

REPUBLIC OF RWANDA



MINISTRY OF HEALTH

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National Community Health Policy

2008

Abbreviations

AIDS	: Acquired Immune Deficiency Syndrome
ARV	: Anti Retroviral
ASC; ASCB	: <i>Agent de Santé Communautaire</i>
CBHI	: Community Based Health Insurance
DHS	: Demographic and Health Survey
EPI	: Expanded Programme on Immunisation
FAO	: Food and Agricultural Organisation
FBO	: Faith Based Organisation
FOSA	: <i>Formations Sanitaires</i> (Sanitation Training)
GAVI	: Global Alliance for Vaccines and Immunisation
MCH	: Mother and Child Health
MDGs	: Millennium Development Goals
MINISANTE	: Ministry of Health of Rwanda; <i>Ministère de Santé</i>
NEPAD	: New Partnership for Africa Development
NGO	: Non Governmental Organisation
PLVVHA	: People Living with HIV and AIDS
PMTCT	: Prevention of Mother to Child Transmission
PNILP	: Programme to combat Malaria
PNILT	: Programme to combat TB and AIDS
PRSP	: Poverty Reduction Strategy Paper
STD	: Sexually Transmitted Diseases
TB	: Tuberculosis
TFR	: Total Fertility Rate
UNAIDS	: United Nations AIDS Programme
UNICEF	: United Nations Children's Emergency Fund
WHO	: World Health Organisation

Translation of Key Terms

<i>Agent de Santé Binôme</i> :	Male and Female Community Health Worker
<i>Agent de Santé Communautaire</i> :	Community Health Worker
<i>Animatrice de Santé Maternelle</i> :	Traditional Birth Attendant
<i>Approche Contractuelle</i> :	Contractual Approach
<i>Binômes</i> :	Male and female
<i>Cellule</i> :	Cell—Administrative unit comprising of <i>imidugudu</i>
<i>Comité Administratif de la Cellule</i> :	Administrative Committee for the Cell
<i>Comité de la mutuelle</i> :	Committee for the Mutual Health Insurance
<i>Mutuelle de Santé</i> :	Community Based Health Insurance
<i>Gacaca</i> :	Weekly Tribunales, the traditional Rwandan court
<i>Imidugudu</i> :	Many villages
<i>Umudugudu</i> :	One Village

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Preface

Improving the health status of the Rwandan population is critical to improving the quality of life of individuals and communities. It's also a key component of the country's development agenda. Although significant improvements have been registered, health indicators continue to show the need for the removal of barriers that restrict the ability of Rwandan households and individuals from fully participating in the development of the country.

Maternal mortality and infant morbidity and mortality remain unacceptably high. Improvements are required in hygiene and sanitation and access to and utilization of family planning methods.

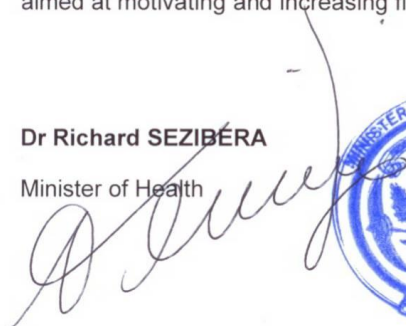
The numbers and quality of qualified health care providers especially in the rural areas remain insufficient.

The Government through the Ministry of Health has invested in addressing preventable health problems through empowering communities to participate in all activities aimed at improving their own health status. The role of individuals and communities in addressing health issues at community level is vital with regard to promotion of healthy lifestyles and fostering positive behavior change. Building on the spirit of voluntarism for health promotional activities that has characterized community health workers, the Ministry of Health seeks to scale up their numbers in order to equitably cover all villages and then build their capacity to improve performance. This with the aim of increasing accessibility to health care services as indicated in Rwanda's Vision 2020. Community support, proper selection of community health workers, their training, consistent supportive supervision and their motivation are key to the success of all community health interventions that lead to better outcomes.

The National Community Health Policy identifies gaps, opportunities and lays out policy guidelines with an aim to contributing to the achievement of health targets as identified in the MDGs, Vision 2020, and EDPRS. Community health approaches and strategies such as; Community Performance Based Financing, and the formation of CHWs' cooperatives have been identified as key initiatives aimed at motivating and increasing financial capacity of CHWs.

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National Community Health Policy

1. Introduction:

After many years of undoing the community in the provision health services, the Rwandan Ministry of Health decided to develop a Community Health Policy to guide and strengthen the provision of community health services and to provide a framework for meeting such international commitments as the Millennium Development Goals and the Lusaka Declaration on Decentralisation of Health Services, whose objectives Rwanda is committed to achieving through the *Vision 2020* and the EDPRS. Increasingly many partners provide community health services at the district and community levels, this policy is expected to assist in building stronger partnerships with all providers and to provide better guidance for all partner and actors in the health sector.

The Rwandan experiences and lessons learnt in implementing community health care services have been used to enrich the policy development process. The Community Health Policy compliments other Ministry of Health Policies already developed, such as:

- *Reproductive Health Policy, 2003*
- *Family Planning Policy, 2005*
- *Nutrition Policy, 2005*
- *National HIV/AIDS Policy, 2005*

Implementation of the provisions of this Policy will also be informed by the following national policies:

- *Decentralisation Policy, 2001*
- *Community Development Policy, 2001*
- *Fiscal Decentralisation Policy, 2001*

Community health in Rwanda embraces the concept of primary health care which is defined as an essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact for individuals, family members and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (WHO, *Alma-Ata Declaration, 1978*).

Primary health care in Rwanda focuses on the four aspects of health care: preventive, promotive, curative and rehabilitative services that form the core components of Community Health. Programmes within this package include the National Programme on Leprosy and Tuberculosis, the National Malaria Control Programme, Environmental Health programmes, the National Programme on Community-Based Nutrition, the National Expanded Programme on Immunisation, the Reproductive Health Programme, Integrated Management of Childhood Infections (IMCI), and Care and Support for PLWHA (See Section 5).

Since 1995, the Community Health Unit of the Ministry of Health, Rwanda, has trained about 12,000 community health workers who are living and working among their

communities. However, as a result of decentralisation, it is estimated that 60,000 community health workers (including the person in charge of social affairs at cells and Umudugudugu level) in all will be needed to service all districts. The community health workers have the advantage of knowing their community well in terms of the community culture, norms, beliefs, traditions, formal and informal networks, support systems, community strengths and, most likely, their communities' health problems. The development of this cadre by the Ministry of Health must be viewed as a strength as these community health workers will take health care to the people and they can be consulted whenever a problem arises as they are easily accessible. They, however, need to be adequately trained, supervised and supported in order to be effective. Standardised packages which integrate community health activities at the community level must be developed and used for training community health workers.

The positive impact of community health workers is already being felt. Based on mobilisation efforts by community health workers, Rwanda's PEV programme has achieved some of the best immunisation levels in Africa. Family planning and reproductive health services are affordable and accessible to the majority of Rwandans; a nationwide community nutrition surveillance programme has been put in place and is reaping good results. Other examples include the engagement of community health workers in Malaria prevention, with a significant results , proving that community volunteers, when effectively used, can bring about positive results. Effective implementation of the provisions of this policy is expected to improve the health of the people of Rwanda, who, in turn, will contribute to the overall development of the country.

1.1 Definition of the Community Health Sector:

The Ministry of Health is charged with the delivery of community health services through decentralised health structures from the district to the *Umudugudu*, and concerns community health workers at the community level. Community Health is seen as a holistic and integrated approach that takes into account the full involvement of communities in planning, implementation and evaluation processes, and assumes communities to be an essential determinant of health and the indispensable ingredient for effective public health practice. Furthermore, Community Health takes into account the tangible and intangible characteristics of the community, i.e. its formal and informal networks and support systems, norms, cultural nuances, institutions, politics, and belief systems.

1.2 Background:

1.2.1 National Context:

The Health System in Rwanda is organised into three levels: the central level with referral teaching hospitals, the districts hospitals and the health centres. Decentralisation of community health will see the health system integrated into the community development services and the administrative structures. The integration is expected to provide an environment which takes into account a holistic approach to community development.

AIDS and Malaria place the most burdens on the health delivery system and economy of the country. Malaria accounts for 40% of all consultations in the health centres (HMIS Report 2007)

AIDS, pneumonia and diarrhoea stand in the second, third and fourth positions respectively as high causes of morbidity and mortality in the under-fives (GoR MINISANTE, *Annual Report*, 2004).

