MOH
Environmental Health

Community Health Workers (CRWs)

Enhancing human & natural resources
MINEDUC
MINAGRI

CBEHPP (CHCs)
MINALOC

National development & poverty alleviation
MINECOFIN

Increasing access to rural & urban WSS
MININFRA

Roadmap for CBEHPP

Community-Based Environmental Health Promotion Programme

REPUBLIC OF RWANDA

MINISTRY OF HEALTH
Environmental Health Desk

REPUBLIC OF RWANDA

MINISTRY OF HEALTH
Environmental Health Desk

ROADMAP for CBEHPP

January 2010

List of Abbreviations

AfDB	-	African Development Bank
ARI	-	Acute Respiratory Infections
CBEHPP	-	Community Based Environmental Health Promotion Programme
CBO	-	Community Based Organisation
CHC	-	Community Hygiene Club
CHW	-	Community Health Worker
DFID	-	Department for International Development (United Kingdom)
DP	-	Development Partner
EDPRS	-	Economic Development and Poverty Reduction Strategy
EH	-	Environmental Health
EHD	-	Environmental Health Desk
EHO	-	Environmental Health Officer
GoR	-	Government of Rwanda
HSSP	-	Health Sector Strategic Plan
JICA	-	Japan International Cooperation Agency
M & C	-	Maternal and Child Health
MDG	-	Millennium Development Goals
MINAGRI	-	Ministry of Agriculture and Animal Resources
MINALOC	-	Ministry of Local Government
MINECOFIN	-	Ministry of Finance and Economic Planning
MINEDUC	-	Ministry of Education
MININFRA	-	Ministry of Infrastructure
MOH	-	Ministry of Health
PEPAPS	-	Programme D'adduction D'eau Potable en Milieu Rural - Province du Sud
PHAST	-	Participatory Hygiene and Sanitation Transformation
RDHS	-	Rwanda Demographic and Health Survey
TA	-	Technical Assistance
ToT	-	Training of Trainers
ToR	-	Terms of Reference
UNICEF	-	United Nations Children's Fund
VLOMM	-	Village Level Operation Maintenance and Management
W & S	-	Water and Sanitation

FOREWORD

Rwanda's health statistics reveal that most of the diseases attended to at health facilities can be prevented through improved hygiene behaviour and sanitation. It is important to note that the top ten leading causes of morbidity and mortality in Rwanda are caused by infectious diseases and that over 90% of consultations at the rural health facilities include malaria, acute respiratory infections (ARIs), diarrhoea, skin diseases, HIV/AIDS, STIs, tuberculosis, typhus, cholera, meningitis and intestinal parasites. (66% of school children are infected with worms and 44% of pupils suffer from amoebiasis). The major contributing factors are inadequate and unhygienic facilities for excreta disposal, poor management of liquid and solid wastes, and inadequate practices of hand washing with soap.

Food and water are of course critically important to sustain life but they are often rendered dangerous by unhygienic human activities. Food and water safety depends mainly on the level of personal and domestic hygienic practices and behaviours. As such, accessibility to safe drinking water infrastructure by itself will not result in a significant reduction of diseases unless fully complimented by improved hygiene behaviour-change and sanitation.

One of the Vision 2020 statements is that all households will "have mastered and be practicing hygiene and waste disposal". Similarly the Health Sector Strategic Plan (HSSP) emphasises the promotion of healthier lifestyles and the prevention of disease. It is therefore very important that a practical approach that fully involves the community is put in place to operationalise these visionary statements. This *Community-Based Environmental Health Promotion Programme* (CBEHPP) aims to do just this in order to significantly reduce the national disease burden.

Implementation of CBEHPP calls for inter-sectoral collaboration. As such, Ministry of Health will provide all necessary technical and capacity building support while Ministry of Local Government will ensure coordination and mobilization of locally available resources. Such collaboration and coordination mechanisms will be established and made functional at National, District, Sector and Community / Umudugudu levels. The *Community Hygiene Club* (CHC) methodology will promote behaviour change and will become the engine for social interaction and development. This approach will be facilitated by our existing 45,000 Community Health Workers (CHWs) who in turn will be supported and mentored by our vitally important Environmental Health Officers (EHOs) who are active at all levels of decentralization.

Ministry of Health is hereby launching this **CBEHPP Roadmap** and invites all our partners to actively support the programme. While the CHWs are already available, their capacity to achieve positive results through the CHCs requires technical support and motivation. Appropriate training materials and financial recourses for this noble cause are going to be critical towards achieving effective implementation and achievement of our objectives in terms of preventative health and national poverty reduction outcomes.

Dr Richard SEZIBERA
Minister of Health

MINISTERE DE LA SANTE

What is CBEHPP?

The Government of Rwanda, through the Ministry of Health, launched the **Community-Based Environmental Health Promotion Programme (CBEHPP)** on 17th December 2009. The purpose of this programme is to significantly reduce, by 2012, the debilitating national disease burden that currently exists, and by doing so, contribute significantly to poverty reduction outcomes. CBEHPP will strengthen the capacity of approximately 45,000 Community Health Workers (CHWs), who are located in 15,000 identified villages, through the adoption of the holistic **Community Hygiene Club (CHC)** methodology, as a means of rapidly attaining hygiene behaviour changes that are both sustainable and cost effective.

