

# Community performance-based financing in health

Incentivizing mothers and community health workers  
to improve maternal health outcomes in Rwanda

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## Executive Summary

The objective of this paper is to illustrate Rwanda's experience on how innovative approach of empowering Community Health Workers (CPBF) and incentivizing mothers through Community performance-based financing (CPBF) approach has improved maternal indicators.

About 6 years ago, the majority of Rwandan population (about 80%) who are mainly located in rural areas lacked access to primary health care services due to several reasons; among them insufficient and unmotivated health workers. WHO recognizes that to improve health outcomes in general and reach the MDGs in developing countries, addressing the human resource for health (HRH) should be one of the priorities (Global Forum on HRH, Thailand, Bangkok, January 2011). For the past decades, Rwanda was faced with a shortage of HRH especially as evidenced by the following ratios: *Doctor/Pop Ratio: 1 /50.000; Nurse / Pop Ratio=1 /3.900; Midwives / Pop Ratio=1 / 100.000 (DHS 2005)*. The HRH crisis is worst in rural areas: only 17% of nurses serve the rural areas whereas Kigali City, with only 10% of the population, is served by 75% of doctors and 60 % of nurses (Basinga, 2009).

To narrow the gap and provide a rapid response, in 2005 the Ministry of Health (MOH) introduced a policy on community health workers (CHW). Despite CHW presence, the improvements in maternal and child health indicators remained modest. In 2009, inspired by the success of clinical performance-based funding (PFB)<sup>1</sup>, the MOH initiated the community PBF (CPBF) as a way to motivate CHW. During the same period, targeting women, a demand-side incentive strategy was introduced to 31 of Rwanda's poorest health centers in 30 sectors as a pilot intervention. Three key maternal and child indicators were selected and monitored over a year period; within this program, a research project was included. In 2010, after 9 months implementing the pilot project, the improvements observed during the preliminary evaluation prompted the MOH to scale up the program. This paper will present the results and lessons learned of the pilot phase because the

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<sup>1</sup> Paulin Basinga, MD, PhD. Tulane University, 2009, Thesis: Impact of Performance-Based Financing on the quantity and quality of maternal health services in Rwanda.

implementation of the national program is on-going. A wider impact evaluation will show comprehensive results and impacts after 2013.

Preliminary results showed that 86% more women accessed antenatal services for the first nine months in 2010 compared to the same period in 2009; antenatal care target was exceeded by 26%. In 2010, 16% more women delivered at health centers compared to 2009. The target for postnatal consultations increases almost three folds. It was concluded that the demand-side incentive strategy targeting women for the first one year showed encouraging results.

Available results demonstrate that access to maternal care is being achieved and set targets are being exceeded. The big challenge seem to point to the financial sustainability of program; however both Governments and Donors continuously look for programs showing highest returns on their investment and CPBF seems to be the case.

Rwanda is steadily showing the path to improving maternal health services; the CPBF is one of the policies that can be replicated in other developing countries; however adaptation according to different contexts should be considered.

## Problem Statement

With a population of close to 11 million and a population density of 436 persons/square km<sup>2</sup>, Rwanda is the most densely populated country in Africa. Located in Great Lakes region of Central Africa, Rwanda consists of 4 provinces plus the City of Kigali. The four provinces make up the 30 districts that are considered as local administration; each district is divided into sectors. Each sector is divided into numerous cells and each cell is further sub-divided into villages (a village consists 50 to 150 households). Community Health Workers (CHW) are elected at village level.

Six years ago, close to 80% of the Rwandan population constituting the informal sector and mainly located in rural areas lacked access to primary health care services due to several reasons; among them is the insufficient and unmotivated number of health workers. WHO recognizes that to improve health outcomes in general and reaching the MDGs in developing countries, addressing the human resource for health (HRH) crisis is one of the priorities (Global Forum on HRH, Thailand, Bangkok,



January 2011). For the past decades, Rwanda was faced with a shortage of HRH especially as evidenced by the following ratios: Doctor/Pop Ratio: 1 /50.000; Nurse / Pop Ratio=1 /3.900; Midwives / Pop Ratio=1 / 100.000 (DHS 2005). The HRH crisis is worst in rural areas: only 17% of nurses serve the rural areas whereas Kigali City, with only 10% of the population, is served by 75% of doctors and 60% of nurses (Basinga, 2009).