The results of the *Demographic and Health Survey* 2005 and 2007 show that the prevalence of HIV in the 15-49 year age group is 3%, with the prevalence higher in urban areas (7.3%) than in rural areas (2.2%)(IDHS 2005). The infection rate is higher in women (3.6%) than in men (2.3%). The infant mortality rate is 62/1000 (IDHS, 2007) live births; Children under five sleeping under ITN: 60% (MIS 2007); and 45% (IDHS 2005) of under-five children are malnourished. 48% of pregnant women deliver in the rural areas and 52% of all the deliveries are assisted deliveries (IDHS 2007). The fertility rate is high at 5.5%(IDHS 2007); modern family planning use is 27%(IDHS 2007). Health service use for general illnesses is 71% (EDSR-III 2007) .

Socio-Economic and Geographic:

Rwanda is a landlocked country in central Africa, bordering Uganda in the north, Burundi in the south, the Democratic Republic of the Congo in the west, and Tanzania in the East. It has a population of: 9,058,392 (Proj.2006 ; NISR) ,45,3% less than 15 years of age % . Its mountainous terrain averages an altitude of 1700 meters and is suitable for producing agricultural products such as coffee, tea and ornamental flowers. A major challenge for Rwanda is the growing population. The population density is high (355 per Sq. km (32 per sq. km) resulting in many families having less than one hectare of land, a level that FAO/Rome states is inadequate for food production for the average family. Rwanda's population grows at about 2.6% per year (EDPRS), and in some regions must accommodate returning citizens who fled the country prior to and during the war and genocide of 1994. A doubling of the population in the next twenty years is a serious consideration for Rwanda's economists. On the other hand, Rwanda has special resources, such as streams and waterfalls which provide the possibility for hydroelectric power. Rwandans are ambitious, eager for more education, and the country is responding with more schools, including technical trade schools and expanding universities and paramedic schools. Rwanda's economic growth rate, at a negative level after the genocide of 1994, was reported at 6% last year by the World Bank and others.

Socio-Political:

Rwanda has adopted a *Comprehensive Development Framework* (CDF, 2005) that focuses on eliminating poverty, reducing inequity, and improving opportunities for generating resources in keeping with World Bank recommendations. The country has taken the lead, both "owning" and directing the development agenda with World Bank and other partners defining their support. Rwanda promotes strong partnerships with donors, society, the private sector, and other development stakeholders in implementing the country strategy.

Following the genocide of 1994, Rwanda has given priority to rebuilding the infrastructure and human resource base of the health sector. The extension of training institutions is still ongoing. In addition, Rwanda recognises poverty reduction as a key strategy for the future, and that the two driving forces are economic growth and the strengthening of the capacities of all to participate in this growth and benefit from it. Human development, health in particular, is considered by the government to significantly contribute to these two processes. Economic Development Poverty Reduction Strategy (EDPRS) supports this position by putting emphasis on socially sustainable development. A strategy of socio-economic transformation in order to accomplish the transition to peace, stability, and development is expanding. Decentralisation has led to a restructuring of Rwanda's governing structures: Rwanda is now divided into 4 provinces and the City of Kigali, 30 districts (which replaced the

existing 106), 416 sectors (replacing the existing 1545), around 9,000 cells and several *Imidugudu*. All districts sign contracts of performance with the President of the Republic of Rwanda and the districts also sign the performance contracts with the sectors and other lower level structures.

Culture plays an important role in enhancing the adoption of health practices. Those cultural norms which are in conflict with the dispensations in health should be identified and discussed with communities as it is only the communities that can change their culture. A supportive environment needs to be created so that communities are not threatened by the change. The Ministry of Health has developed a National Behaviour Change Communication Policy (2006) to facilitate Rwandans to adopt and maintain behaviours conducive to good health. The policy defines the contribution of behaviour change communication in achieving national health priorities; provides a strategic orientation and guiding principles to achieving priority health objectives through behaviour change communication and provides guidance and tools to support behaviour change planning, programming, evaluation and coordination.

1.2.2 Regional and International Context:

This policy describes Rwanda's role in harmonising the health sector and it draws from the Regional and the International policy obligations that the Rwandan government has committed itself to. Rwanda's economic growth rate of 6% (2005) shows unusual progress compared with surrounding countries. Similarly, the movement to get health care all the way to the periphery of the country speaks well for the possibility of achieving the Millennium Development Goals.

According to World Bank publications, the Millennium Development Goals (MDGs) commit the international community (including Rwanda) 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, and one that "recognises the importance of creating global partnerships for development" (World Bank, *Millennium Development Goals, the Road Map*).

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 the MDGs. Information on action at the community level will need to be passed from the community to the higher levels. Rwanda's community health sector information system is therefore right on target.

In keeping with the recommended financing mechanisms of health sectors in sub-Saharan Africa in particular, Rwanda has already taken steps to see these adapted to support the reduction of poverty, financial access to health care, and a better distribution of public expenditure benefits in the context of ongoing decentralisation and democratisation processes.

As a member of the Africa Region, Rwanda also adheres to the *Lusaka Declaration on Decentralisation and District Health Systems* (WHO, 1997). Three strategies are promoted:

- a) The decentralisation of the health system using the health district as the basic operational unit of the system.
- b) The development of the primary health care system through its eight core components.
- c) The reinforcement of community participation in management and financing of services.

The *Health Sector Strategic Plan 2005-2009* states that “the case for investing in health has been further strengthened by evidence that better health contributes to greater economic security and growth. These findings have formed the basis for WHO’s Commission on Macroeconomics and Health recommendations which Rwanda is actively pursuing”. The Government of Rwanda is committed to fulfilling its regional and international obligations in the health sector.

2. General orientation:

The general orientation of the Ministry of Health of Rwanda for community health is built around five major strategies: i.e. *Vision 2020*, *Economic Development Poverty Reduction Strategy* (EDPRS) *National Investment Strategy* (NIS), government programmes and Millennium Development Goals (MDGs), which are briefly described in the following pages.

2.1 Vision 2020:

Vision 2020 for Rwanda states that it “aspires for peace, political stability, physical and social opening; a dynamic, diversified, integrated and competitive economy which can lead the country by 2020, into the club of countries with medium incomes.” Rwandan experts state that by 2020 the population will double, land will become scarcer, and jobs must have been created. Decisions about the economic and social situations are currently taking into account the health needs as well. The document states, “Full development of human resources and emergence of a prosperous knowledge-based population is essential. Rwanda wishes to have a secure, healthy, well fed, educated and informed population characterised by a lower demographic growth rate.”

One of the major aspirations of *Vision 2020* is the development of human resources, integrated with the addressing of demographic, health and gender issues. The areas indicated in the table below are those where community health services will advance the cause. For example, the community health workers will be composed of a male/female *binôme*, ensuring gender equity. They will be educated in health along with persons “elected for health” for their *cellule*.

Table 1. Pillars of *Vision 2020* and its Cross-cutting Areas

<i>Vision 2020</i> Pillars	Cross-cutting Areas
1. An effective and capable state underpinned by good governance	Gender equity
2. Human resource development and a knowledge-based economy	Protection of the environment
3. Infrastructure and Development	Culture, science & technology, including ICT
4. A private sector-led economy, based on a growing class of entrepreneurs with a competitive and creative culture	Regional and international integration
5. Productive High Value and market oriented agriculture	Depends on healthy agricultural work force with low absenteeism, due in part to Malaria control and combat of other diseases such as AIDS.

Table 2. Indicators for *Vision 2020* Selected for Community Health Implications

Vision 2020 Indicators	Situation 2000	DHS 2007	Projected 2010	Projected 2020	International Norms
Rwandan pop.	8.13 million	9.058 million	10,2 million	13 million	NA
Life expectancy. (yrs)	48	52	50	55	n/a
Total fertility rate	6.5	5.5	5.5	4.5	n/a
Infant mortality rate	107	62/1000	80	50	n/a
Maternal mortality rate	1070	750/100000	600	200	n/a
Child malnutrition	30	45%	20	10	n/a
Pop. growth rate	2.9%	2.6%	2.3%	2.2%	n/a
Rate of AIDS prevalence*	13%	3%	11%*	8%*	n/a
Malaria related mortality (%)	51%	22.3% (HMIS)	30%	25%	n/a
Doctors per 100,000 habitants	1.5%	1/33.000	5	10	10
Population in good hygienic conditions (%)	20%	39% safe water; 64% with toilets (HS Plan) 2005-2009)	40%	60%	-
Nurses per 100,000 inhabitants	16%	1/1700	18	20	20
Availability of protein/per/day (% of needs)	35%	-	55	65	70%
Poverty 1US\$/day	64%	-	40%	30%	-

*Above estimates of AIDS prevalence were based on biased data. The DHS 2005 showed an overall prevalence of HIV positivity of 3 %.

