

RWANDA'S COMMUNITY HEALTH WORKER PROGRAM^r



Summary

Background

The Rwanda CHW Program was established in 1995, aiming at increasing uptake of essential maternal and child clinical services through education of pregnant women, promotion of healthy behaviors, and follow-up and linkages to health services.¹ An estimated 45,000 CHWs operating at the village level provide the first line of health service delivery. There are three CHWs in each village: a male-female CHW pair (called *binômes*) providing basic care and integrated community case management (iCCM) of childhood illness, and a CHW in charge of maternal health, called an ASM (*Agent de Sante Maternelle*).¹



Implementation

When the MOH endorsed the program in 1995, there were approximately 12,000 CHWs. By 2005, the program had grown to over 45,000 CHWs. From 2005, after the decentralization policy had been implemented nationally, the MOH increased efforts to improve MCH services, and between 2008 and 2011, Rwanda introduced iCCM of childhood illness (for childhood pneumonia, diarrhea, and malaria). In 2010, the Government of Rwanda introduced FP as a component of the national community health policy.

Training

Although it is acknowledged in the Community Health Development Strategy that the CHWs in Rwanda should be appropriately trained,¹ documentation detailing the duration, format, and content of overall training is difficult to find. However, in-depth information is available about CHW training for specific programs such as community-based provision of FP and community-based IMCI.

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Roles/responsibilities

Three CHWs, with clearly defined roles and responsibilities, operate in each village of approximately 100–150 households.¹ The ASM identifies pregnant women, makes regular follow-ups during and after pregnancy, and ensures deliveries in health facilities where skilled health workers are available. *Binômes* provide iCCM (assessment, classification, and treatment or referral of diarrhea, pneumonia, malaria, and malnutrition in children younger than 5 years of age), community-based provision of contraceptives, DOT for TB, prevention of NCDs, and preventive and behavior change activities.

Incentives

Although CHWs in Rwanda are volunteers, in 2009, the MOH introduced community performance-based financing (CPBF) as a way to motivate CHWs.² CHW Cooperatives are organized groups of CHWs that receive and share funds from the MOH based on the achievement of specific targets established by the MOH. By linking incentives to performance, the MOH hoped to improve quality and utilization of health services.²

Supervision

Cell coordinators, sometimes assisted by an assistant cell coordinator, visit CHWs to monitor activities, monitor supplies and drugs, and compile all reports from CHWs and submit the information to the In-Charge of Community Health on a quarterly basis. As part of this supervision, cell coordinators also make house visits to see how the CHWs are performing their activities there and verify reports that have been sent by CHWs using mobile phone text messaging (SMS) to the health center.¹ In addition to this line of supervision, the CHW cooperatives also perform an evaluative function and CHWs are incentivized based on the performance of the cooperative.

Impact

Rwanda is close to being on track to achieving its MDGs for MCH by 2015. Its CHW program has played an important role in expanding coverage of basic services, particularly community-based FP services and treatment of childhood malaria and pneumonia.

What is the historical context of Rwanda's Community Health Worker Program?

Rwanda started its community health program in 1995 after the genocide. There are four main objectives of the program: (1) strengthen the capacity of decentralized structures to allow community health service delivery; (2) strengthen the participation of community members in community health activities; (3) strengthen CHW motivation through CPBF to improve health service delivery; and (4) strengthen coordination of community health services at the central, district, health center, and community levels.¹

When the MOH endorsed the program in 1995, there were approximately 12,000 CHWs. By 2005, the program had grown to over 45,000 CHWs. From 2005, after the decentralization policy had been implemented nationally, the MOH increased efforts to train and provide supplies to CHWs to deliver MCH services. The program has since grown to include an integrated service package that includes malnutrition screening, treatment of TB patients with DOT, prevention of NCDs, community-based provision of contraceptives, and promotion of healthy behaviors and practices including hygiene, sanitation, and family gardens.¹

What are Rwanda's health needs?