The CBEHPP approach will reach out to all communities and empower them to identify their personal and domestic hygiene and environmental health related problems (including safe drinking water and improved sanitation), thereafter, to actively participate in the problem solving process. CBEHPP is embedded in the Health Sector Strategic Plan (2009-2012) of the Ministry of Health.

Why is CBEHPP vitally important to the water and sanitation sector?

Safe water can reduce diarrhoea by 15%, health promotion reduces diarrhoea by 35%, and frequent hand washing with soap is estimated to reduce diarrhoea by 47%[1]. It is for this reason that hygiene behaviour change is now considered to be an indispensible aspect of every water and sanitation programme. Without this vital component of hygiene behaviour change, W&S programmes inevitably fail in their enormous potential to improve the health and welfare of the nation, and opportunities and resources are unnecessarily wasted. CBEHPP is adopting the CHC approach that is well proven to empower communities, especially women, to take up the responsibility at the village level in operation, maintenance and management (VLOMM), for rural water facilities like hand-pumps, protected springs and piped supplies, thus enabling their long-term sustainability. CBEHPP therefore complements the efforts of MININFRA to provide safe drinking water and sanitation.

Why is CBEHPP vitally important to Local Government?

CBEHPP provides a practical opportunity for MINALOC to achieve greater inter-ministerial and inter-sectoral collaboration at the district and sub-district levels, which leads to increased synergies through efficient mobilisation and use of existing human and material resources. CBEHPP focuses on basic development right down to the level of the family, while the CHC approach has been proven to strengthen social capital and build trust and cohesion within communities.

How will CBEHPP be implemented?

The implementation strategy is through strengthening the capacity of 45,000 CHWs under close mentoring and supervision by Environmental Health Officers (EHOs) who

[1]Curtis & Cairncross, 2003, *Effect of Washing Hands With Soap on Diarrhea Risk in the Community: a Systematic Review. The Lancet, Infectious Diseases*, 3, 275-280

are based in health centres. The CHWs will facilitate the formation of CHCs in every village, in order to achieve practical hygiene behaviour change in every homestead. Institutions like schools, clinics and prisons will be targeted under this programme, which seeks to change hygiene behaviours and place Environmental Health firmly on top of Rwanda's Development Agenda.[2]

What is the Community Hygiene Club (CHC) Approach?

The CHC Approach appeals to an innate need for health knowledge, which is then reinforced by peer pressure to conform to communally accepted standards of hygiene, thereby creating a 'Culture of Health'. The CHC Approach addresses a wide range of preventable diseases within a holistic framework of development, that understands health promotion as an entry point into a long term process of transformation of social norms and values that ultimately lead to poverty reduction outcomes.

Based on an assessment of the priority environmental health threats to the Rwandan population and internationally recognized effective preventive and promotive healthcare interventions to achieve EDPRS, Vision 2020 and the MDGs will compliment the following CBEHPP priorities:-

- Improved household and institutional (schools, clinics and prisons) hygiene and sanitation:
  - Safe excreta disposal with zero open defecation (ZOD), and hygienic use of toilets
  - Hand-washing with soap and water
  - Safe water handling in homes, schools and other public institutions
  - Safe disposal of solid and liquid wastes
- Food safety and improved nutrition
- Indoor air pollution
- Vector Control

What are the '7 Golden Indicators'[3] to be achieved by CBEHPP?

1. Increased use of hygienic latrines in schools and homes from **28%** to **80%**
2. Increased hand washing with soap at critical times from **34%** to **80%**
3. Improved safe drinking water access and handling in schools and homes to **80%**
4. Establishment of CHCs in every village from **0%** to **100%**
5. Achieve ZOD in all villages to **100%**
6. Safe disposal of children's faeces in every household from **28** to **100%**
7. Households with bath shelters, rubbish pits, pot drying racks and clean yards to increase to **80%**

The strength of the CHC approach is not only its ability to engender hygiene behaviour change, but it is also able to quantify behaviour change by using community monitoring tools as an integral part of the process of change. The health promotion training focuses on the most common preventable diseases handled by local health centres. These include diarrhoeal, acute respiratory infections (ARIs), skin diseases, eye diseases, intestinal worms, bilharzias and malaria.

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[2](Refer APPENDIX 1: Detailed Implementation Strategy, page 10)

[3](as per HSSP II Log-frame; baseline taken from RDHS 2005; refer APPENDIX 3, p.17)

How will the anticipated Hygiene Behaviour Changes be monitored?

Each CHC is charged with monitoring the changes within its village membership (usually consisting of between 50 to 150 households). When a CHC is formed, a Chairperson and Secretary are elected, who keep a register of attendance of the members. The CHCs are responsible of ensuring that levels of hygiene are monitored, together with the CHW facilitator, who visit each household to observes the living conditions. These observations, known as a 'household inventory' are conducted on a regular basis, and the information is later entered into an exercise book, thus enabling each CHC to identify exactly when the agreed behaviour and lifestyle changes were made. If a CHC is too large for one CHW to monitor, it can be broken down into clusters of 10 households, and a cluster leader is responsible of conducting the monthly monitoring exercise.