Related to the above would be to increase the level of service use at the health centres. The Ministry of Health reported in the 2004 *Annual Report* that the rates of use (using old geographic boundaries) varied from 12.7% in Gisenyi to 71.9% in Cyangugu. In order to achieve the indicators sited above, Rwanda will need to increase use of services. The main reason for low usage of health services, according to a CWIQ survey, is that they are often perceived as too expensive for the poor. In the four weeks prior to the survey, 23% of people had consulted medical services, but 15% had felt ill but not consulted a health provider because of cost (GoR, *Core Welfare Indicator Questionnaire*, 2004).

Population dynamics are a key part of the *Vision 2020*, since Rwanda is one of the most densely populated countries in Africa (355 inhabitants/km). Rwanda intends to reduce

the total fertility rate (TFR) from 5.5 children per family to 3.9 within the next 20 years(EDPRS). The implication would be that all families have access to family planning services and are willing to limit family sizes. Gender equity in all aspects of health, including family planning, will need to be a high consideration in the programmes of community health. To scale up family planning use, men will have to be actively involved as they are still the major decision makers in fertility issues.

2.2 Economic Development Poverty Reduction Strategy (EDPRS):

Rwanda Economic Development Strategy is meant to provide a medium term framework for achieving the country's long term development aspirations as embodied in Rwanda Vision 2020, the seven year Government of Rwanda (GoR) programme, and the Millennium Development Goal.

The strategy builds on strong achievements in human capital development and promotes flagships programmes that serves as a means to prioritise actions by GoR, mobilise resources for development, and improve policy implementation through more co-ordinated interventions across sectors.

Rwanda's *Poverty Reduction Strategy* is meant to stabilise the burden of debt and adopt a coherent debt management strategy. In particular, projects will be planned and rationally managed to generate real wealth, enabling sustainable poverty reduction and improvement of social and regional equity. Poverty remains the main cause of poor health. *Vision 2020* states that, "although health has improved significantly over the past few years, it is still inadequate. The prevalence of Malaria (40% of hospital consultations) and of HIV-AIDS is high and constitutes a major economic problem."

Rwanda is choosing this strategy and policy actions and measures in order to reinforce the contribution of health interventions to the reduction of poverty and the improvement of the health conditions of the poorest. The EDPRS uses an analytical framework that puts health at the centre of key issues and dimensions of poverty. The framework highlights the point that health conditions of the most disadvantaged, contrasted to the wealthiest groups, result in complex relationships between health and poverty: If poverty leads to a poor health condition, a poor health condition in turn contributes to monetary poverty; moreover, it is widely known that poor health and nutritive conditions are key to poverty.

In the health sector the objectives are to maximise preventive health measures and build the capacity to have 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.

This include strengthening the institutional capacity of human resources, increasing the quality and quantity of human resources, ensuring that health care is accessible to the all population, increasing the geographical accessibility, availability and affordability of drugs, improving the quality of services in the control of diseases and encouraging the demand of such services.

In the area of health, there are ten primary causes that account for 80% of consultations: Malaria, parasitic diseases and respiratory infections. To combat these diseases will require both preventative and curative action, some of which must be "outside the four walls" of health centres. Among adults, lost agricultural work time due to Malaria alone has become an obvious problem. Pneumonia in under-fives remains a killer and needs earlier recognition and treatment, as does Malaria; actions that occur best at the village level. In addition, the well known shortened inter-birth interval when parents lose an infant affects the female proportion of the agricultural work force, an important component in Rwanda.

Table 3. Forecast of Public Investment in Areas Relevant to Community Health
(billions Rwf to the nearest decimal point) (*Long Term Investment Programme*,
MINECOFIN, 2006)

Sector of Investment	2007	2008	2009	2010	2012	Notes on implication for community health workers (ASCBs) (if any)
Environment	2.9	1.4	9.4	0.9	0.4	Clean up of environment may depend on CHWs; for example disposing of waste water; planting trees to combat deforestation, introduction of methods of water distribution to reach every family for safe drinking water
Agriculture	12.5	58.9	61.9	59.0	41.0	Strong overlap to combat malnutrition; planting of nutritious crops in family gardens must be taught; community trainers will be needed
Land, housing, community development	6.9	18.4	28.0	17.0	29.7	Strong overlap with community health; community development involves communication with every family; ASCBs can educate, select families most in need
Water and sanitation	38.6	68.3	44.2	43.2	24.9 5	Water borne diseases are major killers but will not be decreased unless sanitation is taught and more abundant safe water use by families is adopted.
Social, Gender, Family and Youth	4.3	-	5.4	-	-	Training youth is crucial to reduction in STD and HIV transmission; also women's health training begins at this age; introduction of home based women's health record begins in late teens
Health	48.0	38.6	19.2	0.7	16.0	CHW's (ASCBs) distribution 1: 25-50 families with door to door personal prompting is key to equity of health services.
Education	26.7	11.4	26.4	-	23.7	Curriculum development should be updated and include community health component; school children are key to taking messages home to mothers for immunisation, prevention of malnutrition, Malaria prevention
TOTAL	133.9	191.0	194.5	120. 8	135. 75	

2.3 Government Programmes:

Rwanda is committed to ensuring an environment in which people can be free, content, and prosperous, and can participate in decisions that affect their lives. In 2006, the policy for decentralisation gave people even more power in health decision making: Each district is divided into administrative sectors and cells, with each cell encompassing several villages (*Imidugudu*) whose citizenry elect representatives to be in charge of health and social affairs. The cell has an elected staff in charge of health and social

affairs and is under the administrative supervision of a sector in-charge of health and social affairs. The health and social affairs representatives also liaise with the local clinics on regular basis. The following programmes were initiated by government to improve access to health care services by communities.

Community Based Health Insurance (CBHI): The reintroduction of the direct payment system for health services in Rwanda in 1996 resulted in households increasingly finding it difficult to meet their health care costs (health information system). The average rate of modern health service use was 0.28 for new cases per inhabitant per year (representing 50% of the WHO standard of 1 new case per inhabitant per year in urban areas and 0.5 to 0.6 new cases per inhabitant per year in the rural areas in developing countries). One of the frequent reasons given for non-use of health services was the high cost of health care (*Mutual Health Insurance Policy in Rwanda*, December 2004). This result prompted the Ministry of Health to facilitate the introduction of Mutual Health Insurance, which is an autonomous organisation administered by the members of the insurance with respect to the principles of democracy and freedom. In a general assembly, the members adopt the constitution and by laws defining the organisational structure and roles and functions of different management organs, elect members of different organs and define their tasks, and determine the packages of its members and annual premiums.

At the community level, there are local committees that contribute ideas and information to the insurance. These committees include a member of the local health centre. The indigent are taken care of by the government. The current rate of use of health services is at 71% with CBHI in 2007. The evolution of the adherence rate was 7% in 2002, 27% in 2004, 44.1% in 2005, 73% at the end of October, 2006 and 85% in September 2008 (HIMIS 2008).

Community Performance-Based Financing: In an attempt to improve the health of the communities by raising selected health indicators to higher levels, the Ministry of Health embarked on a Community Performance Based Financing Approach (Community PBF). The programme started in all 30 districts in December 2005 as a result of realising the significant positive results of performance indicators in health care following the introduction of the health facility based Performance Based Financing Approach in the former districts of Butare, Cyangugu and Kigali Ngali. Indicators for implementation were selected based on the results of *IDHS 2007*. These are: reduction of maternal mortality through increased health facility deliveries; reduction of deaths due to Malaria through increased use of treated mosquito nets; reduction of under-five deaths due to dehydration through increased use of oral re-hydration solution; improved personal hygiene; and accurate and timely reporting by community health workers. To implement this strategy in 30 districts.

