7: [Community-based Nutrition Promotion (CBNP)]: Good nutrition practices (under fives, school children, pregnant and breastfeeding women) promoted						
	% of children < 5 years screened within CBNP	SISCom	56	70	88	Quarterly
	% of children in nutrition rehabilitation program (/total children malnourished)	SISCom				

*Output 1.8: **[Community-Based Provision (CBP)]:** Delivery of quality CBP services strengthened through its integration in the CHP*

	% of CHWs distributing at least one contraceptive per month	SISCom	0%	70	80	Quarterly
Non-Communicable Diseases (NCDs): *General Indicator for NCD*						
Output 1.10: CHW capacity to deliver NCD and chronic illnesses strengthened						
Key Activities to deliver output	Indicators					
See Activities under Costing for achieving Output 1.10	*F. Indicators for TB:*					
	# of people suspected and referred for TB to HC	SISCom	10%	40%	65%	Quarterly
	# of people on DOTS in the community	SISCom	10%	40%	60%	Quarterly
	G. Indicator for HIV and AIDS:					
	# of people referred for HIV testing	SISCom	0%	50%	70%	Quarterly
	# of HIV positive patients missed appointments and brought back into care and treatment program at health center	SISCom	0	#	#	Quarterly
	# of exposed infants transferred to health center	SISCom	0%	40%	60%	Quarterly
	H. Cancers, chronic obstructive respiratory, metabolic, renal and cardiovascular disorders					
	# of people referred by CHWs	SISCom	0%	30	50	Quarterly
	# of home visits	SISCom	0%	30	50	Quarterly
	I. Indicators for Neuropsychiatric diseases & psychological disorders					
	# of adult patients with mental health disorders referred for mental health care	SISCom	0%	30	50	Quarterly
	# of children with mental health problems referred for mental health care	SISCom	0%	30	50	Quarterly
	# of persons with disability referred to health facilities.	SISCom	0%	30	50	Quarterly
	J. Oral and Eye Health					
	# of patients referred to health center for eye diseases, including cataracts	SISCom	0%	30	50	Quarterly
	# of patients referred to health center for gum diseases, dental caries, oral tumors, and other anomalies	SISCom	0%	30	50	Quarterly
	K. Palliative Care					
	# of patients visited for palliative care	SISCom	0%	30	50	Quarterly

	# of patients needing pain relief who receive recommended pain relief medication	SISCom	0%	30	50	Quarterly
	L. Sexual and Gender-based Violence					
	# of SGBV cases referred to HC by CHW	SISCom	0%	30	50	Quarterly

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

Output 2.1: Community mobilized in community health programs through community gatherings, e.g., Umuganda						
Key Activities to deliver output	**Output indicator**		**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
See Activities under Costing for achieving Output 2.1	Proportion of spots and emissions relevant to community health developed and broadcasted	Reports	40%	60%	70%	Quarterly

Objective 3: Strengthen CHWs Motivation through CPBF to improve health service delivery

Outcome 3: The CHW cooperatives motivation strengthened through CPBF	**Outcome 3 indicator**:					
	% age of CHW cooperatives reaching 80% of targeted annual profits					
	% age of CHW cooperatives that improved at least five main community health performance indicators					
	Proportion of CHW cooperatives scoring above 60% for accurate and organized financial records					
Key Activities to deliver output	**Output indicator**		**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
Output 3.1: CHW cooperatives subsidized for achieving high coverage indicators through CPBF						
See Activities under Costing for achieving Output 3.1	*Per-capita spending on community PBF by the government*	Financial report	100%	100%	100%	Quarterly
Output 3.2: CHW performance indicators updated and reviewed to respond to national priorities						
See Activities under Costing for achieving Output 3.2	*Proportion of HC currently utilizing updated procedures manual*	Reports	100%	100%	100%	Annually
Output 3.3: Local structures capacities enhanced to effectively participate in CHW PBF activities						
See Activities under Costing for achieving Output 3.3	Proportion of sectors trained in CPBF approach (both refresher and training)	Reports	100%	100%	100%	Quarterly
Output 3.4: CHW cooperatives' business activities strengthened						
See Activities under Costing for achieving Output 3.4	*% of CHW cooperatives that have received technical support aimed at strengthening cooperatives activities (statute, marketing, financing management, business plan, procedure manual)*	Survey Reports (SEDC)	40%	100%	100%	Annually
	% of CHW cooperatives which generate profits (survey data)	Survey reports	68%	90%	100%	Annually

Objective 4: Strengthen M&E and coordination of community health services at the central, districts, health centers and community levels

Outcome 4: Quarterly integrated meeting (mainly on evidence-based planning, resource mobilization, and M&E) with partners is strengthened	**Outcome 4 indicator**: Number of coordination meeting conducted and M&E strengthened at all levels

Output 4.1: Reinforced operational planning & monitoring of CHD program						
Key Activities to deliver output	**Output indicator**		**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
See Activities under Costing for achieving Output 4.1	# of meetings with CH partners held to update CH-mapping	Reports	4	100%	100%	Annually
	# of annual plans developed and submitted to CH	Reports	100%	100%	100%	Annually
	Proportion of CH-TWG supervisions conducted	Reports	0%	100%	100%	Bi-annual (March and Sept)
Output 4.2: Reinforced data analyses and use for planning purposes on all levels, with focus on key indicators						
See Activities under Costing for achieving Output 4.2	# of meetings held to share CH key indicators on Dashboard	Reports	0	4	4	Quarterly
	Proportion of districts that received quarterly bulletins and responded to areas for follow up	Reports	0	100%	100%	Quarterly
	# of CH programs evaluations evaluated at national level	Reports	2	5	7	Annually

Output 4.3: Quarterly coordination meeting conducted						
Key Activities to deliver output	**Output indicator**		**Baseline 2012**	**Target 2015**	**Target 2018**	**Time Frame**
See Activities under Costing for achieving Output 4.3	# of quarterly coordination meeting conducted annually	Reports	2	4	4	Quarterly
	# of inter-coordination meeting held within CHD to harmonize various CH programs	Reports	0	4	4	Quarterly