This low cost, simple and effective method enables communities to keep track of any progress made, and to have ownership on information gathered, and consequently be able to manage their health matters. Any 'problem' households are soon spotted by the CHC committee and remedial action can be taken locally. Each CHC encourages the members to improve on matters related to hygiene through group consensus and peer pressure. House-to-house visits by CHC members reinforce the selected target practices. People tend to change if they know that they are being noticed. In addition, some districts may opt to add impetus by providing recognition, rewards and prizes to the best CHC and model homesteads, based on the percentage of behaviour change achieved from the start to the end of six months of CHC training.

What is the way forward?

CBEHPP was officially launched by Dr Richard Sezibera, the Minister of Health, on **17th December 2009.** A series of activities are being carried out to ensure that an appropriate start of the programme is immediately taken up. These activities include the development and printing of CHC training materials that build on previous behaviour change experiences and lessons learnt in Rwanda, including the use of the PHAST approach; the holding of National and Provincial Orientation Workshops that will identify 'start-up' districts (at least one per province). Thereafter, a national core team of principal CHC trainers will be established and trained in the CHC approach, that is based on the familiar PHAST methodology.

The core team will then go around to conduct ToTs to all EHOs and school health officers in every district, starting with the selected 'start-up' districts in the first quarter of 2010. The team of principal CHC trainers will then become the backbone of the programme, by training, mentoring and supervising district EHOs, who in turn will train and support their local community health workers and school health officers to initiate and facilitate the school and village CHCs. Their overall mission is to create an environment that facilitates sustainable behavioural change and hygienic practices among all rural and high-density urban communities.

As per HSSP II, EHOs are required to ensure that all CHWs are trained and supervised to facilitate CHCs to cover a six-month course of 1 to 2 hours (on weekly basis) on health topics, using PHAST participatory techniques, as per the example of a CHC membership card shown on the followiwing page.

Illustrative Example of a Community Hygiene Club (CHC) Membership Card

No.	Topic	Date	Signature	Homework	Signature
1.	Safe water chain			Safe storage and use of water	
2.	Safe food chain			Pot rack; hanging basket, etc.	
3.	Sanitation ladder			Avoid faecal: oral diseases	
4.	Sanitation planning			Improve household latrines	
5.	Diarrhoea ORS			Improve sanitation facilities	
6.	Hand washing			Hand washing facility	
7.	Cholera/ typhoid			Water source cleanup and sanitation	
8.	Skin/eye disease			Bedroom and personal hygiene	
9.	Worms			De-worming	
10.	Nutrition			Nutrition gardens and orchards	
11.	Hygienic kitchen			Fuel efficient stove and ventilation	
12.	ARI			Sleeping mats/room ventilation	
13.	Environment			Garbage pits and faecal-free yard	
14.	Malaria			Drainage and clearing	
15.	Infant care			Infant hygiene and weaning foods	
16.	Bilharzia			Bathing shelter and ZOD	
17.	Drama and songs			Practice health drama and songs	
18.	CHC banner/map			Village map and CHC banner	
19.	Self monitoring			CHC monitoring tools in use	
20.	CHC ExecCom			Constitution and project bank account	

NOTE:- The back-side of this CHC Membership Card has the name and number of each CHC Member, plus club name, village, etc. Ideally it could also include the member's ID photo.

The CHC Facilitator should sign and date the health topics as soon as they have been completed.

The CHC membership card of the CHW is signed by the Chairperson, so that the member's attendance as a facilitator can be verified. This procedure certainly empowers the community and strengthens the 'contractual obligation' to mutually follow through the whole syllabus until completed. CHC executive committees comprising of the Chairperson, Treasurer and Secretary, should be established as soon as all the members of a club feel confident enough to vote for those who are trusted and well respected by the whole community.

Afer every health topic and related 'homework' have been completed by the CHC members

Three year program to roll-out CBEHPP to all 30 Districts by 2012

Milestone Events	2009	2010				2011				2012			
	Q4	Q 1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Programme Launch													
Phase I: Start-up		Start-up in 4 Districts 1/Province											
Phase II: Consolidate						Consolidate & add 4 new Districts							
Phase III: Scale-Up										Roll-out to all remaining 22 Districts			

(each representing a household), they are eligible to receive a CHC graduation certificate at a ceremony to be officiated by high-ranking district and provincial dignitaries. Other than the certificates, there are NO subsidies provided.

In order to achieve the ambitious targets as set out in the HSSP II (2009-2012) which aims to ensure that basic hygiene practices improve in 15,000 villages across the country, it will be necessary to exponentially scale up CBEHPP from the initial start-up districts in each province, to other districts within 36 months.

The basic mechanisms for CBEHPP exponential scale up to be achieved are already in place.