Overall, the Government of Rwanda has demonstrated commitment to the MDGs through its health sector programs and various policies. Notable improvements have been achieved in maternal health: 69% of deliveries are now assisted by a skilled provider, up from 39% in 2005;

maternal mortality has declined from one of the highest in the world (1,071 deaths per 100,000 live births) in 2000 to 487 in 2010; and contraceptive use has increased from 10% in 2000 to 45% in 2010.³ In addition, there has been a vast improvement in the nutritional status of children: between 2005 and 2010, the percentage of children who were underweight declined from 18% to 11% and the percentage of children who were stunted declined from 51% to 44%.³ Infectious diseases—mainly malaria, ARIs, and intestinal parasites—remain the primary cause of outpatient morbidity.³

Although Rwanda has achieved great success in its health sector, it still faces major challenges that include reaching the most vulnerable populations, supporting adequately its CHWs, improving community participation, strengthening programs for NCD prevention, and expanding the financial contribution of the private sector to ensure financial self-reliance of health services.⁴

What is the existing health infrastructure?

Health sector decentralization laws were implemented in 2005–2006. This led to health personnel and financial resources being decentralized to the district level and the MOH changing its role to a technical supervisor while district governments controlled health program implementation.³ Significant authority and resources have been transferred from the district level to the health centers and posts within the district.³ Health services are provided in communities, at health posts (HPs), health centers (HCs), district hospitals (DHs), and referral hospitals. Currently in Rwanda there are four referral hospitals, 42 district hospitals in 30 districts, and 438 health centers.³ At the lowest level, those in charge of community health activities in the catchment areas of health centers supervise CHWs. The CHWs receive financial compensation through performance-based financing (PBF), determined by the number of essential health services provided. Thirty percent of the total PBF funds is shared among individual CHW members while 70% is deposited in the collective funds of CHW cooperatives. Within each district there are Health Center Committees that provide oversight of community health work, which is directly supervised by various units in each health center. These units include outreach, supervision, and financial control.¹

What type of program has been implemented?

In each village of approximately 100–150 households, there is one maternal health CHW (ASM) and two multidisciplinary CHWs (*binômes*, or the man and woman working as a pair). CHWs are full-time, voluntary workers who play a very key role in extending services to Rwanda's village communities. The CHWs are supervised most directly by the cell coordinator and the in-charge of community services at the catchment-area health center. CHWs now use RapidSMS to submit reports and communicate alerts to the district level and to hospitals or health centers regarding any maternal or infant deaths, referrals, newly identified pregnant women, and newborns in the community.

As decentralization occurred beginning in 2005 and MCH is a top priority for the MOH, a huge focus was placed on basic MCH needs. ASMs have been trained to identify pregnant women, make regular follow-ups during and after pregnancy, and encourage deliveries in health facilities where skilled health workers are available. In addition to following up pregnant women and their newborns, the ASM also screens children for malnutrition, provides contraceptives (pills, injectables, cycle beads, and condoms), promotes prevention of NCDs through healthier lifestyles, and carries out household visits.¹ Between 2008 and 2011, Rwanda introduced iCCM of childhood illness (for childhood pneumonia, diarrhea, and malaria) nationwide. *Binômes* were trained and equipped to provide iCCM (including treatment with antibiotics, zinc, and antimalarials), to detect cases of acute illness in need of referral, and to submit monthly reports. In 2010, the Government of Rwanda introduced FP as a component of

the national community health policy, and CHWs were trained not only to counsel but also to provide contraceptive methods including pills, injectables, cycle beads (for use with natural FP), and condoms. This program was first piloted in three districts and later scaled nationwide.

What about the community's role?

Community engagement is a key objective of Rwanda's community health strategy. There are many ways in which communities are involved in improving their health and their access to services; CHWs are but one strategy. Insofar as the CHWs are concerned, however, the community's only role is to recruit CHWs from their villages. Involving the community to a greater degree is a challenge that is documented in Rwanda's new health sector policy documents.⁵

How does Rwanda select, train, and retain its Community Health Workers?

CHWs come from the villages in which they live. They must be able to read and write and be between the ages of 20 and 50 years. They also must be willing to volunteer and be considered by their peers to be honest, reliable, and trustworthy.¹ They are elected by village members¹ in a process that involves gathering the volunteers and villagers on the last Saturday of the month (*Umuganda*, or community service day) and voting "with their feet" in a literal sense. The process has been described (in conversation) as one that involves community members lining up in front of the person they support. The individual with the most support is recruited.