11.7 Annex 7. Costing Community Health Strategic Plan

Items Costed	Budget Estimation (RWF) for Community Health Strategic Plan July 2013-June 2018						
	2013-2014	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**Total**	Cost Description and Assumptions
Outcome 1. Outcome 1: Improved knowledge and skills for CHWs to deliver quality integrated community health package							
Output 1.1:Operational plans, Guidelines, and supervision tools developed and disseminated to all CHWs							
Main Activities 1.1							
Operational plans, guidelines, and supervision tools developed, revised, and disseminated by CHD with input of technical working groups (TWGs)	-	-	-	-	-	-	CHD staff in charge of different programs and corresponding partners develops the operational plan, guidelines, and supervision tools.
CHD and districts coordinate the distribution of the tools with the assistance of partners, as necessary	-	-	-	-	-	-	Communication fees for the
Integrated and supportive supervision at health center and community level (hospital to HC supervision to be included?)	15,780,000	16,569,000	17,397,450	18,267,323	19,180,689	**87,194,461**	DH to HC: 5000 per diem per supervision visit/month for 33 district hospitals; HC to community: 5000 per diem per supervision visit/month. Transport for both 5000 FRW, for 230 health centers.
Sub-Total for Main Activities 1.1	**15,780,000**	**16,569,000**	**17,397,450**	**18,267,323**	**19,180,689**	**87,194,461**	
Output 1.2: TOT (District and HC staff in charge of community health) trained on CHP							
Main Activities 1.2							
District and health center trainers trained in the CHP	16,655,000	-	18,320,500	-	20,152,550	**55,128,050**	Train TOT at district and HC. 2 per district from 30 districts (60). RWF 30,000 per diem. Location 50,000. Training health center staff in all Has 2 staff from 230 health centers (460) and per diem of RWF 30,000. 15 sessions (460/30) with hiring location at 70,000
CHP refresher trainings provided to district and health center trainers	14,850,000	-	16,335,000	-	17,968,500	**49,153,500**	

Master trainers supervise district and health center trainers and develop management plans on an annual basis	-	-	-	-	-	-	No master training required. The central level should conceive and develop the training materials and plans.
Sub-Total for Main Activities 1.2	31,505,000	-	34,655,500	-	38,121,050	**104,281,550**	
Output 1.3: CHWs trained and supervised in the delivery of the Community Health Package (CHP)							
Main Activities 1.3							
CHP refresher trainings provided to CHWs on an annual basis (new CHWs)	136,150,000	142,957,500	150,105,375	157,610,644	165,491,176	**752,314,695**	Train 45000 CHW at rate of RWF 3000 each. A staff from each of the 230 HC trains CHW in HC catchment area at rate of 5000 each. Training materials are provided from the central MOH. The training includes new CHW.
Evaluation of CHW performance on delivery of the CHP completed every two years	10,000,000	-	10,500,000	-	11,025,000	**31,525,000**	Estimation of evaluation study for the CHW performance on delivery of CPH. This include field visit to document best practices as part of the evaluation study.
Cell Coordinators complete supportive supervision visits with every CHW once per month	45,000,000	47,250,000	49,612,500	52,093,125	54,697,781	**248,653,406**	15000 cells. Quarterly supervision incentives of 5000/month for 12 months
In-Charges of Community Health complete supportive supervision visits with every CHW once per quarter	4,600,000	4,830,000	5,071,500	5,325,075	5,591,329	**25,417,904**	Each in-charge from 230 HC supervises CHWs each quarter at per diem of 5000. The transport id provided by health center
Sub-Total for Main Activities 1.3	**195,750,000**	**195,037,500**	**215,289,375**	**215,028,844**	**236,805,286**	**1,057,911,005**	
Output 1.4: Reinforcement of CHW skills to effectively deliver the CHP through frequent and supportive supervision							
Main Activities 1.4							
Train all decentralized levels in new program/interventions	-	-	-	-	-	-	Already costed under another output
Provide means and supervision tools for all supervision levels	-	-	-	-	-	-	No need to cost the activity. Tools can be provided during supervisory visits.
Sub-Total for Main Activities 1.4	-	-	-	-	-	-	
Output 1.5: Supply chain of community essential commodities and materials for community health reinforced							125,550,000
Main Activities 1.5							
Training of Cell Coordinators and Assistant Cell Coordinators on supply chain management	106,120,000	111,426,000	116,997,300	122,847,165	128,989,523	**586,379,988**	230 HC train 15 cell coordinators from each of the HC catchment zone. We estimated one day to be enough for training in each of 15 cells/HC

Provision of tools (e.g. stock cards, resupply worksheets, calculator sheet) to CHWs		-	-	-	-	-	No cost to this activity. This can be done through regular supervision.
TOT of district and health center trainers on supply chain management	126,550,000	-	139,205,000	-	153,125,500	**418,880,500**	Train 3 staff from district (district pharmacist, CHW supervisor, M&E) at cost of 35,000 RWF. Train 3 staff from 430 HCs at cost of RWF 30,000 on supply management. The training is done every two years. Location of hall 50,000 for 10 days
Sub-Total for Main Activities 1.5	**232,670,000**	**111,426,000**	**256,202,300**	**122,847,165**	**282,115,023**	**1,005,260,488**	
Output 1.6 CHW capacity to deliver MNH services strengthened							
Main Activities 1.6							
ASMs are provided with training and regular refresher trainings in MNH	118,987,500	-	124,936,875	-	131,183,719	**375,108,094**	Train CHWs: per diem (30.000*3000); training materials: pens, bloc note (300*30.000), participant guide (500*30.000), flip chart (200*5000), markers (100*3000), tape (50*1000); per diem facilitators: trainers (2*1000*5000), district supervisors (2*500*1000), central level (5*24.500) + (4*24.500+31.250)+ (2*24.500) +(2*31.250)+(2*42.000) + (4*24.500+42.000); Drivers (4*5*5*13750)
TOT of district and health center trainers in MNH	21,300,000	-	22,365,000	-	23,483,250	**67,148,250**	Train 30 staff from district and 230 HC in MNH to train CHW and other staff at decentralized levels. 30,000 per diem each, location of hall 50,000 from all 30 districts. 9 sessions involved (260/30)
Provision of MNH drugs and supplies (e.g. Misoprostol, timers, thermometers, scales) for ASMs	229,320,000	240,786,000	252,825,300	265,466,565	278,739,893	**1,267,137,758**	Printing tools, materials (batteries, thermo, timers, etc., purchased once in the first fiscal year), drugs, and training; unit costs estimated based on 2012 prices
Production, revision, and distribution of MNH tools (e.g. registers, follow-up forms, etc.) to ASMs	-	-	-	-	-	-	No cost for this activity because provision of these materials can be done through regular supervision
Sub-Total for Main Activities 1.6	**369,607,500**	**240,786,000**	**400,127,175**	**265,466,565**	**433,406,862**	**1,709,394,102**	
Output 1.7: [Child Health (ICCM or IMCI)]: CHWs capacity to deliver ICCM services is strengthened							
Main Activities 1.7							