Phase I

EHOs are located in all district health centres. After receiving a one week training in the CHC methodology, the EHOs (using motor cycles), will be able to introduce an 'on-the-job' training to all village CHWs who are located within the catchment area of their respective health centres. Within 6 months (that is by July 2010) all CHWs in the start-up districts should be able to replicate CHCs in their respective villages. By the end of year-one (December 2010), every village in the 4 start-up districts should have active CHCs in place.

Phase II

In July 2010, the programme will expand in exactly the same way to 4 new districts so that there will be at least two active CBEHPP districts in every province, giving a total of 8 active districts by December 2010.

Phase III

Over the next two years, January 2011 to December 2012, the programme will keep scaling up in order to reach the remaining 22 districts so that all 30 districts are running with CBEHPP by December 2012.

Capacity Building for EHD

In order to implement the three phases of CBEHPP as reflected above, it is important to ensure that the EHD is provided with the means. A core team of 5 principal EHOs will be trained in the CHC methodology so that they in turn can roll-out a ToT to all other EHOs in

30 districts. They will need to be provided with adequate transport and running costs, and other logistical support as explained in the Budget below.

Indicative Three-Year Budget (Jan 2010 to Dec 2012)

Per capita cost for CBEHPP = US$ 0.50

This Indicative Budget is based on experience gained in establishing CHCs in several other similar countries to Rwanda[4].

(a). Target population: 80% of total population (9 million) living in rural areas = 7,200,000

(b). 7,200,000 beneficiaries x US$ 0.50 = US$3,600,000

Refer to APPENDIX 1: Detailed Implementation Strategy	US$
1 Preparation Phase: (Oct-Dec 2009)	**300,000**
1.1 Official Launch of CBEHPP	
1.2 Develop CHC Training Materials in Kinyarwanda	
1.3 Pre-test, amend & print Training Materials (Visual Aids, Tool Kits etc.)	
1.4 Hold National Inception Workshop	
1.5 Hold Provincial Orientation Workshops (x4)	
2. Advocacy, Mobilization and Community sensitization (Feb 2010-Dec 2012)	**1,000,000**
2.1 Spot Radio and TV messages	
2.2 Audio-visual drama	
2.3 Documentary films	
2.4 Bill board messages	
2.5 Meetings with leaders	
2.6 Competitions and awards	
3 First-Phase: Implement in 'Start-Up Districts (Jan-Jun 2010)	**350,000**
Establish 'First Round' CHCs under EHOs	
3.1 District Orientation Workshops	
3.2 Train EHOs and School Health Officers to facilitate CHCs.	
3.3 Ensure adequate mobility for EHOs to reach all villages (e.g. motorcycles)	
3.4 Household Inventories and Baseline Surveys	
3.5 Monitoring & Evaluation by MoH 'Core Team'	

[4]Refer Joint Agency Paper by 19 major Development Agencies including: WHO, UNDP, UNEP, EU, World Bank, DFID, ADA, GTZ, etc. (June 2008):- ***"Poverty, Health, & Environment - Placing Environmental Health on Countries Development Agendas"***:- (page 33, Box 6: 'Behaviour Change can be Cost-effective':- CHCs improved a raft of hygiene behaviours at a cost of $3.33 per household).

Item	Amount
4. **Second Phase: Consolidation and Expansion (Jul-Dec 2010)** Establish 'Second-Round' CHCs under CHWs	350,000
5. **Third Phase: Roll-out to all 30 Districts (Jan 2011- Dec 2012)**	2,600,000
Cost for Implementation	3,600,000
6. **Capacity Building Support to EHD to execute CBEHPP**	700,000
SUB TOTAL:	5,300,000
Add 15% Contingency:	645,000
TOTAL INDICATIVE 3-YEAR BUDGET:	**US$ 5,945,000**

NOTE: Capacity Building Support to EHD to execute CBEHPP

EHD will establish a **Core Team** of 5 dedicated EH Officers who will provide the backbone to CBEHPP. As experienced ToTs, this team will be responsible for rolling out the training for CHCs to all EHOs as well as overseeing the quality of training. EHOs will in turn pass on to the CHWs. The core team will ensure quality baseline and post-intervention surveys are conducted, and that CHC behaviour change is tracked from month to month using the cutting-edge Mobile Research Platform (i.e. use of mobile phones for data capture). The budget for this team will ensure transport and other logistical issues are covered in order to ensure an exponential scale up CBEHPP to all 30 districts is achieved within 3 years.

APPENDIX 1: Detailed Implementation Strategy

Step 1. Analysis of existing Behaviour Change Strategy in Rwanda using PHAST

Analyse the current situation with regard to:- (i). existing health education methods (e.g. PHAST); (ii). existing training materials; (iii). existing disease patterns and priority areas of concern for local environmental/ community health officials; and (iv). existing attitudes by Local Government and especially the target communities towards hygiene education programmes. This phase would also identify suitable locations (i.e. districts and *imidugudu*), where the CHC methodology is likely to have rapid success and uptake with strong and supportive local leadership (Provincial and District). It is vital that the start-up phase achieves some 'quick wins' from the start. Appreciating that 'nothing breeds success like success', convincing and measurable improved hygiene behaviour change within the first six months of start-up is critical; not only to have a good story to tell and to demonstrate, but to be sure that the CHC methodology is eventually taken up enthusiastically and confidently by all districts across the country.

