ANNUAL REPORT

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Organization Name:	**Rwanda Ministry of Health - Environmental Health Desk/Africa AHEAD**

Institutional official authorized to submit and accept grants on behalf of the organization:					
Prefix	Permanent Secretary, Ministry of Health of Rwanda				
First Name	Dr Solange		**Surname:**	HAKIBA	
Address	Ministry of Health, P.O Box 84, Kigali, Rwanda				
Telephone	+250 788308079		**Fax**		
Email	solhakiba@gmail.com		**Web Site:**		www.moh.gov.rw

Project Director /Contact:					
Prefix	Head of Division of MCCH, RBC-Ministry of Health Rwanda				
1st Contact	Dr. Fidele NGABO		**Email**	ngabog@yahoo.fr	
Address	Ministry of Health, P.O Box 84, Kigali, Rwanda				
Telephone	+250 788304750		**Web Site**	www.moh.gov.rw	
2nd Contact	CEO of Africa AHEAD Dr Juliet Waterkeyn	**email**	**juliet@africaahead.com**	www.africaahead.com www.chcahead.com	

Geographic Location(s) of Project **Rusizi District, Western Province, RWANDA**

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Monitoring Community Health Clubs

in Rusizi District, Rwanda

Submitted to the Bill & Melinda Gates Foundation

July 16th 2015

CHC Members Rukuraza village, Rusizi district during a graduation ceremony

April 2014—March 2015

Compiled for Ministry of Health by Africa AHEAD Rwanda

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Acronyms

AA-R:	Africa AHEAD Rwanda
AHEAD:	Applied Heath Education and Development
ASOC:	Affaire Sociale
CBEHPP:	Community Based Environmental Health Promotion Programme
CEO:	Chief Executive Officer
CHC:	Community Health Club
CHW:	Community Health Worker
CSV:	Comma Separated Values
EH:	Environmental Health
EHD:	Environmental Health Desk
EHOs:	Environmental Health Officers
HC:	Health Centre
HH:	Household
IPA:	Innovations for Poverty Action
M&E:	Monitoring and Evaluation
MCCH:	Maternal Child and Community Health
MoH:	Ministry of Health
RBC:	Rwanda Biomedical Center
RCT:	Randomized Control Trial
SEDO:	Social Economic Development Officer
HSSP:	Health Sector Strategic Plan
ZOD:	Zero Open Defecation

Executive Summary

This report highlights activities and achievements implementing the Community Based Environmental Health Promotion Programme (CBEHPP) in Rusizi District from April 2014 to March 2015. Africa AHEAD-Rwanda (AA-R), supported the Ministries of Health and Local Government to adopt the Community Health Club (CHC) Methodology. Activities during this past year consisted of monitoring CHC activities, training facilitators of so-called 'Lite villages', moderate overall supervision, conducting mid-line and end-line surveys, holding Graduation Ceremonies for Classic CHCs, together with national advocacy and registration activities.

The INGO license for AA-R was renewed and the new District Senior Administration in Rusizi is well informed about the dual roles of AA-R and IPA towards fulfilling all requirements of the RCT. After the 20 dialogue sessions within each of 50 village CHCs, the CHC Committees conducted a survey to determine the members who were eligible for graduation. Criteria included attendance in all sessions and the implementation of the 'home-work' (i.e.. physical improvements of local sanitary facilities in the home).In June 2014, a total of 50 ASOCs were trained in the Lite version of the CHCs and this was done by Rusizi District staff with support from AA-R and MoH. Also present were staff from IPA (7) and a representative from UR/SPH. The ASOC were handed the black and white visual toolkits and training manual to conduct the 8 sessions in their respective villages. Monitoring was minimum within the Lite CHCs (an average of 2-4 visits for the total of just health topics).

The monitoring at village level was conducted by the Classic CHC committee to ensure that the households were implementing the desired homework. The EHOs with the help of a mobile app 'Mobenzi' collected data for mid-line and end-line. In order to ensure that the project is running as planned in all villages, three motorbikes were donated to the district of Rusizi to ensure the mobility of Environmental Health Officers for project monitoring, who are considered one of the ways hygiene is reinforced in the Classic CHC Model.

Comparison between the mid-line and end-line surveys within the 50 Classic CHC villages shows improvements across as many as 17 hygiene indicators. The highlights include ***'drinking water'*** which has improved significantly with a 21.6% increase in treatment and safe storage. '***Latrine coverage'*** is high with 68.3% improved latrines of which 69.5% are clean. Sanitation upgrading took place with 21% having made improvements on existing latrines and there are 18.3% more clean latrines and 87.8% maintained them clean. Households with appropriate handwashing facilities increased by 17.1% of which 76% are used and 77.2% have both water and soap. The community is practicing safe waste management with 15.4% more recycling and 88.9% using it for compost. Safe food preparation has also seen a change with 9.3% adhering to clean surfaces and 14.5% increase in storage of utensils (using pot/dish racks) while 27.8% have changed to use fuel efficient stoves. Kitchen hygiene is improving with 23% of them having better ventilation in the cooking area while 24% more have proper kitchen floors. The promotion of kitchen gardens as a means to increase the vitamin uptake by the community has led to an additional 8.4% households creating them in their own backyards. Safe drainage of waste water also increased to 20%.
Overall the response from the community in the implementation of home works given after each dialogue session has been exceptional.