Annual restitution/training of CCM team building and new community Health staff at DH and HC	30,863,200		33,949,520		37,344,472	**102,157,192**	Orientation meeting: (5Facitators*transport for 2 days); Team building with districts trainers (4 trainers/hospital: 43*per diem: 2700*in 3 days, training at District level: 4 people/HC: 476*3*5000
Annual training of new CHWs on CCM	69,320,000		76,252,000		83,877,200	**229,449,200**	Per diem for CHWs (100/DH*43*3000 in 4 days, Per diem for HC (4 persons*5000F*in 4 days for 476 HC; Supervision of DH: 5000F/per supervisor*4/Hospital: 43*in 3 days.
CHWs attend monthly report and feedback meetings at the HC	1,620,000,000	1,701,000,000	1,786,050,000	1,875,352,500	1,969,120,125	**8,951,522,625**	CHW to get 3000 each for transport reimbursement when they come to HC
Supply of management tools and drugs	320,320,000	336,336,000	353,152,800	370,810,440	389,350,962	**1,769,970,202**	Printing tools, materials (cupboard, MUAC, timer, torches, etc…), and drugs.
TOT and training of CHWs on resupply procedures	-	-	-	-	-	-	This activity was costed under supply chain training
CHWs follow resupply procedures for iCCM commodities on a monthly basis by going to the HC for provision of medication and supplies,	-	-	-	-	-	-	No cost for this activity. CHW can get these supplies through routines travels to the HC for meetings and reporting
Update/revision of training manuals and guidelines, iCCM tools	-	-	-	-	-	-	No cost for this activity. The staff at CHD and partners can revise these manuals.
CHWs attend monthly report and feedback meetings at the HC	1,080,000,000	1,134,000,000	1,190,700,000	1,250,235,000	1,312,746,750	**5,967,681,750**	CHW to get 3000 each for transport reimbursement when come to they HC
Regular performance assessment and evaluation of CHWs and CH supervisors	-	-	-	-	-	-	No cost for activity. CHD staff will perform this activity through regular activities
TOT on ICCM for CH supervisors Training and refresher on ICCM for CHWs	-	-	-	-	-	-	No cost for this. Can be conducted along with MNH
Sub-Total for Main Activities 1.7	**3,120,503,200**	**3,171,336,000**	**3,440,104,320**	**3,496,397,940**	**3,792,439,509**	**17,020,780,969**	
Output 1.8: [Community-based Nutrition promotion (CBNP)]: Good nutrition practices (under-fives, pregnant and breastfeeding women) promoted							
Main Activities 1.8							

CHWs are provided with training and regular refresher trainings in CBNP	135,500,000	-	149,050,000	-	163,955,000	**448,505,000**	Train CHWs: per diem (30.000*3000); training materials: pens, bloc note (300*30.000), participant guide (500*30.000), flip chart (200*5000), markers (100*3000), tape (50*1000); per diem facilitators: trainers (2*1000*5000), district supervisors (2*500*1000), central level (5*24.500) + (4*24.500+31.250)+ (2*24.500) +(2*31.250)+(2*42.000) + (4*24.500+42.000); Drivers (4*5*5*13750)
Production and distribution of all CHW tools (e.g. Length board, growth monitoring charts, scales, registers) for CBNP	2,227,000,000	-	-	-	-	**2,227,000,000**	Cost Description: Length Board (10.000*115.700); Scales (10.000*91.000); Registers (20.000*3000); Growth chart (10.000*15.000)
Purchasing and distribution of nutrition products (e.g. Vitamin A, albendazole, micronutrient powder)	-	-	-	-	-	-	TBD
Conduct sensitization meetings with communities and local leaders to encourage appropriate nutrition behaviors	-	-	-	-	-	-	No cost for this activity because its conducted at the community level where CHWs also participate as members as community
TOT provided for district and health center CBNP trainers	42,807,000	-	47,087,700	-	-	**89,894,700**	TOT refresher: per diem (453*3*25.500); training materials: pens, bloc note (1000*450), participant guide (500*450), flip chart (30*2*5000), markers (3000*60), tape (30*1000); drivers (30*3*16750); meeting room (30.000*3*30); fuel (30*3*30000)
CHWs conduct monthly screening for malnutrition among children under five and pregnant and lactating women	-	-	-	-	-	-	No cost for this activity because it is paid through com PBF indicators
CHWs refer malnourished children and pregnant/lactating women for treatment	-	-	-	-	-	-	No cost for this activity because its paid through com PBF indicators
Produce and distribute the cooking demonstration cookbooks to 25 % of households	957,929,000	-	-	1,245,307,700	-	**2,203,236,700**	Cost description: 25% of household will receive one cookbook
Sub-Total for Main Activities 1.8	**3,320,429,000**	**-**	**149,050,000**	**1,245,307,700**	**163,955,000**	**4,878,741,700**	
Output 1.9: [Community-Based Provision (CBP)]: Delivery of quality CBP services strengthened through its integration in the CHP							
Main Activities 1.9							

CHWs are provided with training and regular refresher trainings in CBP	621,099,600	-	683,209,560	-	751,530,516	**2,055,839,676**	Train CHWs: per diem (30.000*3000); training materials: pens, bloc note (300*30.000), participant guide (500*30.000), flip chart (200*5000), markers (100*3000), tape (50*1000); per diem facilitators: trainers (2*1000*5000), district supervisors (2*500*1000), central level (5*24.500) + (4*24.500+31.250)+ (2*24.500) +(2*31.250)+(2*42.000) + (4*24.500+42.000); drivers (4*5*5*13750). We took the planned budget of the three districts (* 3)*2 in order to get 621099600.
Sensitization during launching of the CBP in anew district	-	-	-	-	-	-	
TOT provided for district and health center CBP trainers	-	-	-	-	-	-	No cost for this activity. Already costed
Refresher training on CBP							
Provision of contraceptive methods for CHWs (e.g., Depo-Provera, cycle beads, condoms, pills)	-	-	-	-	-	-	Planned in the FP desk
Provision of assorted other CHW tools and supplies (e.g. safety box, cotton, registers individual cards, etc.)	678,980,000	-	746,878,000	-	821,565,800	**903,722,380**	Ask UNICEF for full cost of providing these packages by CHWs.
Provision of per diems for health center staff during the CHW validation process	-	-	-	-	-	-	Already in the PBF package
Sub-Total for Main Activities 1.9	**1,300,079,600**	-	**1,430,087,560**	-	**1,573,096,316**	**2,959,562,056**	
Non-Communicable Diseases (NCDs): *General Indicator for NCD*							
Output 1.10: CHWs capacity to deliver NCDs and chronic illnesses strengthened							
Main Activities 1.10							
A. Indicators for TB:							
TB tools developed and disseminated	-	-	-	-	-	-	No cost for this activity. Staff in charge of the program and partners can develop these tools
CHWs trained on TB symptoms, tools, and data collection and reporting, and TB supply chain management	-	-	-	-	-	-	
CHWs trained on DOT	-	-	-	-	-	-	