Community health workers and local administration staff at the *cellule* and Umudugudugu, play key roles in achieving and reporting on the set indicators and get paid for achieved targets upon signing contracts with sector coordinators on behalf of the districts. An evaluation of this approach will inform the Ministry of Health of the outcomes of selected indicators and consequently form a basis for scale up to include other pertinent community health indicators. Other community programmes include: the National Programme on Leprosy and Tuberculosis, the National Malaria Control Programme, Environmental Health programmes, the National Programme on Community-Based Nutrition, the National Expanded Programme on Immunisation, the Reproductive Health Programme and Family Planning Integrated Management of Childhood Infections (IMCI), and Care and Support to PLWHA.

2.4 International Development Goals (MDGs, NEPAD, etc.):

Rwanda is committed to the international and regional agreements for which it is a signatory such as the MDGs and NEPAD. The Millennium Development Goals (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.

Table 4. MDGs and the Role of the Community Health Sector

MDG by 2015	Role of Community Health Sector
Eradicate extreme poverty and hunger	<p><i>Target 1:</i> CH will contribute to the reduction of the number of persons in severe poverty by providing effective community health services that will maintain the population of Rwanda healthy and productive to participate in the labour force with reduced absenteeism due to poor health.</p> <p><i>Target 2:</i> Enhance and expand nutrition surveillance and intervention to reduce by half the number of malnourished children. CH will strengthen community based growth monitoring, nutrition education and support nutrition supplementary community projects, i.e. gardening and small live stock.</p>
Reduce child mortality	<p><i>Target 5:</i> CH will contribute in reducing by 2/3, by 2015, the under-five mortality rate through use of CHW's to enhance immunisation services, to combat diarrhoea through Oral re-hydration therapy (ORT), provide early treatment for key killing diseases such as Malaria and childhood pneumonia and strengthen community IMCI.</p>
Improve maternal health	<p><i>Target 6:</i> CH will assist in reducing by ¾ the maternal mortality ratio through overcoming access barriers to services, by education of parents, and by community involvement in maintaining access to health centres. 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, including effective engagement of TBAs.</p>
Combat HIV/AIDS, Malaria and other diseases	<p><i>Target 7:</i> 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 (<i>Umudugudu</i>) about HIV/AIDS, motivating for counselling, distributing condoms and through making sure all patients with AIDS or Tuberculosis receive and adhere to treatment (directly observed therapy, DOTS for TB) and support.</p> <p><i>Target 8:</i> CH will assist MiniSanté to have halted by 2015 and begun to reverse the incidence of Malaria and other major diseases. CH collaborates with the PNILP, PNILT and other programmes by moving curative and preventive care to the periphery, including key IMCI services, through services by community health workers.</p>
Ensure environmental sustainability	<p><i>Target 10:</i> Reduce by half the proportion of people without sustainable access to safe drinking water. The Environmental Health in CH has set targets in the <i>Health Strategic Plan (2005-2009)</i> to increase the proportion of people accessing safe water supplies.</p>

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 MDGs. Information for action will be necessary, from community level to the central level. Rwanda's community health sector information system is therefore right on target (World Bank).

The New Partnership for Africa's Development (NEPAD): Rwanda is an active member of NEPAD, and is therefore expected to have transparency in its health sector as regards financing and management. The principles of NEPAD are:

- good governance as a basis for peace, security and sustainable socio-economic development;
- African ownership and leadership;
- Anchoring the development of Africa on its resources;
- Partnership between and amongst African peoples;
- Acceleration of regional integration;
- Building the competitiveness of African countries;
- Forging a new international partnership that changes unequal relationships between African countries and the rest of the world.

As regards the health sector, the main objectives of NEPAD as identified by the Rwandan NEPAD secretariat are included in the following table accompanied by a statement of how community health will work to help achieve the objectives:

Table 5: NEPAD Health Sector Objectives and Community Health:

Primary NEPAD Objective	Role of Community Health
Eradicate poverty	Provide effective community health services that will maintain the population of Rwanda healthy and productive.
Place African countries on a path to growth and development	Provide effective community health services that will maintain the population of Rwanda healthy and productive. Community health activities reduce the cycle of unemployment due to illness, enabling more persons to remain in the work force and productive activities.
Accelerate the empowerment of women	Accelerate gender equality and equity in health delivery.
Halt the marginalisation of Africa in the globalisation process and enhance beneficial integration into the global economy	Many reasons for marginalisation are related to the status of women. In reducing the maternal mortality rate, Rwanda saves mothers who continue to raise their families; they in turn will be exposed to knowledge about family planning and child spacing. Their acceptance of modern contraceptive methods can help reduce the rapid population growth that impinges on economic progress. Furthermore, active participation of women in the country's development will reduce gender inequalities.

The Ministry of Health prioritises the provision of services and prevention to combat major causes of mortality and handicapping diseases and conditions affecting families, to move services to the periphery as far as possible, and to engender as much community

participation as possible. In order to reduce maternal and childhood mortality, preventive and curative services must go beyond the self selected population that shows up at the health centres and must strive to reach each individual and all family members with primary health care, so that no family member is left out. Such an orientation assumes that every pregnant woman deserves antenatal, safe delivery and post natal care and family planning services, and that every child deserves immunisation and primary health care and that he or she deserves to be well nourished to improve resistance to infections and that their capacity for learning is not hampered. Community nutrition surveillance and immunisation for under-fives and for pregnant and lactating mothers must be easily accessible. These activities could be organised at churches and schools or in shaded market areas. The home based child growth chart for preschool children is an example of the kind of instrument that will be used. A woman's health record that records more than just one pregnancy has been designed as well.

3. Community Health Sector Presentation:

The roles of the Ministry of Health in community health are to:

- Elaborate and supervise short and long term strategic plans and budgets for community health programmes, in keeping with directives of the permanent secretary and in keeping with approved objectives and strategic plan.
- Take responsibility for development of directives for the workforce that implement community health programmes, both sectoral and provincial.
- Coordinate and harmonise programmes and policies for community health and assure their effectiveness.
- Develop and coordinate partnerships with private voluntary and non governmental organisations that participate in community health.
- Set norms and standards for community health at sectoral, *cellule* and *imidugudu* levels.
- Develop and coordinate programmes for supervision, inspection, management and to assure transparency in the disposition of state resources for community health.
- Offer technical support to districts in the implementation, monitoring and evaluation of community health programmes, reinforcing community participation in management of their own health.
- Engage in advocacy for capacity building of community health workers and other community volunteers through training and retraining.
- Elaborate and initiate community based financing programmes throughout the country to improve performance and reduce poverty levels.

3.1 Problems Facing the Community Health Sector:

There are a number of problems that confront the Community Health sub sector in its efforts to deliver high quality health services. These include:

- Utilisation of health services in the event of illness 71%(EDSR-III 2007)
- Shortage of commodities at village level. These commodities include sachets for oral re-hydration and condoms.
- Roads and transportation pose problems to many rural people. Ambulance availability is limited to areas with roads.

- Inadequate community based information system that reaches beyond the health centre and reports on pregnancies, pregnancy outcomes, births, deaths, and key types of morbidity at the village/*cellule* level.
- Inadequate reinforcement of community participation at the *cellule* level.
- Low immunisation coverage -- all immunisations are below 80% (IDHS, 2007).
- Low deliveries at health centres; only 52% (IDHS 2007) deliver at a health centre.
- High morbidity and mortality due to preventable diseases such as Malaria, AIDS and diarrhoea.
- Shortages of manpower at the decentralised levels.
- Low access to safe drinking water (39.6%) and latrines (64.4%) (GoR, Ministry of Health, *Strategic Plan 2005-2009*).
- High poverty levels among the communities: 56.9% live below the poverty datum line (Households Living Conditions Survey II).

3.2 Challenges and Opportunities for the Health Sector:

Given these problems, the Ministry of Health and its partners have identified the key challenges and the current opportunities which will enable the health sector to meet these challenges.

3.2.1 Challenges:

- Building the capacity of decentralised structures to deliver quality health services.
- Effective monitoring of the decentralised programmes at all levels, including at the community level.
- Coordinating services at the community levels to enhance synergy.
- Integrating services, training, harmonisation of training materials of different organisations for training of community health workers and other volunteers providing services at the community levels.
- Increasing access to services for all by making services affordable through the provision of Mutual Health Insurance coverage for all including the poor families.
- Scaling up interventions to halt preventable diseases.
- Standardising compensation packages for all volunteer workers.
- Developing community capacities in management of income generating activities through their associations.
- Empowering communities to actively participate in problem identification, planning, implementation and monitoring of community programmes.
- Developing a model for interaction with the steering committee for the mutuelle and administrator committee of cells piloting it in some districts.
- Setting up apprenticeships and developing curriculum in the model area for
 - Training of trainers (TOT) for *cellule* leaders, including some staff from health centres.
 - Training of trainers of health centre staff on how to support the new *Binômes* at the *cellule* level; assisting them in using their registers to derive disaggregated data on services offered and to report this to the next higher level.
- Developing a training manual for community health workers.
- Developing a guide for *cellule* leaders in how to supervise family registration, use the register of under-fives and the register of women 15 – 49 years of age (for example, to use their home based health records to record immunisations, antenatal care for those pregnant, and the like).