To cover the gap and provide a rapid response, the Ministry of Health (MOH) introduced a policy on CHW and inspired by the success of clinical performance-based financing (PBF)<sup>2</sup>, the MOH initiated the community PBF (CPBF) as a way to motivate CHW. PBF concept is based on the assumption that linking incentives to performance will contribute to increases in health care utilization and quality of services. It emphasizes output financing mechanisms rather than relying solely on input-based financing. However, the clinical PBF was more effective on services where providers had more control and less on patients' decisions. The evidence produced by the impact evaluation of health center PBF showed that prenatal care and family planning utilization remained relatively low. This convinced even more the MOH to introduce CPBF with the aim of providing incentives to mothers and CHW in order to ensure early follow up and transfer of women from the community to health centers.

The objective of this paper is to illustrate Rwanda's experience in implementing an innovative policy aimed at empowering CHW and incentivizing mothers to attend prenatal care and assisted deliveries. Generally, CPBF has three intervention arms: supply-side, demand-side, both supply and demand-side, and control. This documentation will show how initial improvements in demand-side<sup>3</sup> strategy have been achieved; however, the overall impact of the CPBF program will be shown by a prospective "CPBF impact evaluation" started in 2009 and expected to end in 2013 when implementation period also ends.

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<sup>2</sup> Paulin Basinga, MD, PhD. Tulane University, 2009, Thesis: Impact of Performance-Based Financing on the quantity and quality of maternal health services in Rwanda.

<sup>3</sup> The available data as is limited to the demand-side strategy.

## Context

As said previously, the rural area where 80% of the population is located was underserved in term of HRH and as a result, it was lagging behind in term of maternal health indicators. The demographic health surveys (DHS) of 2005 and the preliminary results illustrate the gap between the urban and rural areas: In 2005, the total fertility rate (TFR) was 6.1 children in general with 4.9 for urban women, and 6.3 for rural women while the use of modern contraceptive methods was estimated at 10% overall with rural areas getting a coverage of 9% while the urban area was covered with 21%; the children delivered with trained birth attendant were estimated at 39% with the rural area served at 36% and the urban area at 63%. The lack of proper access to family planning and antenatal care of the majority rural women was contributing significantly to the reducing but still significant maternal mortality ratio estimated in 2005 at 750 deaths for every 100,000 live births.

Rwanda is determined to achieving its Vision 2020 laid out in its development agenda, the Economic and Development and Poverty Reduction Strategy (EDPRS). The EDPRS is designed to achieve both the Rwanda Vision 2020 and the MDGs, including maternal and child MDGs. Thus the main objective of the CPBF program was to address the huge HRH deficit through a rapid mobilization of an important mass of health workers rapidly available at community level. Before 2006, CHW were purely volunteers and although they were working hard, they were not delivering as expected. The MOH introduced CPBF for specific key indicators<sup>4</sup>. Thus, the subsequent step was to create a community-level governing structure that would allow CPBF funds to flow from the MOH and development partners to grassroots mothers community health workers to support existing efforts to improve health priorities envisioned in Rwanda's Vision 2020 and the MDGs.

The Community Health Desk within the Ministry of Health was introduced in 1995 in an effort to support the implementation of community health activities in order to improve access to Primary Health Care (PHC) services. In working at reaching national and international goals, community health was further strengthened by The National Community Health Policy of 2008 and the Rwandan Economic Development and Poverty Reduction Strategy (EDPRS) of 2008-2012. In trying to make it

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<sup>4</sup>With the aim of accelerating the achievements of the MDGs, the focus was made on high impact community level health interventions. Several indicators were selected based on priority intervention and MDGs; among are prenatal care, assisted deliveries and postnatal care.

more concrete, the Rwanda Health Sector Strategic Plans (HSSP) outline concrete actions in community health. Currently, the MOH is implementing the HSSP II, 2009-2012 with key proven strategies. The mid-term evaluation of the HSSP II has been done and provides evidence of the contribution of CPBF in improving key maternal health outcomes.