CHWs go to health center monthly for resupply of TB drugs	-	-	-	-	-	-	
B. Indicators for HIV and AIDS:							
Refresher training on VCT and referrals						-	
C. Indicators for cancers, chronic obstructive respiratory, metabolic, renal, and cardiovascular disorders							
Tools on symptoms of cancer and other diseases (chronic obstructive respiratory, metabolic, renal and cardiovascular disorders) developed and disseminated	135,500,000	-	142,275,000	-	149,388,750	**427,163,750**	Train CHWs: per diem (30.000*3000); training materials: pens, bloc note (300*30.000), participant guide (500*30.000), flip chart (200*5000), markers (100*3000), tape (50*1000); per diem facilitators: trainers (2*1000*5000), district supervisors (2*500*1000), central level (5*24.500) + (4*24.500+31.250)+ (2*24.500) +(2*31.250)+(2*42.000) + (4*24.500+42.000); drivers (4*5*5*13750)
CHWs trained on symptoms of cancer and other diseases, tools, and data collection and reporting,	-	-	-	-	-	-	No cost on this activity. It can be combined with above activity
D. Indicators for Neuropsychiatric diseases & psychological disorders	-	-	-	-	-	-	
Tool on mental health symptoms in adults and children developed and disseminated to all CHWs	-	-	-	-	-	-	No cost for this activity. Can be done the MOH in charge of the program with support of partners
CHWs trained on symptoms of mental health, tools, and data collection and reporting,	135,500,000	-	142,275,000	-	149,388,750	**427,163,750**	Train CHWs: per diem (30.000*3000); training materials: pens, bloc note (300*30.000), participant guide (500*30.000), flip chart (200*5000), markers (100*3000), tape (50*1000); per diem facilitators: trainers (2*1000*5000), district supervisors (2*500*1000), central level (5*24.500) + (4*24.500+31.250)+ (2*24.500) +(2*31.250)+(2*42.000) + (4*24.500+42.000); drivers (4*5*5*13750)
Community Mobilization (Umuganda, Mental Health Day) on mental health	-	-	-	-	-	-	Already costed for under communication RCC for IEC materials under outcome 2
Community Mobilization (Umuganda, Mental Health Day) on mental health	-	-	-	-	-	-	Already costed for under communication RCC for IEC materials under outcome 2
Tool for mental health symptoms including epilepsy in children developed and disseminated to all CHWs	-	-	-	-	-	-	No cost for this activity. Can be done the MOH in charge of the program with support of partners

CHWs trained on mental health diseases including epilepsy, tools, and data collection and reporting,	-	-	-	-	-	-	This activity can be combined with above activity on training CHW on mental health and data collection.
E. Indicators for eye disease							
Eye disease tool developed Eye disease tool disseminated to CHWs	-	-	-	-	-	-	No cost for this activity. Can be done the MOH in charge of the program with support of partners
CHWs trained on symptoms of eye diseases, tools, and data collection and reporting,	135,500,000	-	142,275,000	-	149,388,750	**427,163,750**	Train CHWs: per diem (30.000*3000); training materials: pens, bloc note (300*30.000), participant guide (500*30.000), flip chart (200*5000), markers (100*3000), tape (50*1000); per diem facilitators: trainers (2*1000*5000), district supervisors (2*500*1000), central level (5*24.500) + (4*24.500+31.250)+ (2*24.500) +(2*31.250)+(2*42.000) + (4*24.500+42.000); drivers (4*5*5*13750)
F. Indicators for dental and oral health problems							
Tool for oral health diseases symptoms developed and disseminated	-	-	-	-	-	-	No cost for this activity. Can be done the MOH in charge of the program with support of partners
CHWs trained on oral health diseases symptoms, tools, and data collection and reporting	-	-	-	-	-	-	This activity can be combined with above activity on training CHW on eye symptoms and other conditions related to the eye.
G. Indicators for SGBV							
Tool on SGBV and existing support systems at village, cell and sector level developed and disseminated to CHWs	-	-	-	-	-	-	No cost for this activity. Can be done the MOH in charge of the program with support of partners
CHWs trained on SGBV and how to refer, tools, and data collection and reporting,	135,500,000	-	142,275,000	-	149,388,750	**427,163,750**	Train CHWs: per diem (30.000*3000); training materials : pens, bloc note (300*30.000), participant guide (500*30.000), flip chart (200*5000), markers (100*3000), tape (50*1000); per diem facilitators: trainers (2*1000*5000), district supervisors (2*500*1000), central level (5*24.500) + (4*24.500+31.250)+ (2*24.500) +(2*31.250)+(2*42.000) + (4*24.500+42.000); Drivers (4*5*5*13750)
CHWs conduct sensitization campaigns on SGBV in their villages	-	-	-	-	-	-	Activity costed under Outcome 2
H. Indicators for disabilities							

Tool on management of people living with a disability at home developed and disseminated to all CHWs	-	-	-	-	-	-	No cost for this activity. Can be done the MOH in charge of the program with support of partners
Number of teaching sessions conducted by the CHW to equip family members on the management of their family member living with a disability	-	-	-	-	-	-	**Consults units in the MOH in charge of health care for disability: how many family have the problem, so that we can cost it**
Sub-Total for Main Activities 1.10	**542,000,000**	**-**	**569,100,000**	**-**	**597,555,000**	**1,708,655,000**	
Total Cost to achieve Outcome 1						**30,531,781,331**	
Outcome 2: Communities (in all imidugudu) fully participate in all community-based health programs							
Output 2.1: Community mobilized in community health programs through house to house, community gatherings, e.g. Umuganda*, church, and media, such as radio*							
Main Activities 2.1							
Master training	6,693,000	-	7,362,300	-	-	**14,055,300**	National trainers(30*2700)Materials of training, lunch and break coffee, in 3 days, transport
Training of trainers at district level	129,706,200	-	142,676,820	-	-	**272,383,020**	
Training of CHWs on community health protocols	372,324,600	-	409,557,060	-	-	**781,881,660**	CHWs (45,011, materials of training, 3days, per diem of trainers(476*2*5000), supervisors at DH(43*2*5000)and transport:10000
Avail tools/IEC/BCC materials to all CHWs	137,985,000	-	151,783,500	-	-	**289,768,500**	Cost of the tool: 3000, for 45,011 CHWs, for DH: 43*2, for HC (476*2)
Design relevant messages to be disseminated via community gathering	148,400,000	-	163,240,000	-	-	**311,640,000**	Workshop for designing message of 5 days of 20 participants, with transport of 10000: 37000*5*20+10000*20; dissemination of the message at DH (in coordination meeting): 19500* 150 participants; dissemination at community level: 45,011*3000(transport of CHW)
Monitoring of Community Health protocol implementation	13,200,000	-	14,520,000	-	-	**27,720,000**	Supervision of NC and DH at the community level (per diem: 27000; in 5 days, in 5 province, by 2 supervisors in 4times by a year
Disseminate results for the data analysis report with all stakeholders (local leaders, partners, etc.) at district level	8,152,800	8,560,440	8,988,462	9,437,885	9,909,779	**45,049,366**	Workshop of dissemination of results: 2 participants per HC; transport: 10000, conference room: 100 000:flipchat:6000 and marker:4000,