This Research and Analytical work would require an experienced local TA to EHD/ MoH (with active support from an external CHC consultant), who will spend about 2 to 3 weeks with community and environmental health officials at central and district levels, as well as with interested stakeholders including development partners like UNICEF, DFID, JICA, Austria, Belgium, SNV, WaterAid, etc. District Mayors and Deputy Mayors (Social Services) in the process of selecting suitable locations for the 'start-up' phase. During this phase, the volume of work required to develop the necessary training materials, training manuals and designing of the membership cards (all to be translated into Kinyarwanda), will be determined.

Step 2. Development of training materials

The duration of this phase will be determined by the quantity and quality of existing PHAST training materials, their appropriateness, and also determining how many gaps there are, that will need to be filled with carefully developed graphic training materials so that all 20 to 25 health topics (as per the CHC membership cards) are well catered for with ethnographically sensitive training materials (i.e. rural Rwandan specific); and the amount of work required to develop the actual training manuals that will provide specific guidance for all CHC facilitators and their supervisors within the Rwandan context; in addition to the time required for everything to be translated into Kinyarwanda. This Step should be undertaken immediately after completing the initial analysis and fact-finding stage under step 1 above.

Step 3. Pre-testing and printing of materials

Once developed, the training materials (now in Kinyarwanda) will be pre-tested in order to ensure over 80% comprehension by the target groups. Some adjustments may be necessary before printing the materials in

sufficient quantities, so as to cover the pilot implementation phase of the programme.

Step 4. Training of about 15 principal CHC facilitators (5 to 10 days)

As soon as all the CHC training materials are printed, a training for the so-called principal facilitators will take place. This training phase has been carefully packaged to cover rationale, explanation and training of the CHC methodology within 3 Modules:-

Module 1: Rationale for the CHC Approach (One day workshop)

Target group: Local Government officials including the District Mayor, programme planners, professionals, district stakeholders and opinion leaders.

Objectives: To offer an introduction of CHCs and how they work

· To provide a rationale for the CHC approach

· To explain why CHCs are popular and effective

· To stimulate speculation within districts as to whether this approach is feasible in project area

Module 2: Planning/How to start a CHC Project (2 to 3 days)

Target group: Local Government officials, programme planners, managers, district hospital and health centre personnel, stakeholders and opinion leaders from the community where hygiene clubs may be started.

Objectives: To identify priority issues and how to adapt the CHC methodology to fit into new areas

· To plan how CHCs can be started in each area

· To design/adapt the membership cards for the particular needs of the project in the appointed location

· To provide monitoring and evaluation tools that will ensure that hygiene behaviour is quantified and baseline data is captured.

Module 3: Training (5 days)

Target group: CHC facilitators (i.e. EHO's as trainers/supervisors of CHWs and school health officers)

Objectives: To train CHC who in turn will train CHWs on how to establish and facilitate health clubs using updated PHAST tool kits and to eventually supervise, mentor and monitor all CHWs that work within the radius of the health centre where the EHO is based.

Depending with the level of experience with the PHAST tool kit and how much primary healthcare training the EHOs already have, the training required for this cadre of CHC supervisors and trainers of community health workers will normally require a full time workshop of about 5 days.

Ideally the Workshop should cater for about 25 to 30 EHOs and school EHOs. One such workshop will be required in each of the start-up districts.

It is important to stress that in order for the CBEHPP to succeed, the EHOs need to be able to reach all villages within their respective areas of responsibility on a regular basis (i.e. weekly), so as to supervise, mentor and monitor the activities of the CHWs and their respective clubs. For this to be achieved, the EHOs need to be provided with reliable motor cycles, safety equipments, and basic training in maintenance, in order to achieve 'zero down-time' for their motor cycles.

Step 5. Implementation of Community Hygiene Clubs (CHCs)

After the training is completed the EHOs will return to their respective health centres and begin establishing and running CHCs in 3 to 5 nearby villages. The EHO would meet each CHC once a week for about 1 to 2 hours, in order to eventually cover all of the 20 health topics as scheduled on the membership card as per the example below. During this initial phase of the programme (i.e. first round of CHCs under EHOs), all CHWs within the catchment area of the health centre would be expected to participate in these 4 or 5 initial CHCs per EHO in order to participate and learn about each of the 20 topics. Aftr 6 months of 'on-the-job' training, the CHWs should be confident and capable enough to return to their respective *Imidugudu* to initiate CHCs, and the EHO's role will revert to supervision, mentoring and monitoring of the CHCs within the catchment area of the health centre.