## Planning

Once the decision to implement CPBF was taken, in 2008, the planning process began; the MOH selected Technical Working Group (TWG) composed of staff from MOH and development partners to lay a foundation with basic principles<sup>5</sup>, such as: (1) decentralization of CPBF funds to the sectors and

health centers, (2) formation of a data verification committee at the sector level, (3) development of contracts between stakeholders, and (4) standardization of data collection tools and reports. The Government of Rwanda (GoR) set up an administrative model to ensure good governance of the CPBF program. From the CPBF planning process, two phases were identified:

**The pilot phase (demand-side incentives):** This phase aimed at assessing the acceptability of a demand-side incentive strategy before scale up; it was implemented in 2009 for a period of 10 months (between 2009 and 2010). This phase involved 31 health centers included in 30 Sectors; each Sector selected represented the poorest Sector within a District (Rwanda is made of 30 Districts and 416 Sectors). Only one poorest Sector had 2 health centers selected because it was a very large Sector unusually containing two health centers<sup>6</sup>. The MOH took advantage of the already selected VUP<sup>7</sup> sectors as priority areas to introduce the program. In selected VUPs, Districts were asked to rank their sectors according to poverty level, using 5 criteria: (1) food security, (2) water access, (3) distance to education, (4) distance to health centre, and (5) level of village settlement. In mid 2010, an assessment of the impact of the pilot phase was made; the results showed a dramatic

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<sup>5</sup> Community PBF Handbook, February 2009, Ministry of Health.

<sup>6</sup> Every Sector has one health center.

<sup>7</sup> VUP stands for "Vision 2020 Umurenge Project" and it's a social protection program developed by Government of Rwanda to tackle extreme poverty within each District and make it a model for the rest of the District.

improvement in maternal health indicators that will be presented in the next sections. The subsequent sections of this paper which provides details of the implementation, the evaluation of the impacts and lessons learned will focus on this pilot phase because the implementation of the scaled-up program is on-going.

**The scale up phase:** The dramatic improvements recorded in maternal health services after the evaluation of the pilot phase led the MOH and donors to decide to scale-up the demand-side component. The challenges faced during the pilot phase informed the MOH and its partners to scale up demand-side components and at the same time introduced the supply-side component in the CPBF program because motivated CHW were needed. From 2010-2013 or 48 months, an impact evaluation was planned, nested in the proposed CPBF program with four intervention arms aimed at providing scientific evidence of the CPBF. It was planned that this period would mostly depend on the pace of the intervention and upon satisfaction and approval by principle researchers that the intervention period has been enough to cause an impact on the ground. CPBF program and the prospective impact evaluation was initiated to further build evidences on what work, what doesn't

work, and of course assess the cost of the interventions vis-à-vis the intended benefits. For research purpose, 200 health centers were randomly selected: 50 randomly selected, received a demand-side intervention, 50 others received supply-side intervention, the next 50 health centers received both the demand and supply-side intervention, while 50 did not receive the intervention and served as control.

(1) The demand-side intervention: it was initially designed to overcome barriers women in the VUP sectors were facing in accessing timely maternal and child health services. Geographic accessibility to health center was one of the most important challenge; most women were not willing to spend time away from their households to travel long distances. In addition, women were not willing to incur out-of-pocket expenses for health care transportation when they don't consider themselves in urgent need of care. The purpose of the in-kind incentives therefore was to encourage women in rural areas to utilize essential maternal and child health services. The specific objectives of demand-side model include:

1) To increase the number of pregnant women consulting the health center for timely



prenatal care visits within first 4 months of pregnancy.

- 2) To increase the number of women delivery in health facilities.
- 3) To increase the number of mother-child pairs receiving postnatal care at health center within 10 days of birth or discharge.

To address the geographic and financial barriers women were faced with and to give them incentives as they make a trade-off between household work and early follow up of their pregnancy, this intervention provided a market where *mothers sell* their time in fulfilling the MOH policies related to antenatal, natal and post-natal care. Using both Government and Donor resources, the *health center* is the *purchaser* of the services women will attend whereas the *sector steering committee*<sup>8</sup> behaves as the *controller*. The budget is transferred from central MOH level to the CPBF health centre sub-account.