3.2.2 Opportunities:

- *Mutuelle de Santé* provides opportunities for all members to access health care.
- Political will to improve the health of the population of Rwanda provides opportunities for resource leveraging.
- Decentralisation has a potential to increase access to community based structures and often improves the commitment to increase community based support systems that reduce demands on institutional care.
- National adoption of poverty reduction strategies that are expected to generate resources to enable the country to address the needs of poor households and communities.
- The government has signed relevant conventions and protocols related to human, women and child rights which need to be fulfilled. These can be used as advocacy tools for adequate resource allocation.
- Increased partnerships with international organisations, local NGOs, associations, CBOs, and Faith Based Organisations (FBOs) that provide services, as well as financial and technical support.
- Community based performance financing offers an opportunity to improve performance of community health workers and other community volunteers and consequently reduce poverty levels through payments for realised indicators.
- NEPAD offers investment opportunities that would generate funds which can increase the flow of funds to Community Health and its decentralised structures.
- Already there are community health workers and other volunteer workers that offer various services at the community level. Harnessing this human resource adequately can make a lot of difference in community health outcomes.

3.3 Guiding Principles of the Community Health Policy:

3.3.1 Integration:

Community health services are integrated into the community development services and administrative structures. Integrating community health services at every level is very important as it improves the quality of services for the clients by reducing missed opportunities that often result from vertical programmes. Integration also saves on costs as it compels the programme managers to look at where combined financing can be achieved and reduces duplication of services. However, the success of integration is largely dependant on the commitment of the programme managers to integrate services, share information, develop guidelines for integration and management of programmes at different levels and provide support to the implementation areas. At the health centre and community levels, it is not always easy to do so when integration and collaboration are not enforced at the district and central levels. Programmes need to talk to each other more at all levels for effectiveness. These linkages, if well cultivated, enhance synergy for the benefit of the communities that benefit from the services provided and create a supportive environment for service provision. Operational research must be integrated into programme implementation to get evidence-based outcomes for improved planning, implementation, monitoring and evaluation.

3.3.2 Human Rights Approach to Programming:

This policy confirms that each member of the community has a right to health and that communities have a right to participate and manage community health programmes. It is important to seek and listen to the voice of the people as they prioritise their own health needs through, for example, community health committees, the cell committees, and “Community Partnership Improving the Quality” boards. Use of participatory, community-centred, capacity development methodologies allows communities to assess and analyse their problems and come up with plans of action for implementation, monitoring

and evaluation by the communities themselves. This community involvement allows communities to lead in their own development, promotes self-reliance, and enhances ownership and sustainability. For effective community involvement, the capacity of the districts should be strengthened to facilitate the transfer of skills to communities.

3.3.3 Decentralisation:

Decentralisation offers the potential for communities to be more involved and participate in decisions which relate to their development. It is expected to lead to an improvement in the health of the population if it enables an increase in the quality of health inputs, and if these health inputs adjust to the particular needs of the local citizens. However, although decentralisation can result in greater total health gains, it may also lead to increased inequalities in health care if financial allocations are not adequately distributed and managed. There are advantages to decentralisation such as:

- Building ownership of programmes by districts and communities.
- Sharing national benefits equitably among the districts and communities.
- Building self confidence for districts and allowing for professional growth.
- Empowering communities to participate in management of community health programmes
- Promoting leadership development at the district and lower levels for implementation of developmental projects.
- Promoting adequate transfer of skills to communities, increasing access to communities and strengthening supervision for projects undertaken at the community level.
- Fostering accountability and improving financial management and monitoring.
- Facilitating increased proximity to the project areas and reducing transport costs.
- Permitting formulation of integrated action plans which can be monitored by the districts.

3.3.4 Equity and Excellence in Service for all Levels of Society:

Equity in health is a basic right of all citizens of the country. The Ministry of Health will ensure removal of socio-economic, gender, age, geographic and cultural inequities in health care.

3.3.5 Equitable and Equal Access to Quality Health Care for Children:

The principle of equity in health includes access to health for all children with special reference to orphans and other vulnerable children (OVC). Rwanda has developed a National Plan of Action for OVC primarily to strengthen all service delivery to the OVC, including health. The Integrated Management of Childhood Illnesses (IMCI) strategy must be strengthened both at the institutional and community level. At the institutional level, the strategy focuses on enabling health workers to manage childhood infections. At the community level, the strategy aims at mobilising communities for the implementation of community IMCI. The strategy includes: sensitisation of communities about the key household practices on the care of the sick child, training of community members on prevention of childhood illnesses, recognition of signs and symptoms of an onset of infection and early referral to the health centre for further management. Unlike adults, children often do not vocalise their feelings, so family members and volunteers need to have a list of signs to look for and to consult professionals whenever they are in doubt. Critical to the effective engagement of communities is the direction, support and direct field supervision of communities by health workers. Transfer of skills and knowledge to communities fosters ownership and enhances sustainability. A special mention needs to be made for the treatment and care of OVC, especially those in child headed families. Volunteers and community leadership need to be vigilant to identify children needing treatment and care before complications set in.

3.3.6 Gender Equality and Equity in Community Health:

Gender sensitive programmes in health need to be developed to reduce gender inequalities. Men and women deserve equal respect for their rights. Developing partnerships between spouses in seeking health options should be encouraged as it cultivates positive attitudes to accessing health. Currently there are more women than men involved in prevention, care and support services for family and community members. If scaling up community health prevention and care activities is to become a reality at the district and community levels, men need to be involved more so as to share responsibilities with women. After all, men have a lot of influence in communities as traditional leaders and decision makers, making it possible for them to provide leadership and support to prevention and care activities. The district health teams need to motivate men to participate in community health activities such as home based care, reproductive health, family planning, and TB, Malaria, HIV and AIDS/STIs prevention.

3.3.7 Promotion of Community Based Health Insurance:

Community-based health insurance is a strategy that allows the whole population to be able to afford health care and to improve the quality of care available. It also allows for the mobilisation of additional resources by the government and those financing healthcare structures. Community-based health insurance is one of the tools in the fight against poverty. By 2007, there were 6,702,391 people that were registered for the health insurance, representing 75% of the population of Rwanda. Health facility use has also gone up to 85% in September 2008 (HIMIS 2008). Showing that removal of financial barriers improves attendance at health facilities in cases of illness.

3.3.8 Reinforcement of Coverage of the Entire Population through Community Health Workers:

Community health workers form the link between the health centres and the community, serving as the mouth piece and ears of the health service at the community level. They know the communities well as they live and work among them, and they are often respected individuals. Enhancement of this cadre in terms of skills and knowledge can do a lot of good for the communities. The fact that there are two community health workers at the village level means that people are given an opportunity to deal with either male or female providers, which is important because most people prefer to talk to the same sex care provider when discussing reproductive and sexual issues.

Engaging traditional birth attendants to sensitise women on safe motherhood and to ensure that pregnant women reach health facilities for safe delivery services is also important. The capacity of the community health workers for the pregnant women and newborn should be strengthened through training, provision of information in Kinyarwanda language, provision of protective clothing and reassurance that the health care service will partner with them in ensuring safe health facility deliveries and not condemn them.

Volunteers managed by different organisations get different packages for their contribution to the care process. Different packages for people doing the same work within the same locality may cause a lot of dissatisfaction and prompt a tendency for volunteers to move from one organisation to the other in search of greener pastures. Through the Ministry of Health and its partners, there is a need to regulate incentives, allowances, and minimum packages for volunteers, thereby strengthening volunteer coordination and service delivery.

3.3.9 Community Participation:

Community participation in planning, implementation, monitoring and evaluation of services for the communities is essential to build sustainability and self reliance. All sectors of the community, including people living with AIDS, young people, traditional healers, traditional birth attendants (TBAs), women, men and community associations, should be mobilised to participate in health care delivery.