The course usually takes between 6 to 9 months to complete all 20 health topics (at the rate of one per week), as there are usually repeat sessions to cater for late comers to the clubs, and also a provision for the reinforcement of particular topics where necessary. Each topic has the requirement of some **'homework'** following the session. This might be to make

Example of a Membership Card with 20 Topics and 'Homework'

No.	Topic	Date	Signature	Homework	Signature
1.	Safe water chain			Safe storage and use of water	
2.	Safe food chain			Pot rack; hanging basket, etc.	
3.	Sanitation ladder			Avoid faecal: oral diseases	
4.	Sanitation planning			Improve household latrines	
5.	Diarrhoea ORS			Improve sanitation facilities	
6.	Hand washing			Hand washing facility	
7.	Cholera/typhoid			Water source cleanup and sanitation	
8.	Skin/eye disease			Bedroom and personal hygiene	
9.	Worms			De-worming	
10.	Nutrition			Nutrition gardens and orchards	

Continued: **Example of a Membership Card with 20 Topics and 'Homework'**

No.	Topic	Date	Signature	Homework	Signature
11.	Hygienic kitchen			Fuel efficient stove and ventilation	
12.	Drama and songs			Practice health drama and songs	
13.	Environment			Garbage pits and faecal-free yard	
14.	Malaria			Drainage and clearing	
15.	Coughs and colds			Mats and ventilation	
16.	Bilharzia			Bathing shelter	
17.	TB			Community project	
18.	HIV/AIDS			Community project	
19.	Home based care			Community project	
20.	Family Planning			Community project	

a simple hand washing facility, for example, a 'tippy tap', a compost pit, a pot drying rack, a bathing shelter, and of course, a suitable hygienic latrine. The required homework is listed on the membership card but frequently, CHC members go beyond the requirements and start improving their homes in all sorts of ways. It is not uncommon for them to put up properly ventilated kitchens with fuel-efficient stove, and then go ahead to ensure that bedrooms are properly ventilated, mosquito nets are used properly, yards are kept clean, and a nutrition and herbs garden is started. These household improvements will all come about WITHOUT any form of material subsidy!

Later on, a whole range of income generating activities are likely to be taken up by the CHC such that within one year or so, they will have their own constitution, a democratic leadership structure and even a bank account for new community based projects. Well structured CHCs quickly gain a reputation for credit worthiness and become eligible to gain access to supplies of items such as seeds, fertilizers, or bags of cement on credit facilities from the local suppliers. These CHCs later acquire characteristics similar to those of CBOs and are likely to become eligible to benefit from micro-credit schemes.

Once the CHC members have completed all topics as listed and signed off by the facilitator on their membership cards, there will be a graduation ceremony to acknowledge their accomplishments. This ceremony is usually a joyous occasion attended by district dignitaries, where certificates are awarded to those who complete all 20 health topics together with the required home improvements tasks.

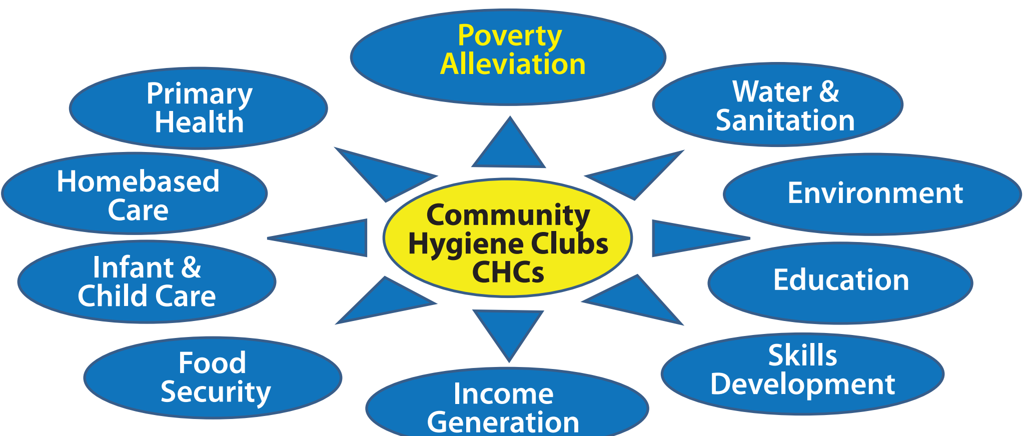
It may also be a good strategy within the Rwandan tradition of *'imihigo'* (performance contracts), to acknowledge and reward the CHCs which perform well, and establish local district based competitions for model homes, model villages and even model districts, as this would increase the enthusiasm and dynamics

for the hygiene behaviour changes that are so urgently required.

Step 6. Supervision and Monitoring

Once the CHC facilitators (i.e. CHWs) return to their communities and start up CHCs in their areas, they will require careful supervision, monitoring and mentoring, especially during the early stages, as these new and inexperienced CHC facilitators build up their confidence to cover all of the 20 selected health topics. The supervision role should be carried out by the EHO, with backup from the district hospital technical supervisor. Systems need to be put into place by district authorities to carefully ensure that the whole process is kept on track and that progress is carefully monitored. It is essential that a detailed and accurate 'baseline survey' is completed in every area at the initial stage, before the hygiene club facilitation begins. This is important because it accurately measures hygiene behaviour change over a period of six to nine months, and again over the next few years, to be able to measure all the important issues on sustainability of the new hygiene practices. Rates of change can then be measured against a number of control groups who have not yet undergone the CHC process.