(2) The supply-side intervention: many women do not have accurate health information and are often unaware of potential benefits at health facilities, e.g. free primary healthcare services,

delivery, antenatal, family planning services, higher chances for their babies survival, etc. To bridge the knowledge gap amongst women and to bring women from the community to the health center where services are provided, informed community members were necessary to ensure the success of the demand-side intervention. Because CHW were available, providing them with incentives was critical if any rapid progress was to be made. CHW are provided incentives through their cooperatives based on reporting and performance (quantity and quality of services rendered) on pre-determined indicators.

(3) The demand-side and supply-side intervention: as discussed earlier, 50 health centers had both CHW provided with financial incentives while mothers received in-kind incentives.

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<sup>8</sup> The Sector Steering Committee is composed of the in-charge of social affairs in the sector, the health centre delegates and other members of public institutions such as teachers and civil society organizations

- (4) The control region: constituted with 50 randomly selected health centers which did not receive any intervention.

## Implementation

The Government of Rwanda and Development Partners earmarked funds for a 3 years implementation period for the CPBF program. Key development partners such as the World Bank, the Global Fund on HIV and AIDS, TB and Malaria, the National Malaria and TB Program, and USAID have played an important role (technical support and funding) during the planning and implementation phases. The poorest sector in each district was assigned to the first phase of the VUP program (VUP “Vision 2020 *Umureng*” and was identified for the pilot of the CPBF demand-side intervention. CHW played an important role in community sensitization using tools such as: brochures, posters in public places, oral messages at strategic public gathering like churches and outreach immunization programs to ensure that women understood the CPBF program.

The first picture on the right shows one of several sensitization campaigns by CHW to ensure that women turn up for maternal and child health services at the right time; for example, pregnant women are required to fulfill the four standard visits before delivery; the most important visit is the first visit which takes place before fourth month of pregnancy. The second picture illustrates the in-kind incentives given to mothers. CHW do not work alone is mobilizing women, churches and local leaders<sup>9</sup> have contributed significantly.

The baseline number for women expected for the three demand-side indicators were used to estimate the budget required for each of the incentive packages. For example if a health center expects 10 pregnant women in the first trimester, then the monthly budget was estimated as:  $10 \times 5.30$  \$. For the quarterly budget, it will then be:  $10 \times 5.30$  \$  $\times$  3. The same principle was applied for other indicators and incentive packages. As the size of the population changes and the number of women accessing maternal services increases, health centers implementing the demand-side strategy develop quarterly budgets and submit to the MOH for review and approval. The data generated from distribution is used to reorder incentive materials

and to reconcile against amount of money received from the central level to request further funding.



Picture 1: Women during sensitization campaigns



Picture 2: This picture was taken during incentive distribution

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<sup>9</sup> Umuganda is compulsory community service performed by citizens on the last Saturday of every month

Table 1 summarizes the in-kind incentives offered to women accessing maternal and child health at health facilities. A woman is eligible to receive up to 3 incentive packages, depending on how many indicators she meets. The value of the incentives per indicator is also itemized in Table 1. In order to mitigate adverse behavior of some beneficiaries, such as getting pregnant sooner than planned as a result of the material incentives, a woman is ineligible to receive incentives before 3 years after delivery.

**Table 1: The in-kind demand side incentives**

<i>Eligibility</i>	<i>Indicator</i>	<i>Incentive Package</i>	<i>Incentive Value (\$) <sup>10</sup></i>	<i>Payment Freq.</i>
<i>Women consulting health center in the 4 first months</i>	# of pregnant women receiving prenatal care within first 4 months	Adult cloth <sup>11</sup> , water treatment tablets, baby clothes	5.3	<b>Once</b>
<i>Institutional Delivery</i>	# of women delivering in health centers	Baby soap, cloth and bed sheet	7.0	<b>Once</b>
<i>Mother &amp; child pair consulting health center within 10 days delivery</i>	# of mother-child receiving postnatal care at health center within 10 days of delivery	An umbrella and water treatment tablets or adult cloth	3.5	<b>Once</b>
<i>Total</i>			<b>15.80</b>	