Drama, interactive programs, organize radio and TV shows, SMS, radio and TV programs, TV/Radios spots,	12,280,000	-	13,508,000	-	-	**25,788,000**	Radio program 15minutes, one minute cost 150, every week, per year, production: 100,000; and spot radio: 250,000F once per month
Conduct quarterly meeting with stakeholders on Community health protocols	52,520,000	-	57,772,000	-	-	**110,292,000**	meeting at DH 43*2 participants and 25 facilitators from NC, 2 participants from HC (476)
Sub-Total for Main Activity 2.1	**881,261,600**	**8,560,440**	**969,408,142**	**9,437,885**	**9,909,779**	**1,878,577,846**	
Output 2.2: Community members involved in a process of analyzing local health needs and propose solutions							
Main Activity 2.2							
Conduct community health assessment needs through Umuganda once a semester (District local authorities involved in the identification of community health needs)	-	-	-	-	-	-	No cost for this activity
Insure the integration of community health assessment needs in district performance at all level	400,000	-	440,000	-	-	**840,000**	Meeting at village level: choose 30 participant (opinion leader: health club) for 2 days, per diem of 5000; hiring the conference room (50 000)
Organize evaluation on awareness on Community Health Programs	28,880,000	-	31,768,000	-	-	**60,648,000**	Workshop to prepare the evaluation: conference room for 2 days*50 000; 20 participants, transport, CL to coordinate the evaluation: 2 facilitators; per diem for 5 days; cars for 5 days
Sub-Total for Main Activity 2.2	**29,280,000**	**-**	**32,208,000**	**-**	**-**	**61,488,000**	
Output 2.3: Community health service utilization increased	-	-	-	-	-	-	
Main Activity 2.3							
Organize meeting to encourage community to initiate cooperatives to increase households income	400,000	-	440,000	-	-	**840,000**	Meeting at village level: choose 30 participant (opinion leader: health club) for 2 days, per diem of 5000; hiring the conference room (50 000)
-conduct campaign on community-based health insurance trough medias, community meetings and umuganda	400,000	-	440,000	-	-	**840,000**	Meeting at village level: choose 30 participant (opinion leader: health club) for 2 days, per diem of 5000; hiring the conference room (50 000)
Feedback meeting on audit recommendations	215,995	-	237,595	-	-	**453,590**	Meeting at DH with HC: transport of 5000 f
Training on customer care	25,431,000	-	27,974,100	-	-	**53,405,100**	Training of one person on customer care at DH and HC; per diem of 2 days and transport
Organize interactive radio programs on health services delivery	2,160,000	-	2,376,000	-	-	**4,536,000**	Radio program of 60 minutes: one second is 150*60*60 once per quarter and 4 times by a year
Sub-Total for Main Activity 2.3	**28,606,995**	**-**	**31,467,695**	**-**	**-**	**60,074,690**	

Total Outcome 2						**2,000,140,536**	
Outcome 3: CHW cooperatives and health service delivery strengthened and utilization increased through monetary and non-monetary incentives							
Output 3.1: CHW cooperatives subsidized for achieving high coverage indicators through CPBF							Hire consultant for 30 days at
Main Activities 3.1							
Conduct needs assessment for the implementation and sustainability of CPBF	15,799,980	-	17,379,978	-	20,855,974	**54,035,932**	2 National Consultants recruited at rate RWF 238,333/day for 30 days to do needs assessment. Dissemination of needs assessment report at estimated cost of 1,500,000FRW. Needs assessment to be done every 2 years
CHW cooperatives remunerated based on quarterly performance on predetermined indicators	4,800,000,000	4,080,000,000	3,468,000,000	2,947,800,000	2,505,630,000	**17,801,430,000**	Average budget for the CPBF per quarter is RWF 4,800,000,000. With the current CHW cooperatives profits increasing, we estimate to decrease the budget going to the CHW cooperatives by 15% annually.
Sub-Total for Main Activities 3.1	**15,799,980**		**17,379,978**		**20,855,974**	**17,855,465,932**	
Output 3.2: CHW performance indicators updated and reviewed to respond to national priorities							
Main Activities 3.2							
Annual review of community PBF indicators and assessment tools.	5,725,000	8,587,500	12,881,250	19,321,875	28,982,813	**75,498,438**	Invite: 25 participants. Per diem for only 5 days at RWF 42,000; local travel at RWF 10,000; training hall at RWF 150,000; training material at FRW 3,000
Refresher training to update all community PBF stakeholders	8,160,000	-	12,240,000	-	13,464,000	**33,864,000**	30 participants to be trained: 3 days in 2 sessions (6), per diem RWF 42,000. local travels for 30 participants at 10,000; training location: RWF 15,000/2 days
Disseminate reviewed tools to all community PBF stakeholders	400,000	-	440,000	-	484,000	**1,324,000**	Print 500 copies at RWF 50/copy for 10 copies. Transport for 50 at 3000/person

Quarterly CPBF indicators analysis and feedback meetings to stakeholders	125,760,000	132,048,000	138,650,400	145,582,920	152,862,066	**694,903,386**	Invite 60 participants: 3 days and 4 sessions (12), per diem for 60 participants at RWF 42,000; travels for 60 participants at RWF 10,000, and location for 4 days: 150,000 for 4 days.
Conduct annual CPBF system audit	9,840,000	10,332,000	10,848,600	11,391,030	11,960,582	**54,372,212**	Vehicle costs: visit 10 sites for an average duration of visit at 4 days (40) at RWF 78,000. Per diem for participants and a drive (4) at RWF 42,000.
Sub-Total for Main Activities 3 .2	**149,885,000**	**150,967,500**	**175,060,250**	**176,295,825**	**207,753,460**	**859,962,035**	
Output 3.3: Local structures capacities enhanced to effectively participate in the CHW PBF activities							
Main Activities 3.3							
Conduct functional analysis of the roles and responsibilities of different CPBF structures.	8,500,000	-	9,350,000	-	10,285,000	**28,135,000**	Recruit National (7,150,000) consultants for 40 days. Provide additional 500,000 RWF for transport and incidentals.
Review the CPBF institutional set up and ToRs of different structures.	8,500,000	-	9,350,000	-	10,285,000	**28,135,000**	
Conduct integrated supervision on CPBF	89,712,000	94,197,600	98,907,480	103,852,854	109,045,497	**495,715,431**	Vehicle costs: 42 sites to be visited for average duration of 2 days per visit (84), cost car-hiring 78,000. per diem for participants: 3 participants at each of 42 sites and a drive (126) and daily rate of 42,000. conducted 3X a year
Participate in the joint supervision (with partners) on CPBF	12,816,000	13,456,800	14,129,640	14,836,122	15,577,928	**70,816,490**	Vehicle cost: 8 selected sites visited for average 2 days (16 days). Per diem for 3 participants and drive at rate of 42,000
Sub-Total for Main Activities 3.3	**119,528,000**	**107,654,400**	**131,737,120**	**118,688,976**	**145,193,425**	**622,801,921**	
Output 3.4: CHW cooperatives' business activities strengthened							
Main Activities 3.4							
Subcontract private companies to support the management and business orientation of CHW cooperatives.	250,000,000	250,000,000	250,000,000	250,000,000	250,000,000	**1,250,000,000**	Annual cost of RWF 250,000,000 estimated based previous companies doing similar work for MOH
Develop procedures manual of CHW cooperatives	11,690,000	-	-	13,443,500	-	**25,133,500**	Per diem for 30 for 5 days for 1 session at 42,000 rate. Local travel for 30 participants at rate of 10,000. Training hall hiring 150,000 for 1 day. Training materials. Printing costs for 500 copies at 10,000 FRW