Placing the community at the centre of integrated development



APPENDIX 2: Programme Preparations and Roll-Out

Programme Preparation

As a follow up to the official launch by the Minister of Health on 17th December 2009 and in order to begin implementing CBEHPP in 2010 as intended by the MoH (EHD), there is urgent need to focus on the following critical activities:-

1. Ensure availability of appropriate CHC training materials
2. Arrange National inception meetings and four provincial orientation workshops (possibly consider merging these into one event)
3. MoH and Provincial Governors to engage in identifying the start-up districts (at least one start-up district per province)
4. Engage with start-up districts to develop budgets and work plans and plan ToT workshops
5. Arrange for the training of the principal CHC trainers who will then train the district EHOs. For this initial principal trainers workshop, it will be necessary to have external support from experienced CHC facilitators.

The estimated total indicative budget for CBEHPP over three years is US$ 5,945,000 with a per capita unit cost of 55 cents (US$). When this is compared to the average budget for Roads or Infrastructure, then for such high returns on environmental health and poverty reduction outcomes, it is extremely good value for money!

It will be during the provincial orientation workshops that DPs already supporting water and sanitation programmes will be expected to contribute funding and logistical support to CBEHPP in the significant start-up districts. In order to initiate the programme in the start-up districts, it is vital to ensure that there is adequate financial and logistical support made available. Already there are strong indications of such support from MININFRA and the water and sanitation sector. With an existing budget of approximately **US$150 million for ongoing water and sanitation projects.** The relatively modest amount of under US$ 5 million that is required to achieve significant hygiene and sanitation behaviour change outcomes should not prove too elusive, especially as CBEHPP would add tremendous value and sustainability to all existing water and sanitation programmes.

The W&S working group under the Chairmanship of the AfDB has already expressed strong support and backing for CBEHPP, and has even proposed that a MoU should be drawn between MININFRA and MoH. The PEPAPS water and sanitation programme (Belgian Aid) have indicated that they will support CBEHPP in at least one district in the southern province, and the same applies for UNICEF in the northern province where there has already been mention of at least 5 or 6 districts being included. JICA in the eastern province has also expressed the same interest.

District selection for the start-up will be undertaken in ways that will enable the programme to rapidly expand in all other districts in each of the four provinces as well

as to Kigali, as quickly as possible. Being a national programme, CBEHPP is expected to cover all 15,000 *Imidugudu* by 2012 as per the Logical Framework of HSSP II. It is therefore important to ensure that the districts that are NOT included in the first six months of Phase One (January to June 2010) are reassured that the CBEHPP will be coming their way soon and must be informed exactly what is required of the District Mayor and his/her staff in order for this to come about at the earliest opportunity. This is where MINALOC will provide a vital role in mobilizing the existing resources of personnel, transport and budgets within their respective districts in order to rapidly implement CBEHPP down at the village level and at all schools.

Another critical aspect to consider is that, for the programme to begin to work effectively, all EHOs in the start-up districts (and eventually in all 30 rural districts with a combined total of almost 15,000 villages) will need to be provided with reliable motor cycles and safety equipments, plus running costs of the motor cycles. Unless EHOs are mobile, they simply cannot undertake their role in training, supervising and mentoring all of the 45,000 CHWs under their command and within the catchment area of their respective health centres.

Within one year of the start-up (i.e. by January 2011), MoH should have statistical evidence from health centres within the initial catchment areas of CBEHPP that clearly demonstrate improved health outcomes of a reduction in diarrhoea, intestinal worms, ARIs, etc. This will provide additional validity and support for advocacy efforts for the exponential roll-out of CBEHPP to all villages throughout Rwanda over the remaining two years of the programme.

APPENDIX 3: CBEHPP within context of HSSP II

The importance being afforded by GoR to the CBEHPP is revealed in the Health Sector Strategic Plan (HSSP II: 2009–2012) that was recently endorsed by Dr Richard Sezibera, the Minister of Health, after it had first received full Cabinet approval in July 2009. HSSP II (page 16) states the following:-

> ***"In 2009, MoH will be launching a National Community Based Environmental Health Promotion Programme (CBEHPP). This aims to strengthen the capacity of all 45,000 Community Health Workers under close mentoring and supervision by Environmental Health Officers based at Health Centres. CBEHPP plans to adopt the internationally validated Community Health Club methodology (in the Rwandan context they will be called Community Hygiene Clubs - CHCs) in order to achieve rapid and sustainable behaviour change and poverty reduction outcomes".***