3.3.10 Effective Referral Systems:

Effective referral systems and discharge guides for further management of clients and patients will be strengthened so that patients and clients do not miss the opportunity to access services. This system should provide for both vertical (health facilities to the community) and horizontal referrals (to organisations outside the Ministry of Health that offer support to patients or clients). A smooth hand-over and take-over of patients from health institutions to the community strengthens the relationship between the communities and the health care system and also ensures that the patients get the needed care. It is therefore prudent for the Ministry of Health to establish effective discharge guides that prompt institutions to refer patients to specific levels for continued care.

3.3.11 Home Based Care:

Home based caregivers are faced with particular constraints regarding access to drugs and implementation of universal precautions. Managing pain in home based care is very important. Most patients will respond to basic analgesics given by the volunteers, but some will need stronger drugs that can be ordered by the health institutions. Universal precautions for home based care givers will also be given priority. The programme must view every community care patient and care giver as a potential carrier of some infection which could be passed on to others. The use of universal precautions should follow national guidelines, which address such issues as a continuous glove supply and implementation no matter what the ill person's condition. National guidelines and manuals on universal precautions for professionals will be translated into Kinyarwanda language, for use by the communities offering care at home and in the community. In addition, caring for the care givers should be planned for in developing care plans for home based care.

3.3.12 Partnership Building to Enhance Community Health:

A successful community health service provision must be based on harnessing all partners that are working in the community, e.g. Local government, Ministry of Education, NGOs, FBOs, CBOs, the private sector and other professional groups providing complementary services. The roles and responsibilities of government and the complementary organisations will be identified.

For effective partnership building emphasis will be put on the follow there must be:

- Explicit policy direction on what partners can do in response to community health needs.
- Explicit guidance in the Strategic Framework on how to include other partners.
- Capacity strengthening for health institutions to respond to the needs of new partners offering community health services.
- Capacity building for new partners to improve their skills, knowledge and attitudes, since poorly prepared partners find it difficult to fit into the broader partnership and this tends to derail the national efforts.
- A shared vision with partners and clarity of roles at the district level, thus promoting commitment to the national goals.
- Joint planning, evaluation and monitoring as possible

3.3.13 Effective Co-ordination:

Developing an effective co-ordination system is critical for the success of community health services. Coordination means to provide leadership, manage, direct, organise, synchronise, harmonise and bring together things that otherwise would have been separate entities. As there are many organisations such as FBOs, NGOs and CBOs and international partners providing health services at the district and community level, the Ministry of Health will establish a clear coordination system at the central, district, health centre and community levels that will build a cohesive team. As the local health centre forms the link between the district and the community, the capacity of the local health centres to coordinate community health activities will need to be developed to render leadership, supervision, and support to communities and other organisations implementing health projects at the community level. It should, however, be realised that for the local health centre to perform its duties of coordination and collaboration adequately, it will need adequate support from higher levels to nurture it into a position where it can perform well. Guidelines for coordination which should be explicit in how, when and what to coordinate will be developed.

3.3.14 Monitoring, Evaluation and Dissemination:

Monitoring and evaluation systems are integral to the planning and implementation of community health services. They provide programme managers, implementers and policy makers with timely information not only on the status of implementation of programme activities, but also, importantly, on the key issues of effectiveness, efficiency and continued relevance. For monitoring and evaluation of community health activities to be effective, there must be development of a monitoring and evaluation package which sets out a minimum of clear, achievable, and time-bound objectives, outputs and outcomes; realistic targets and meaningful indicators; and standardised tools for data collection. These must be backed by the National Health, National AIDS, Community Health, MCH and Family Planning Policies, the Millennium Development Goals and the Strategic Frameworks. This package will be accompanied by monitoring and evaluation plans for implementation by the central, district, health centre and community levels.

3.4 Vision:

The vision of the *National Community Health Policy* is to ensure the provision of holistic community health care services for all, for the betterment of the entire population of Rwanda. The policy embraces the values of equity in service distribution and solidarity with the disadvantaged as they seek health care. It also embraces the highest standards of ethics as services are implemented, so that gender, age and positive cultural norms in relation to healthy lifestyles are respected. The Policy capitalises on active participation by communities in the planning process, implementation, monitoring and evaluation of programmes and projects geared at improving their health with greater emphasis on improved feedback mechanisms.

3.5 Mission:

The mission of the *National Community Health Policy* is to engender conditions for achieving good health for the entire population to enable them to contribute to sustainable development in Rwanda. The mission of the policy is also to contribute to those activities and processes that 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. It therefore seeks to guide the elaboration and implementation of the strategic, monitoring and evaluation plan so as to enhance the

capacity of community health workers to provide quality services that will create an environment for physical, mental and psycho-social growth by ensuring that community health services reach individuals and all family members in the community. It further seeks to reinforce linkage between the community and the health care system.

3.6 Policy Objectives:

3.6.1 General Objective:

The general objective of the *National Community Health Policy* is to provide clear guidance for the provision of holistic and sustainable health care services to communities with their full participation.

3.6.2 Specific Objectives:

The specific objectives of the policy are to:

- Reinforce coordination of community health services at the central, district, health centre and community levels.
- Guide the development of operational guidelines and management tools.
- Guide the mobilisation of resources for the implementation of community health programmes.
- Reinforce integrated community health package of services for all community health workers and at all health centres.
- Strengthen the capacity of decentralised structures and health service provision.
- Strengthen the participation of individuals and all family members in community health.
- Advocate and build partnerships for the provision of community health.
- Guide the development of monitoring and evaluation systems that will sufficiently inform the provision of community care services at all levels.
- To strengthen community health workers cooperatives, integrate the community health workers in the Intorerero Z'Ubuzima.

4. Policy Strategy in Brief:

The *National Community Health Policy* and the concomitant Ministry of Health policies, programmes and projects aim to improve the health of the Rwandan people through their full involvement and participation in the health delivery system at all levels. A specific sectoral strategic plan is to be put in place to address the challenges and gaps identified in community health. A monitoring and evaluation (M & E) plan will also be put in place to ensure successful implementation of the policy. The following strategies have been identified.

Strategies:

- Building the capacities of the Ministry of Health staff for coordination of community health activities at all levels.
- Strengthening the capacity of decentralised health structures for programme design, implementation, monitoring and evaluation of community health.
- Mobilising communities for their full participation in community health care provision.
- Strengthening the capacity of community health workers to provide quality community health services.
- Reinforcing integration at all levels.

- Advocating and mobilising resources to support implementation of the community health programmes.
- Building partnerships for community health.
- Developing a monitoring system that will also capture community activities at the community level.

5. Community Health Programmes:

This policy will guide the present and the future of community health programmes. The following are current community health programmes offered by the Ministry of Health: the National Programme on Leprosy and Tuberculosis, the National Malaria Control Programme, Environmental Health programmes, the National Programme on Community-Based Nutrition, the National Expanded Programme on Immunisation, the Reproductive Health Programme and Family Planning Integrated Management of Childhood Infections (IMCI), and Care and Support to PLWHA.

The following pages briefly describe the health components currently offered under the ambit of community health and offer guidelines for further development.

5.1 Curative Services:

5.1.1 Integrated Management of Childhood Illnesses (IMCI):

IMCI aims at preventing, detecting and providing early treatment for childhood illnesses. The main strategies in IMCI are, first, institutional capacity building to enable health workers to gain knowledge, skills and attitudes to plan, implement, monitor and evaluate IMCI activities, including support for communities to carry out the community component of IMCI. The second strategy is mobilisation of the communities for the implementation of community IMCI, including 15 key family practices adopted by the Ministry of Health out of the 16 elaborated in 1990 by WHO and UNICEF. These family practices are based on sensitisation and promotion of communities regarding care for the sick child suffering from, for example, acute respiratory tract infections, Malaria etc. Activities include training of community members on prevention of childhood illnesses, recognition of signs and symptoms of an onset of the infection and early referral of children to the health centre for further management where indicated. Critical to the effective engagement of communities is the direction, support and direct field supervision of communities by health workers. Transfer of skills and knowledge to communities fosters ownership and enhances sustainability. Well performing districts could be used to mentor the ones not doing well. However, IMCI should be integrated into other child health activities.