Training of CHW cooperatives on business plan elaboration	118,500,000		136,275,000	-	149,902,500	**404,677,500**	100 participants for 2 days for 30 sessions (60 training days per diem) at rate of RWF 14,000. Travel expenses: 100 participants for 30 sessions at rate of RWF 8,000. Training hall for 30 sessions at rate of RWF 150,000. Training materials for 100 participants, for 30 sessions at rate of RWF 3,000.
Quarterly assessment of CHW cooperatives' performance	20,000,000	21,000,000	22,050,000	23,152,500	24,310,125	**110,512,625**	Print 500 copies at cost of 1000 for 10.
Document and disseminate best practices on CHW cooperatives' businesses	5,042,000	-	5,546,200	-	6,100,820	**16,689,020**	Print 500 copies at cost of 1000 for 10. TPT for 42 at cost of 1000 each
Facilitate exchanges and study tours between CHW cooperatives	210,000,000	-	-	241,500,000	-	**451,500,000**	Study tour costs on 42 sites at cost of 5,000,000 each
Conduct integrated supervision on CHW cooperatives' activities							Already costed from other activities
Collaborate with specialized organs to facilitate financial audits of CHW cooperatives	83,700,000	87,885,000	92,279,250	96,893,213	101,737,873	**462,495,336**	Vehicle costs: Visit 50 sites each site for average 2 days (250), at cost car hire RWF 78,000. per diem for participants and a drive for 2 days in 50 sites (100) at rate RWF 42,000.
Institutionalize financial management software of CHW cooperatives							This is a process that will be guided by MOH staff and partners. There is no cost for this
Newsletter							
Conduct assessment of individual and cooperative benefit through their incomes generation activities.	10,000,000	-	11,000,000	-	12,100,000	**33,100,000**	Recruit local consultant at rate of RWF 200,000 for 40 days. Field transport and other logistics estimated at 2,000,000
Sub-Total for Main Activities 3.4	**708,932,000**	**358,885,000**	**517,150,450**	**624,989,213**	**544,151,318**	**2,754,107,981**	
Out 3.5: Community demand in health activities increased through non-monetary incentives (in-kind incentives)							
Main Activities 3.5							
Document the administrative process for delivering in-kind incentives.	-	8,588,000	-	-	-	**8,588,000**	Recruit local consultant: rate 200,000/day/40 to guide documentation processes. Per diem for 2 days and 2 sessions training (4) at rate of RWF 42,000. Training hall for 2 days for RWF 150,000. Training materials for 20 participants at cost of RWF 3,000.
Reformulate CH policy based on impact evaluation results of demand side.	-	6,000,000	-	-	-	**6,000,000**	Recruit local consultant: rate 200,000/day/30 to guide policy reformulation processes.
Sub-Total for Main Activities 3.5	-	14,588,000	-	-	-	**14,588,000**	
Total Cost to achieve Outcome 3						**22,106,925,868**	

Outcome 4: Reinforced coordination, planning, monitoring and evaluation of CH program at all levels							
Output 4.1: Joint CH annual operational planning developed and regularly monitored and evaluated							
Main Activities 4.1							
Develop joint CH annual operational planning by May at all levels	9,820,000	10,311,000	10,826,550	11,367,878	11,936,271	**54,261,699**	Operational plan workshop 100 people from DH, CHD, and Partners at 28500 FRW each for 3 days (100*28500*3). Transport of participants of 10,000 RWF each (10,000*100). Cost of training materials: preparation and printing costs (90,000/per day*3)
Organize bi-annual joint supervision (March & September)	9,930,000	10,426,500	10,947,825	11,495,216	12,069,977	**54,869,518**	supervisions to be done by 10 staff for 5 days by quarter(26250*5*10*4) and transport (78000*5*3*4)
Organize joint bi-annual reviews (April & October) of the operation plan (using joint supervision reports and M&E framework)	19,640,000	20,622,000	21,653,100	22,735,755	23,872,543	**108,523,398**	Bi-annual review with stakeholders. 100 people from DH, CHD, and Partners at 28500 FRW each for 3 days (100*28500*3). Transport of participants of 10,000 RWF each (10,000*100). Cost of training materials: preparation and printing costs (90,000/per day*3)
Implement annual assessment of priority CH program components and disseminate findings	89,343,750	93,810,938	98,501,484	103,426,559	108,597,887	**493,680,617**	Develop protocols and questionnaire, piloting questionnaire for 3 days (26250*5*3), train 60 evaluators for 3 days (26250*3*60 +transport (10000*60*3), and then conduct assessments of programs for 30 days (26250*30*60) +transport(78000*15*30)+ communication for the organizers(2500*30)
Conduct mid term and final evaluation of strategic plan implementation	4,905,000	5,150,250	5,407,763	5,678,151	5,962,058	**27,103,221**	workshop to conduct mid term evaluation with stakeholders and CHD FOR days. (28250*70*2)+transport (10000*70)+workshop hall (100000*2)+printing tools (50000)
Sub-Total for Main Activities 4.1	133,638,750	140,320,688	147,336,722	154,703,558	162,438,736	**738,438,453**	
Output 4.2: Capacity of CH staff on coordination, planning and M&E strengthened							
Main Activities 4.2							
Administrative Planning and overheads	60,000,000	63,000,000	66,150,000	69,457,500	72,930,375	**331,537,875**	