Source: Ministerial Instruction on Community PBF, (MOH) July 2010

Health Centers purchase and distribute incentive materials. The MOH gave this responsibility to health centers because they possess tender committees responsible for carrying out tender bid processes and ensuring that tendering procedures are carefully observed. The tender committees authorize the purchase of other commodities for health centers. To control the purchase and distribution of incentive materials, health centers use *stock cards* for every incentive item and a *distribution registry* to record

<sup>10</sup> Rate of Exchange US\$1=568.55

<sup>11</sup> This is a typical African

women's complete physical address and incentives taken for easy identification and tracking. The distribution registry can also be used to verify the number of clients who consulted the health center at a certain point in time, and this information can be matched with *stock cards* to see how many incentive materials were distributed to how many women. A *voucher system* makes it possible to track incentive distribution and conduct verification and counter-verification. Each voucher has an original and two carbon copies: the original stays with the health care provider who consulted the woman, the second copy remains with the personnel in charge of CHW activities (person who distributes incentives), and the third copy belongs to the client (the woman).

## Evaluation

As discussed earlier, a program evaluation was nested within the CPBF program; the Rwanda School of Public Health and the World Bank are the major evaluating bodies. The findings presented below are coming from the analysis of the pilot study of the 2009-2010 demand-side intervention, *the Community Performance-Based Financing (CPBF) Program in Rwanda: Initial Lessons from the Demand-Side Incentive Model (Pilot)*. Additionally, the *Preliminary Results of the 2010 Demographic Health Survey (DHS, 2010)* showcase the contribution of the program to rapidly improving maternal and child health in Rwanda. Finally, the recent *Midterm Evaluation of the Health Sector Strategic Plan II* done in August 2011 shows consistent results with the initial evaluation of the Pilot phase<sup>12</sup>. The final impact evaluation will illustrate the real impact of the CPBF; and this is expected to be available before 2013.

The total catchment population for the 31 health centers in 2010 was 720,408 people<sup>13</sup>. Of these, 4.1 % (29, 537) were expected to be women in need of maternal health services per annum. The antenatal care indicator (visit before or during 4<sup>th</sup> month of pregnancy) was targeted to reach at least 30 % of women in 2010 or 738 women per month. The indicator on delivery was targeted to achieve 85 % of women delivering in health facilities. The postnatal indicator was targeted to reach 15 % of women in 2010. It took several months of training and sensitization before the program was capable to run

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<sup>12</sup> The Midterm review (MTR) of the Rwanda Second Health Strategic Plan was done by an external evaluation team

<sup>13</sup> 2009 population obtained from SISCom and increased with a projection rate of 2.6552% for 2010 population.

effectively. Data verification was a key component of the planning, implementation and evaluation processes. Health centers keep registers with information on women accessing services for each of the indicators. Data from registries are aggregated monthly and presented on a data collection form sent to Districts. The district supervisors collect, verify and report on the three demand-side indicators. The data manager at central level compiles data, checks for quality, validity and analyses before dissemination. Central level staffs conduct regular supportive visits to health centers and present inconsistencies in data for verification and improvements. Discrepancies found in the data are addressed accordingly.

Generally, there has been improvement in all the three indicators targeted: antenatal care, assisted deliveries and postnatal care. The “*CPBF Program in Rwanda: Initial Lessons from the Demand-Side Incentive Model*” shows the results of the CPBF program:

- **Qualitative results:**

- Health center staffs involved in the program affirmed that women found the quantity and choices of demand-side incentives satisfactory. However, considerable number of beneficiaries and some health center staff think health centers would attract more beneficiaries if improvements on the quality of incentive items are made.
- Health centers directors are concerned that the infrastructure and staff available are not well prepared to care for the increasingly number women coming for maternal health services. There is need for improvement in infrastructure (particularly maternity and consultation rooms), equipment, and HRH.