5.2 Preventive services:

5.2.1 Programmes to Combat TB and AIDS (PNILT) and Malaria (PNILP):

As programmes to prevent Malaria, TB and AIDS are different programmes at the central levels, but link at the community level in terms of prevention education, adherence to treatment and counselling, it makes sense to combine HIV and AIDS prevention with TB and Malaria control into activities run by the community health workers and other volunteers at the community level. The directly observed treatment short course (DOTS) strategy could be integrated with community based health care services such as IMCI, immunisation, hygiene, reproductive health, nutrition and AIDS education at the community level. An integrated community prevention package for TB, Malaria and HIV and AIDS for use by the community volunteers and community health workers will be developed and volunteers trained to use the information package for maximum benefits.

To enhance the Ministry of Health's efforts to prevent communicable diseases, community mobilisation needs to be strengthened to develop health seeking behaviour which enables communities to take charge of their own health by getting them involved in integrated prevention, treatment and care efforts.

5.2.2 Expanded Programme on Immunisations (EPI):

Child immunisations are cost effective ways of ensuring prevention of childhood diseases and improvement of child health. Rwanda has achieved high levels of immunisation coverage of 98% for BCG, 100% for DPT-Hep B/HIB, 95% for Measles and 102% for Polio. This is a commendable achievement which should be maintained.

5.2.3 Nutrition:

Programmes that combat malnutrition are as follows: 1) Nutrition and growth surveillance; 2) Nutrition rehabilitation/education, and 3) Distribution of Vitamin A, iron and other micronutrients. In addition, the IMCI recognises nutrition as a key ingredient to treatment. The following are community based nutrition programmes which involve the community health workers:

- Growth monitoring and counselling.
- Nutrition rehabilitation and mother education.
- Distribution of micronutrient supplements.
- Distribution of nutrition supplements such as Vitamin A, Iron/folate, Zinc supplementation.

5.2.4 Environmental Health:

Environmental health focuses on improving access to safe water, effective waste disposal, and generally promoting individual, family and community hygiene. Low access to safe water, poor disposal of waste and poor hygiene predispose individuals, families and communities to water and food borne diseases such as diarrhoea, cholera and typhoid. Community health can improve the knowledge of communities on prevention of food and water born diseases. Strengthening the knowledge base of communities can be done by enabling community health workers to undertake community education and through partnership with the media for a wider circulation of information.

5.2.5 Reproductive Health:

The Ministry of Health is currently developing a reproductive health package for use by the community health workers to mobilise and inform communities. While the majority of people who use reproductive health services are women, efforts to increase service utilisation by communities will also target men as they are the major decision makers, often control the family resources and can easily influence their peers in a positive way.

Interventions to reduce Mother-to-Child Transmission of HIV include primary prevention of HIV infection among women, family planning, ART, minimisation of invasive obstetric procedures during vaginal delivery and provision of infant feeding alternatives. Offering ART to HIV positive mothers to prevent transmission of HIV infection to their babies is difficult in districts where many women deliver at home due to long distances to the clinic, failure to pay for the service required and due to religion. Community involvement in PMTCT is key to turning some of the community challenges into opportunities. Community mobilisation for PMTCT must be integrated into the activities of community health workers. Community health workers also motivate pregnant women to attend ante-natal (ANC) and post-natal care visits at the health centre.

5.2.6 Family Planning Programme:

Community health workers inform communities on the advantages of family planning and distribute condoms and pills.

5.3 Care and Support:

5.3.1 Care for Orphans and other Vulnerable Children (OVC):

Rwanda has developed a *National Plan of Action for Orphans and other Vulnerable Children* (2006-2011) with participation of children as key stakeholders. The plan seeks to ensure that OVC are able to access education, food, health services, legal support, birth registration, protection from abuse and exploitation through coordinated efforts by government, NGOs and civil society with full participation of children.

Efforts to strengthen community social safety nets for OVC at the district and community levels have been put in place in the form of child mentor associations. The child mentors are chosen by the orphans themselves on the basis of trust and mutual understanding with the mentor. The activity is facilitated by the local authorities. Communities have responded by making bricks or building the shelters for orphans with support from the NGO community. Projects that support orphans and other vulnerable children in the community include small live stock, vegetable gardens, motor and bicycle taxis and handicrafts. Multi-sectoral, collaborative and coordinated responses are essential for care of orphans and other vulnerable children.

5.3.2 Home Based Care for Terminally Ill Patients:

Providing home based care for people who suffer from life threatening diseases is a hallmark of a humane and caring society. Many people within our society, however, have little or no preparation at a personal level for dealing with death and bereavement, and yet dying is a natural process. It is expected that the Ministry of Health will promote strengthening of linkages within different services to improve the quality of care for those who need it. Ideally, when communities are well prepared for the introduction of the services, every sector of the community identifies with the care services provided. This ownership goes a long way towards ensuring the acceptance and continuity of the service. Motivated communities have been known to validate and support community health workers, family caregivers and community care volunteers, as well as to mobilise local resources for care.

A supportive environment forms the basis of care and support for PLWHAs. Their nutrition, for example, will be enhanced by the transmission of information on balanced diets and assistance in starting projects such as vegetable gardens that contribute to good nutrition. Most importantly, stigma and discrimination at all levels must be eliminated. In its advocacy and communication strategies, for communities, Community Health at the district level will need to work with the AIDS programme to develop messages that build a supportive environment for people living with AIDS. All HIV positive people must be encouraged to join associations of HIV positive people for support. Members of the associations will need to be trained in counselling for them to offer support to their peers. Integrating them with other volunteers outside the associations may be very beneficial in terms of reducing stigma.

5.4 Promotive Services -- Behaviour Change (BC):

The Ministry of Health has developed a *National Behaviour Change Communication Policy* to guide health communication planning, coordination, implementation and monitoring and evaluation. By integrating behaviour change communication into health planning, programming and implementation, the policy will facilitate Rwandans to adopt and maintain behaviours conducive to good health.

In particular, the policy defines the contribution of behaviour change communication in achieving national health priorities; provides a strategic orientation and guiding principles to achieving priority health objectives through behaviour change communication; and provides guidance and tools to support behaviour change planning, programming, evaluation and coordination.

Changing individual and community behaviour is key to all preventable diseases and conditions such as Malaria, TB, AIDS, STDs, childhood infections, water born diseases and malnutrition. Use of interactive methods in communication such as interpersonal communication has been found to be very effective for behaviour change. Interpersonal communication is a person-to-person, two-way, verbal and non-verbal interaction that includes sharing of information and feelings between individuals or in small groups. It facilitates the establishment of trusting relationships. Behaviour change must take place at both individual and societal levels, making it necessary that communication for societal change must be developed along side with communication targeting individuals. Communication messages at the district and community levels must be delivered through accepted community based media such as drama, poetry, story telling, song and dance. However, drama groups need training in order to provide effective communication performances. Community newspapers written in local languages can also play an important role in promoting attitude change and popularisation of safer behaviour.

5.4.1 Behaviour change can be facilitated in many ways such as:

- Stimulation of community dialogue: Communities are stimulated to discuss factors that contribute to the spread of infectious diseases and conditions and situations that create them. Such factors may include traditional customs and norms which have negative effects to reducing the spread of infections. These may include poor hygiene, religion that discourages immunisations for children, gender disparities, domestic violence, child abuse, discrimination and stigma.
- Provision of Information and Education: Information provides individuals, families and communities with basic knowledge enabling them to make informed choices. Such information should be given in the languages that the communities understand, using communication media that is familiar. For example, the use of drama, song and dance, poetry, popular theatre at strategic points, community newspapers in local languages and the radio is very effective.
- Advocacy: Promotion ensures that community and political leaders at the district level stay informed on the epidemics and are motivated to get involved and provide leadership in prevention, care and mitigation activities.
- Stigma Reduction: Many people in communities have been stigmatised for reasons such as poverty, TB, cancer, orphan-hood, AIDS and skin conditions. Communication both provides information and a venue for discussing the issues of stigma, thereby reducing the depth or extent of stigmatisation. Stigma can lead to isolation of the infected and affected in communities and hinder them from accessing services provided for them. Role plays, dance, and group discussions can play a very important role in reducing stigma by giving correct facts on diseases. Use of community case studies where possible can also be useful.
- Promotion of services available: Communication promotes information on all health conditions and accessible services provided. Information can be provided on TB, Malaria, STI and HIV prevention, treatment, immunisations, reproductive health counselling, HIV testing services, support groups for the HIV positive, post test clubs, OVC, PMTCT, clinical care for opportunistic infections, ART and social and economic support for the affected families.