Sustain skilled staff for CH coordination, planning and data management (hiring, career development)	76,350,000	80,167,500	84,175,875	88,384,669	92,803,902	**421,881,946**	Hiring 3 managers for 12 months(1050000*12*3) , external training of 5 CH staff for 2 weeks; air ticket and DSA (130000*14*5+650000*5), 10 for external workshops(130000*7*20+400000*20)
Develop, implement and monitor annual capacity building plan as part of the annual operational plan (by May) for CH staff at all levels	2,950,000	-	3,097,500	-	3,252,375	**9,299,875**	1 consultant for 10 working days(230000*10+650000)
Ensure routine and targeted supportive supervision of CH staff (tools, transport…)	35,784,000	37,573,200	39,451,860	41,424,453	43,495,676	**197,729,189**	DSA for 6 people(30000*6*42*3), transport (78000*4*42)
Sub-Total for Main Activities 4.2	**115,084,000**	**117,740,700**	**126,725,235**	**129,809,122**	**139,551,953**	**960,448,885**	
Output 4.3: CH data quality and routine use are reinforced to inform decision making							
Main Activities 4.3							
Establish a multi-stakeholders monitoring framework for CH interventions (bottlenecks and key dashboard indicators)	37,200,000	39,060,000	41,013,000	43,063,650	45,216,833	**205,553,483**	Institutional consultant to update and maintain CH E-Systems(3000000*12), 3 days workshop to develop MCH multi-stakeholder monitoring framework(30000*10*3+100000*3)
Harmonize data collection tools at all levels and ensure constant availability on the field	488,400,000	-	512,820,000	-	538,461,000	**1,539,681,000**	5 day workshop(30000*10*5+100000*5), 30 participants, cost of printing(45000*3*500+45000*2500), Data dissemination meeting with districts(30000*520*2+100000*2), dissemination meetings at districts(45000*3000*2) Trainers(500*5000*2)
Ensure well-functioning community e-health system (RHMIS, RapidSMS, mUbuzima, CHW-CF)	4,680,000	4,914,000	5,159,700	5,417,685	5,688,569	**25,859,954**	On site visit to support community e-health system (78000*5*12)
Conduct data quality audits and ensure timely feedback	598,160,000	628,068,000	659,471,400	692,444,970	727,067,219	**3,305,211,589**	5 day workshop(30000*10*5+100000*5), 30 participants, Data quality audits in districts(30000*30*5*30*4), Transport for 30 people(78000*6*30*4)
Ensure monthly data cleaning	-	-	-	-	-	-	No funds required
Ensure quarterly data analysis for selected key indicators according to the M&E plan (including data triangulation)	-	-	-	-	-	-	No funds required
Implement data sharing coordination meetings (monthly at HC and community levels and quarterly at district level)	15,000,000	15,750,000	16,537,500	17,364,375	18,232,594	**82,884,469**	5 day meeting with districts (30000*100*4+100000*5*4), Transport for 100 people(10000*100)

Ensure dissemination of feedback through quarterly bulletin, including verbal autopsy activity recommendation	250,000	262,500	275,625	289,406	303,877	**1,381,408**	Printing of bulletins(500*500)
Sub-Total for Main Activities 4.3	**15,250,000**	**16,012,500**	**16,813,125**	**17,653,781**	**18,536,470**	**84,265,877**	
Output 4.4: Strategic participatory partnerships are reinforced							
Main Activities 4.4.							
Organize quarterly CH TWG and monthly sub-TWG (including M&E team)	-	-	-	-	-	-	No funds required . Partner (Co-chair) of the CHD to host the members
Ensure quarterly CH coordination meeting with all stakeholders including feedback and follow-up of recommendations	70,200,000	73,710,000	77,395,500	81,265,275	85,328,539	**387,899,314**	5 day workshop with stakeholders and district officials (120*5*26250), transport fees (10000*120) +meeting room (120000*5)
Conduct annual partners' mapping for equitable geographical CH services coverage (March), including detailed service CH package	-	-	-	-	-	-	meeting with partners to discuss the mapping of the community health activities.
Sub-Total for Main Activities 4.4	**70,200,000**	**73,710,000**	**77,395,500**	**81,265,275**	**85,328,539**	**387,899,314**	
Output 4.5: Operational research on CH priorities supported and conducted							
Main Activities 4.5.							
Advocacy for resources mobilization for operational research	-	-	-	-	-	-	No funds required
Implement operational research and dissemination	100,000,000	105,000,000	110,250,000	115,762,500	121,550,625	**552,563,125**	Operational research and dissemination(20000000*10)
Ensure regular documentation on global CH operational research findings to inform innovations	10,480,000	11,004,000	11,554,200	12,131,910	12,738,506	**57,908,616**	Participation in international research workshops for 3 people (130000*7*3+650000*3), Organizing international workshops on Community health(60*6000*5+3000*60*2*5+400000*5), Materials(200000)
Sub-Total for Main Activities 4.5	**110,480,000**	**116,004,000**	**121,804,200**	**127,894,410**	**134,289,131**	**610,471,741**	
Total Cost to achieve Outcome 4						**2,781,524,269**	
Grand Total						**57,420,372,004**	

11.8 Annex 8. Resource Gap Analysis

Resource Gap Analysis for Community Health Strategic Plan 2013-2018 (RWF)