Within each of the villages (*Umdugudu*), *Binômes* are trained in community-based IMCI by preparing them to be first responders to a number of common childhood illnesses, including pneumonia, diarrhea, and malaria. The CHWs are also trained on when and how to refer severe cases to the facility. IMCI refresher training is provided through a supportive supervision model, where the supervisor conducts training to strengthen the CHW's knowledge and skills in providing quality case management services in their communities.⁶

Another example of program-specific training is the ten-day training for community-based provision of FP services.⁷ A total of 3,061 CHWs in three districts have received this training, which uses participatory methods, having CHWs brainstorm ideas and practice exercises such as role plays and performing rapid diagnosis tests for malaria.⁷

In 2001, prior to the introduction of performance-based incentives and CHW cooperatives, health workers in Rwanda had very low, fixed salaries that were distributed regardless of performance. This led to a demotivated and low-performing workforce.⁴ In 2009, the MOH introduced CPBF as a way to motivate CHWs.² CHW Cooperatives are organized groups of CHWs that receive and share funds from the MOH based on the achievement of specific targets established by the MOH. Currently, 449 CHW cooperatives exist in Rwanda, with approximately half of these being formally registered and legally recognized.² Each health center in Rwanda supervises the CHWs that make up one CHW cooperative. By linking incentives to performance, the MOH hoped to improve quality and utilization of health services.² In 2009–2010, the Government of Rwanda piloted the CPBF, and saw a dramatic improvement in maternal health indicators. This demand-side model, which uses CHWs to ensure that women seek appropriate maternal care, led to marked improvements in reported indicators such as the number of deliveries attended by a trained provider and the number of ANC visits.²

How is the program financed?

Rwanda's health system financing originates from two main sources. On the supply side, the central treasury transfers funds to districts and health facilities. On the demand side, the system provides health insurance payments for documented services.³ In recent years, much of

the total health expenditures of the Government of Rwanda have come from external sources such as the Global Fund to Fight AIDS, Tuberculosis and Malaria; PEPFAR (the President's Emergency Plan for AIDS Relief); and the President's Malaria Initiative. In 2011, 47% of the government's total health expenditures (\$407 million) was supplied by donors.³

However, the Government of Rwanda has increased its own spending on essential health services since 2005; spending is projected to reach 15% of the government's total budget by 2015.³ Community-based health insurance schemes have allowed for 92% of the population to be insured. This has greatly increased access to health care service and drugs.³

What are the program's demonstrated impact and continuing challenges?

The most notable achievements in the health sector include an increase in facility-based deliveries (from 45% to 69%), the introduction of maternal and child death audits at all health facilities, an increase in vaccination coverage (from 80% to 90% for coverage of the complete vaccination scheme), CHW follow-up of all pregnant women, and provision of community-based FP services.³ CHWs are currently testing all suspected cases of malaria with a rapid diagnostic test and providing treatment when indicated, making it possible now to treat 91% of children younger than 5 years of age who have malaria within 24 hours.³

The challenges faced by the Rwanda CHW program are similar to challenges faced by CHW programs in other countries. These include (1) the financial and administrative difficulties in supporting and continuing to build the capacity of CHWs as they increase in number and as the scope of their work expands; (2) the challenge of supervising and effectively equipping CHWs to perform their duties; and (3) low community participation in the health sector and the strong influence of traditional beliefs and traditional medicines. As the number of CHWs has risen rapidly in Rwanda and as their tasks have increased, the Government of Rwanda faces a constant battle to increase the capacity of CHWs and to provide them with the equipment and supplies they need. Refresher trainings are too few and provision of essential equipment is delayed due to insufficient financial resources.⁴ Field supervision of CHWs and the transfer of skills and knowledge to the communities to foster ownership and enhance sustainability is a continuing challenge.³ Each CHW is supposed to be supervised by either the In-Charge of Community Health or the cell coordinator on monthly basis. However, recent findings show that supervisory visits occur only quarterly, if that.⁷

References

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