- **Quantitative results:**

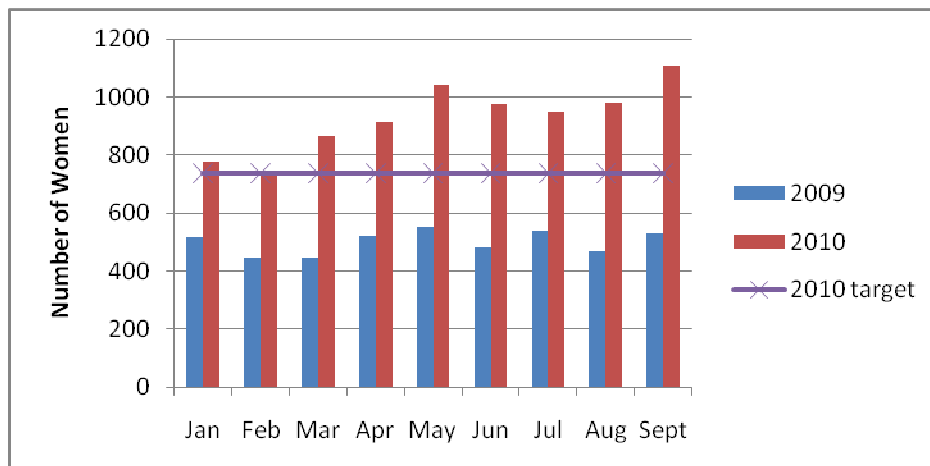
- Visit within the 4 first months of pregnancy
  - During the first 9 months or pilot phase, the average monthly antenatal visits in the 31 health centers was 30 visits compared to 17 visits during the same period of the previous year, representing a 77% increase.
  - In 2010, the 31 poorest health centers or VUPs reached 38% of the population, exceeding the target of reaching 30%.
  - Figure 1 illustrates what has been said above, however, we cannot attribute all this increase to CPBF since other



health centre activities have not been accounted for; the CPBF impact study underway will demonstrate comprehensively the impact caused by the demand-side incentive model.

- By September 2010, 1,110 women attended services in the 31 health centers. When the third quarter (July to September) data of 2009 is compared to the same period in 2010, a 98 % increase was noted (512 ANC visits in 2009 compared to 1,013 visits in 2010).

**Figure 1: Number of women received prenatal care in health centre within the 4 first months of pregnancy**



○ Institutional Deliveries

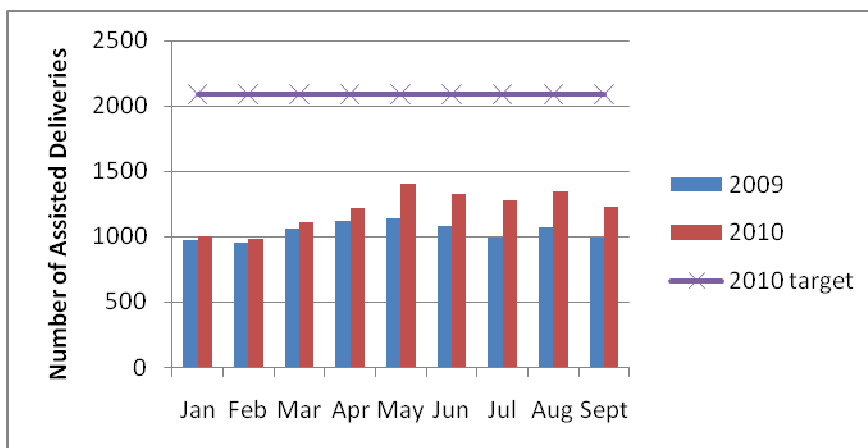
- Approximately 16% more women than the previous year delivered at the 31 health centers. However, the ambitious target was not reached; it was expected that 67 deliveries will be done per health center, per months but the average number of deliveries per health centre per month was 35 in 2009 and 39 in 2010. This shows that more work is needed to increase the number of assisted deliveries. The impact evaluation will also illustrate current efforts to address this challenge.