5.5 Other Ministry of Health Programmes:

Community health plays a key role in other Ministry of Health Programmes, including:

- Programmes and services for the handicapped: ASCBs will be expected to continue to identify the handicapped and refer them for help to government programmes, beginning at the health centre level.
- Programmes to prevent violence against women: ASCBs will receive special training about how to detect and report this problem, as well as to refer victims to health centres and to proper authorities.
- Participation in programmes/activities for those in need of psychological counselling/support: *Agents de Santé* are urged to participate in all activities of the peace and reconciliation movement, including the weekly tribunals (*Gacacas*).

5.6 The Community Based Health Information System:

The community based health information system includes:

- Simple mapmaking that depicts each household.
- Family registration and a family register form.
- Derivation and use of a health worker's register of under-fives.
- Derivation and use of a health worker's register of women aged 15-49.
- A vital events reporting system.
- Home based records for children under five and women aged 15-49.
- Planning for feedback of information for action from *cellule* leaders to their village partners.
- A record of maternal deaths and under five mortality.

6. Institutional Framework for Policy Implementation:

6.1 Coordination:

At the National level, the Ministry of Health will coordinate and provide leadership in the implementation of this policy.

At the District level, coordination will be done by the district authority with clear guidance and support from the central level.

At the Community level, coordination will be done by the local health centre or a designated community structure with a clear mandate, guidance and support from the district authority. The Ministry of Health will develop an effective system that will coordinate all national community health services provided by the Ministry of Health, other government ministries, international agencies, international NGOs, local NGOs, FBOs, CBOs and communities. In doing so, the Ministry of Health will have to develop collaboration and linkages with other partners and programmes that provide services in community health.

6.2 Advocacy:

The role of the Ministry of Health in advocacy will be to advocate with other Government of Rwanda ministries such as the Ministry of Finance, MINALOC and MIGEPROF for resource allocation for the policy's implementation. It will also advocate with other partners, such as the international agencies, to mobilise external resources and to help build the system by providing technical support. Advocacy should also involve NGOs and FBOs that can implement elements of the Community Policy using their own resources. In the process of this advocacy, effective partnerships with different organisations in accordance to their comparative advantage should be developed and managed effectively.

6.3 Financing:

The Ministry of Health will identify funding for the implementation of this policy. Funds will be needed for translations into different languages, printing, distribution and implementation of the provisions of the policy.

6.4 Implementation:

For implementation of this policy, the Ministry of Health will lead the process of developing guidelines, training manuals and building the capacity of all levels for coordination and reinforcing adherence. At the district level, districts will oversee the implementation of this policy.

6.5 Monitoring and Evaluation:

Monitoring and Evaluation of the process as well as the outcomes of the policy implementation are very critical to inform the Ministry of Health of the progress being made in the policy implementation. The Ministry of Health will have to review the monitoring tools to assess their adequacy for the monitoring of the Policy implementation. Disaggregated data collected at the periphery will need to be interpreted, discussed and used to inform the local structures for their information and

inclusion of data in their planning. The Ministry may need to assist the districts to develop data bases where they do not exist.

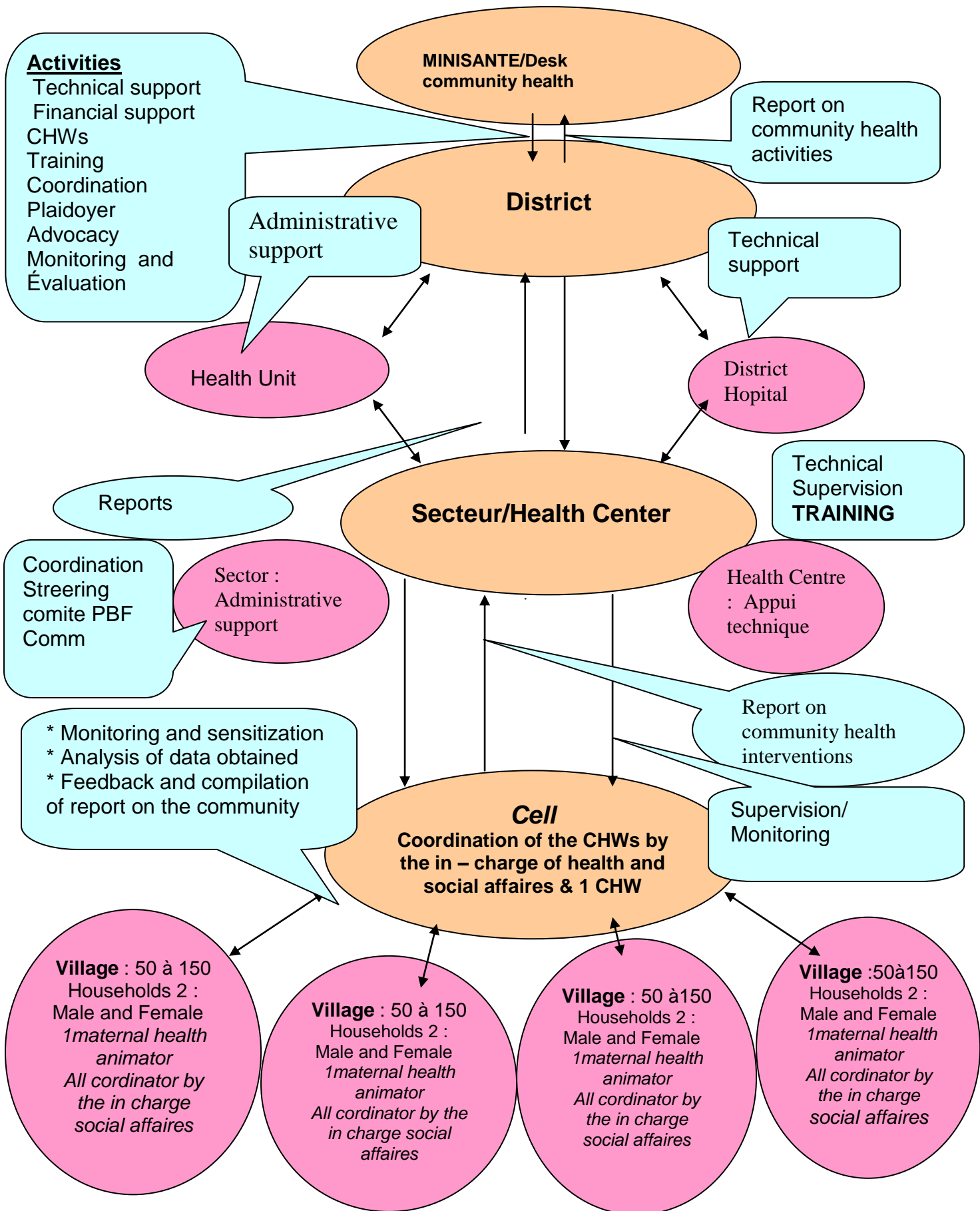
6.6 Institutional Capacity Building:

The Ministry of Health will develop the capacity of community health staff at national and district levels to undertake coordination, collaboration, building linkages with other programmes and partners at the district level and also to gain skills to train, support and supervise community structures providing community health. The package may include training for skill building, building support, developing positive attitudes, accountability and knowledge. Information packages will have to be developed for different levels of implementation to use as reference materials.

6.7 Community Participation:

Community participation in this policy implementation is critical. Effective methodologies to engage communities as partners in policy implementation should be devised. Communities, through community leaders, will, for instance, participate in the elaboration, implementation and evaluation of community health strategies.

Schéma 2. Coordination of Community Health Workers des *Agents de Santé Communautaire*



7. Conclusion:

The *National Community Health Policy* provides a framework to guide present and future programme design, planning, implementation, monitoring and evaluation. Its implementation will strengthen decentralisation of structures and services to the district level and down to the villages (*imidugudu*). The decentralisation of services and structures is expected to strengthen the mobilisation of communities for their full involvement in the provision of community health services, both as individuals, family members and communities. Community involvement is expected to empower communities to become self reliant, to lead in their health development and to promote sustainability. The policy offers an instrument to build and manage partnerships for community health and also advocates for leveraging of resources. It will be used for advocacy for adequate resource mobilisation and allocation to the Ministry of Health by the Government of Rwanda. It is crucial that the coordination and monitoring of the implementation of this policy at the central, district, health centre and community levels be effective. The obligations of this policy will be expressed in a Strategic Plan for Community Health. Overall, the policy provides the framework to improve community health and contribute to the attainment of national, regional and international goals such as the Decentralisation Outcomes, the *Vision 2020*, and the Millennium Development Goals.

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