Main Strategic Actions for Outcomes	Resource Needs					Total Resources needs (5yrs)	Estimated Resources Available from GVT and Partners					Total Resources Available (5 yrs)	Resource Gap					Total Resource Gap (5 yrs)
	2013/14	2014/15	2015/16	2016/17	2017/18	2013-2018	2013/14	2014/15	2015/16	2016/17	2017/18	2013-2018	2013/14	2014/15	2015/16	2016/17	2017/18	2013-2018
Outcome 1																		
Sub-Total for Main Activities 1.1	15,780,000	16,569,000	17,397,450	18,267,323	19,180,689	**87,194,461**				-	-	-	15,780,000	16,569,000	17,397,450	18,267,323	19,180,689	**87,194,461**
Sub-Total for Main Activities 1.2	31,505,000	-	34,655,500	-	38,121,050	**104,281,550**	-	-	-	-	-	-	31,505,000	-	34,655,500	-	38,121,050	**104,281,550**
Sub-Total for Main Activities 1.3	195,750,000	195,037,500	215,289,375	215,028,844	236,805,286	**1,057,911,005**	3,356,640	-	-	-	-	**3,356,640**	192,393,360	195,037,500	215,289,375	215,028,844	236,805,286	**1,054,554,365**
Sub-Total for Main Activities 1.4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sub-Total for Main Activities 1.5	232,670,000	111,426,000	256,202,300	122,847,165	282,115,023	**1,005,260,488**	367,000,000	467,400,000	509,872,000	-	-	**1,344,272,000**	(134,330,000)	(355,974,000)	(253,669,700)	122,847,165	282,115,023	**(339,011,512)**
Sub-Total for Main Activities 1.6	369,607,500	240,786,000	400,127,175	265,466,565	433,406,862	**1,709,394,102**	-	-	-	-	-	-	369,607,500	240,786,000	400,127,175	265,466,565	433,406,862	**1,709,394,102**
Sub-Total for Main Activities 1.7	3,120,503,200	3,171,336,000	3,440,104,320	3,496,397,940	3,792,439,509	**17,020,780,969**	-	-	-	-	-	-	3,120,503,200	3,171,336,000	3,440,104,320	3,496,397,940	3,792,439,509	**17,020,780,969**
Sub-Total for Main Activities 1.8	3,320,429,000	-	149,050,000	1,245,307,700	163,955,000	**4,878,741,700**	97,192,000	184,607,760	216,155,993	-	-	**497,955,753**	3,223,237,000	(184,607,760)	(67,105,993)	1,245,307,700	163,955,000	**4,380,785,947**
Sub-Total for Main Activities 1.9	1,300,079,600	-	1,430,087,560	-	1,573,096,316	**2,959,562,056**	-	-	-	-	-	-	1,300,079,600	-	1,430,087,560	-	1,573,096,316	**2,959,562,056**
Sub-Total for Main Activities 1.10	542,000,000	-	569,100,000	-	597,555,000	**1,708,655,000**	-	-	-	-	-	-	542,000,000	-	569,100,000	-	597,555,000	**1,708,655,000**
Total Cost	**9,128,324,300**	**3,735,154,500**	**6,512,013,680**	**5,363,315,536**	**7,136,674,735**	**30,531,781,331**	**467,548,640**	**652,007,760**	**726,027,993**	-	-	**1,845,584,393**	**8,660,775,660**	**3,083,146,740**	**5,785,985,687**	**5,363,315,536**	**7,136,674,735**	**28,686,196,938**
Outcome 2																		
Sub-Total for Main Activities 2.1	881,261,60	8,560,440	969,408,14	9,437,885	9,909,779	**1,878,577,84**	-	-	-	-	-	-	881,261,60	8,560,440	969,408,142	9,437,88	9,909,779	**1,878,577,846**

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Sub-Total for Main Activities 2.2	29,280,000	-	32,208,000	-	-	**61,488,000**	-	-	-	-	-	-	29,280,000	-	32,208,000	-	-	**61,488,000**
Sub-Total for Main Activities 2.3	28,606,995	-	31,467,695	-	-	**60,074,690**	-	-	-	-	-	-	28,606,995	-	31,467,695	-	-	**60,074,690**
Total Cost	**939,148,595**	**8,560,440**	**1,033,083,837**	**9,437,885**	**9,909,779**	**2,000,140,536**	-	-	-	-	-	-	**939,148,595**	**8,560,440**	**1,033,083,837**	**9,437,885**	**9,909,779**	**2,000,140,536**
Outcome 3																		
Sub-Total for Main Activities 3.1	15,799,980	-	17,379,978	-	20,855,974	**17,855,465,932**	2,313,429,142	2,412,967,211	1,568,864,009	1,183,313,270	1,183,313,270	**8,661,886,902**	(2,297,629,162)	(2,412,967,211)	(1,551,484,031)	(1,183,313,270)	(1,162,457,296)	**9,193,579,030**
Sub-Total for Main Activities 3.2	149,885,000	150,967,500	175,060,250	176,295,825	207,753,460	**859,962,035**			-	-	-	-	149,885,000	150,967,500	175,060,250	176,295,825	207,753,460	**859,962,035**
Sub-Total for Main Activities 3.3	119,528,000	107,654,400	131,737,120	118,688,976	145,193,425	**622,801,921**	-	-	-	-	-	-	119,528,000	107,654,400	131,737,120	118,688,976	145,193,425	**622,801,921**
Sub-Total for Main Activities 3.4	708,932,000	358,885,000	517,150,450	624,989,213	544,151,318	**2,754,107,981**	-	-	-	-	-	-	708,932,000	358,885,000	517,150,450	624,989,213	544,151,318	**2,754,107,981**
Sub-Total for Main Activities 3.5	-	14,588,000	-	-	-	**14,588,000**	-	-	-	-	-	-	-	14,588,000	-	-	-	**14,588,000**
Total Cost	**994,144,980**	**632,094,900**	**841,327,798**	**919,974,014**	**917,954,177**	**22,106,925,868**	**2,313,429,142**	**2,412,967,211**	**1,568,864,009**	**1,183,313,270**	**1,183,313,270**	**8,661,886,902**	(1,319,284,162)	(1,780,872,311)	(727,536,211)	(263,339,257)	(265,359,093)	**13,445,038,966**
Outcome 4																		
Sub-Total for Main Activities 4.1	133,638,750	140,320,688	147,336,722	154,703,558	162,438,736	**738,438,453**	23,000,000	57,250,000	57,250,000	-	-	**137,500,000**	110,638,750	83,070,688	90,086,722	154,703,558	162,438,736	**600,938,453**
Sub-Total for Main Activities 4.2	115,084,000	117,740,700	126,725,235	129,809,122	139,551,953	**960,448,885**	50,930,350	50,930,350	50,930,350	-	-	**152,791,050**	64,153,650	66,810,350	75,794,885	129,809,122	139,551,953	**807,657,835**
Sub-Total for Main Activities 4.3	15,250,000	16,012,500	16,813,125	17,653,781	18,536,470	**84,265,877**	59,940,000	79,920,000	-	-	-	**139,860,000**	(44,690,000)	(63,907,500)	16,813,125	17,653,781	18,536,470	**(55,594,123)**
Sub-Total for Main Activities 4.4	70,200,000	73,710,000	77,395,500	81,265,275	85,328,539	**387,899,314**	-	-	-	-	-	-	70,200,000	73,710,000	77,395,500	81,265,275	85,328,539	**387,899,314**
Sub-Total for Main	110,4	116,0	121,8	127,8	134,2	**610,47**	-	-	-	-	-	-	110,4	116,0	121,804,2	127,	134,289,13	**610,471,741**

Activities 4.5	80,000	04,000	04,200	94,410	89,131	**1,741**							80,000	04,000	00	894,410	1	
Total Cost	**444,652,750**	**463,787,888**	**490,074,782**	**511,326,146**	**540,144,828**	**2,781,524,269**	**133,870,350**	**188,100,350**	**108,180,350**	**-**	**-**	**430,151,050**	**310,782,400**	**275,687,538**	**381,894,432**	**511,326,146**	**540,144,828**	**2,351,373,219**
Grand Total						**57,420,372,004**						**10,937,622,345**						**46,482,749,659**