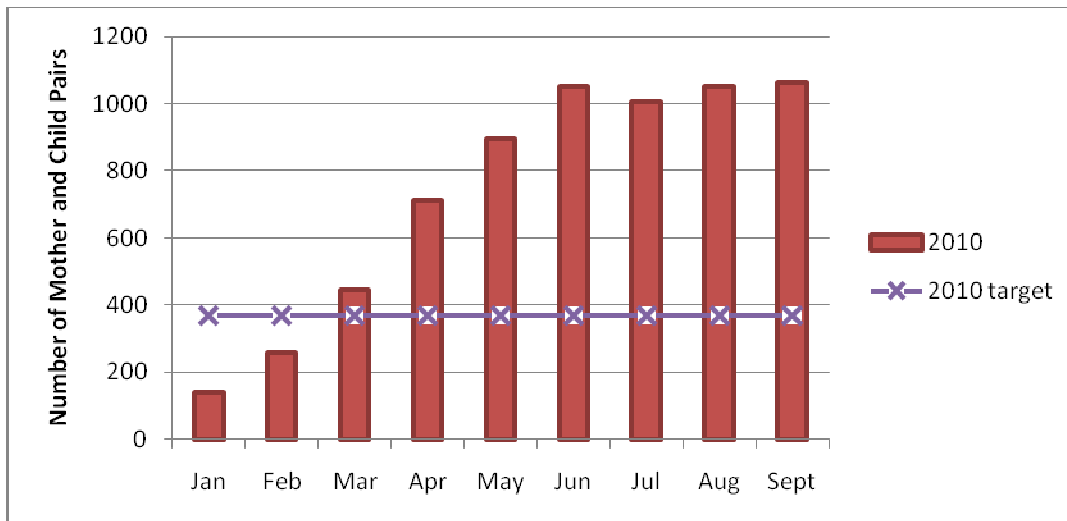
○ Postnatal care

- Postnatal care is a new indicator introduced along with the demand-side initiative in 2009. This indicator intends to increase the number of mothers and babies (mother-child pair) receiving postnatal care at the health center within 10 days of birth or discharge. In 2010, on
- average there were 24 mother-child pairs per health centre per month or 736 pairs for all the 31 health centers. Since there was no history or baseline for this indicator, the target was set low at 15 % per health center per month for subsequent monitoring; overall, the 15% increase expected was exceeded. Figure 3 illustrates an encouraging trend in 2010 from what were expected using rough estimations from DHS.

**Figure 2: Number of women with assisted deliveries in health centers**



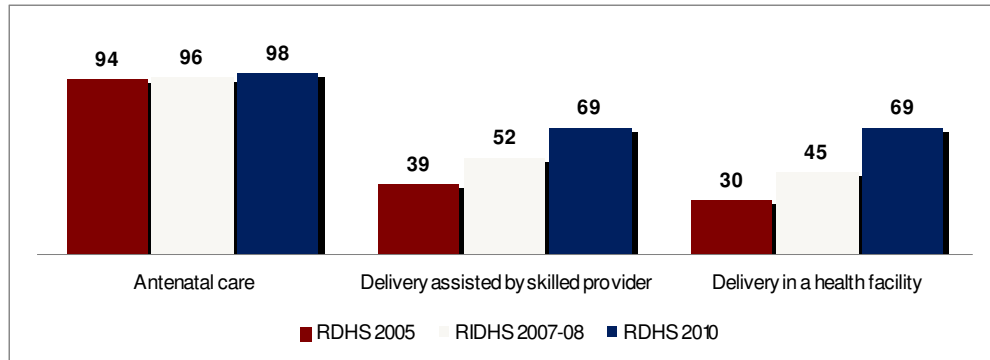
**Figure 3: Number of mother-child pairs receiving postnatal care at health center within 10 days of delivery**



*The Midterm review of Rwanda's Second Health Strategic Plan (External evaluation)* results are consistent with other documents predicting an impact of CPBF; it reports improvements in maternal indicators: antenatal visits were increased from 24% in 2009 to 35% in 2010, assisted deliveries from 45% in 2009 to 69% in 2011. Although the report cites the CPBF as an important policy, it recommends that an impact evaluation is critical to assess the net contribution of CPBF to maternal and child health services.