HSSP-II also lists the following CBEHPP Verifiable Indictors:-

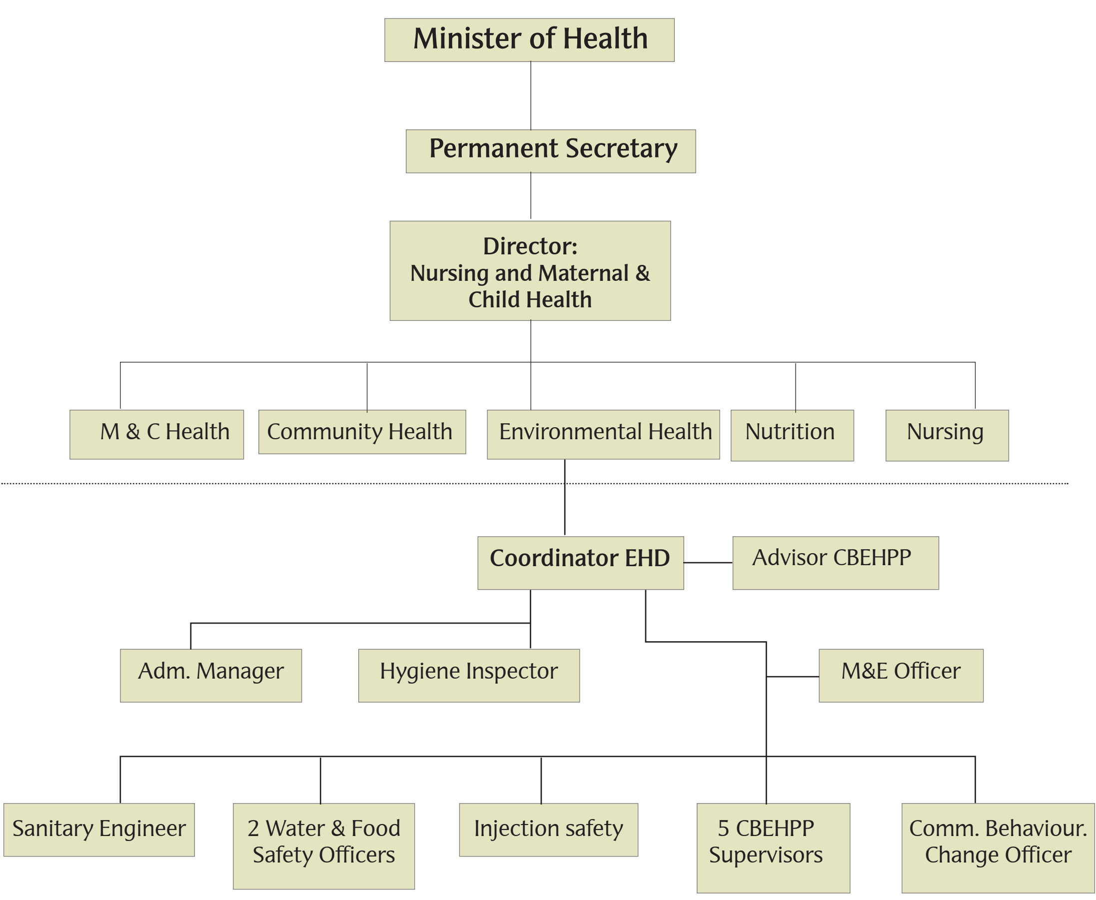
- **Percentage of households and institutions using hygienic latrines and hand-washing with soap increases;**
- **Percentage of households and schools exercising safe drinking water handling increases;**
- **Number of CHCs put in place in *Imidugudu***

(In addition, HSSP II includes CBEHPP in the **Logical Framework** as follows from the section extracted from page 36)-

Extract from HSSP II Logical Framework.

Program Objectives	Strategic Interventions	Outcomes	Indicators	Target 2012 (baseline)
	Health Promotion and Healthy Lifestyles			
2. To consolidate, expand and improve services for the prevention of diseases and promotion of health	Improvement of the environmental health and hygiene conditions of the population	The use of hygienic latrines and hand washing facilities in households and institutions are promoted	% of households and institutions using hygienic latrines and hand- washing with soap	**Target: 80%** for latrines and hand washing (baseline: hand-washing with soap 34%, hygienic latrines: 28%, 2005 RDHS),
		Improved drinking of potable water in households and schools	% of households and schools exercising safe drinking water handling	**Target: 80%** (baseline: to be set after survey)
		Environmental health data included in HMIS	Environmental health data published on MoH website	**Quarterly**
		Participatory hygiene and sanitation transformation (PHAST) education ensured	The number of Community Hygiene Clubs (CHCs) put in place in Imidugudu	**Target: 100%** (Baseline: 0%)

Organisational Chart for EHD[5]



Proposed organizational structure for Environmental Health Desk

The recent changes within the organisational structure of MoH reflects an elevated position for EHD as indicated above. This indicates the seriousness with which MoH and the Government appreciates the impact that improved hygiene behaviour change will have in achieving enhanced national health and poverty reduction outcomes in Rwanda.

The EHD structure as reflected above has yet to be completed. Once the CBEHPP gets underway in early 2010, it will be necessary to recruit 5 CBEHPP facilitators who will be in charge of training, supervision and mentoring of the CHC programme as it rolls out to all 30 districts. Each facilitators will require a 4-Wheel Drive vehicle to be able to adequately cover all implementing districts and to fully execute their ToR effectively.

[5](ref HSSP II: Organisation Chart - Ministry of Health; extracted from page 71).

For more information, please contact

Mr. Joseph Katabarwa
Head of Environmental Health Desk, Ministry of Health
P.O. Box 84, Kigali, Rwanda
Email: joseph.katabarwa@moh.gov.rw
Phone: +250 788 461076

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