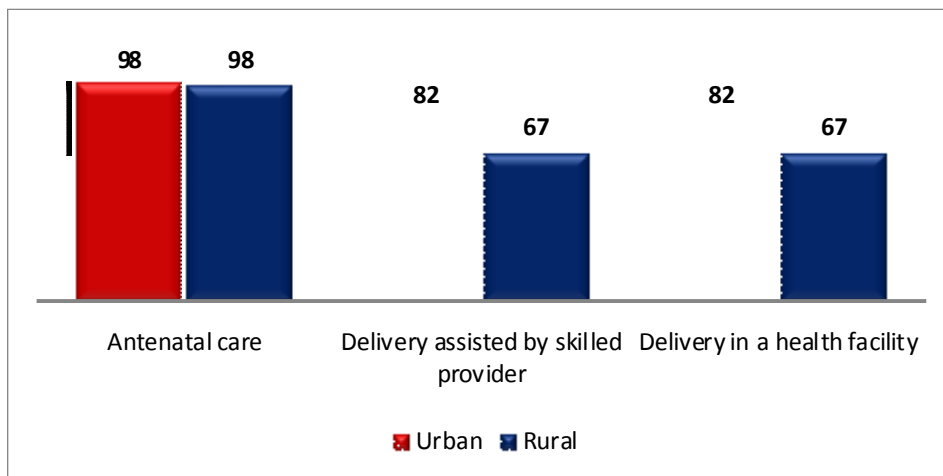
*The Preliminary 2010 DHS results* shows some of the greatest improvements worth to be noted in which CPBF has contributed.

Figure 4: Trends in Maternal Health Services in term of Percentage Covered (DHS, 2010)



The trend over time is showing improvement in maternal health indicators.

Figure 5: Maternal Health Indicators by Residence (RDHS, 2010)



In 2005, the DHS of 2005 reported that 54% of women deliver with medical assistance in urban areas against 23.8% in rural areas. The 2010 results show that Rwanda is closing the gap between rural and urban areas. With these results Rwanda can be sure of not only promoting equity in the access of health services but also the nation is confident it is reaching the MDGs by 2015. The net contribution of CPBF in reaching the targets will be presented in the comprehensive impact evaluation underway.

### Follow-up and Lessons learned

The overall purpose of the demand-side incentive strategy was to improve access and increase utilization of key maternal and child health services. Initial results from the 30 VUP sectors has shown promising results; the subsequent scale up is showing an impact documented in different evaluations done so far and will be confirmed with the final impact evaluation of the program expected in 2013. Available results demonstrate that access to maternal care is being achieved and set targets are being exceeded. This program should be sustained as long as women are still located far from health centers and their capacity to get health information is still limited. The big challenge would be to sustain financially such a program; however both Governments and Donors continuously look for programs with highest return on their investment and CPBF seems to be the case.

There are refinements, improvements to be done within the CPBF program; a combination of the impact of this program accounting for other Government policies should be considered. Some of the recommendations coming from the evaluation of the pilot phase provide a way forward:

- There is a need to set new projections (possibly to be achieved in 2013 depending on the budget). With these projections, the MOH should conduct an affordability and capacity analysis of the demand-side intervention.
- It is important to explore the possibility of expanding the current infrastructure at the point of service to ensure that increasing number of clients does not compromise the quality of care through prolonged waiting time, insufficient staff (quality and quantity), and space.
- The contribution of the current use of mobile technology to transmit data should be explored.



- A robust data verification method is needed particularly since incentives are offered according to numbers reported.
- Additional staff at central level is needed to collect, record, and report on indicators.
- The communication channel is lengthy and most data can be lost in transition. The possibility of using cell phone/mobile technology to access messages via internet should be explored. Considering the nature of this program, regular assessments are needed to find out if beneficiaries still like the incentives.
- The level of knowledge of CHWs needs a review to document their ability and capacity to carry out different health activities at community level.

In conclusion, the overall results are extremely encouraging; Rwanda is steadily showing the path to improving maternal health services; the CPBF is one of the policies that can be replicated within other developing countries, however adaptation according to different contexts should be considered. Some of the lessons learned show that:

- Providing incentives to women can be considered as a reimbursement of their time spent at health center and may convince both woman and families that it is worth sacrificing the mother's time for early care and follow up of her pregnancy.
- A transparent governing body of the program is critical with different stakeholders taking different responsibilities.
- In replicating this program in other countries, it is critical to assess interrelated policies in Rwanda on which the CPBF has laid foundation such: CHW, local administrative structures, the *umuganda* policy, etc.

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