1. Introduction

The Community-Based Environmental Health Promotion Programme (CBEHPP) was started by the Government of Rwanda, through the Ministry of Health in 2010. This programme is implemented through community structures at village level, initially known as Community Hygiene Clubs and later on transformed into Community Health Clubs (CHCS). The training received on health related topics in the 24 weekly meetings is considered as means of attaining sustainable hygiene behaviour changes in order to reduce the incidence of hygiene related diseases. To this end, Bill and Melinda Gates Foundation have funded this pilot project for Monitoring Behaviour Change and Improved Health Outcomes through the CHC methodology in Rusizi District. Africa AHEAD, the originator of the CHC Model, is the main partner supporting MoH to implement the programme. Research through a Randomised Control Trial (RCT) is now being conducted by Innovations for Poverty Action (IPA) which will reach 150 villages: 50 villages are to be given the 'classic' CHC model comprising of 24 sessions of hygiene promotion, 50 villages will receive 8 WASH sessions in the so-named 'Lite training' and 50 villages will be a Control for two years. However, all these 150 villages will be at the same level of CHC sessions by the end of project implementation. By this time the RCT will have measured the effectiveness of the CHC model in terms of community mobilisation strategy, hygiene behaviour change, reduction of disease, sustainability and cost effectiveness. In addition, IPA is seeking to measure various socio-economic changes including increase in social capital and the empowerment of women that come about as a result of active CHC activities.

1.2. Project Area

Rusizi district

Figure 1 Map of districts and provinces of Rwanda

Rwanda is situated in East Africa. It borders Uganda in the North, Tanzania in the East, and DRC in the West and Burundi in the South. The country is landlocked and divided into five main provinces, North, South, East and West and City of Kigali. The country has made huge strides in level of development in the past decade and is one of only 5 countries in Africa to

have already met and surpassed the water and sanitation MDG Targets. There are approximately 11 million people, with 14,860 villages.

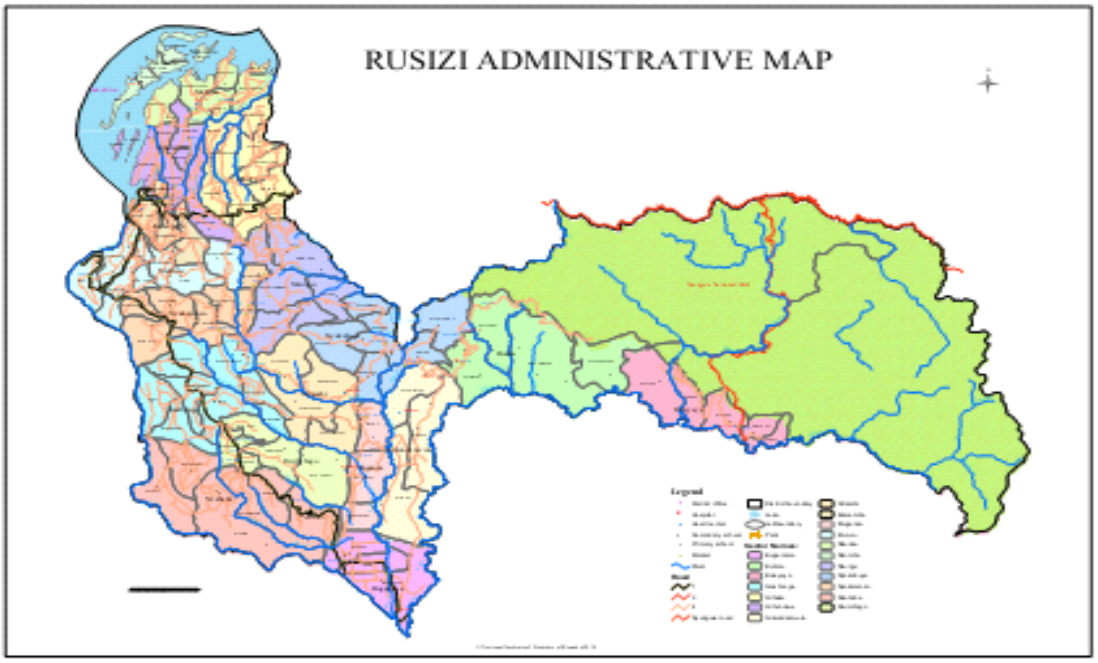

Figure 2 Administrative map of Rusizi district showing sectors

Rusizi District is one of seven districts of the Western Province in Rwanda and it is divided into 18 sectors, 89 cells and 595 villages. Rusizi District borders with the Republic of Burundi in the south Nyamasheke District in the north, Nyamagabe and Nyaruguru Districts in the east and the Democratic Republic of Congo in the west and south west across the water of Lake Kivu and Rusizi River. Thus it is strategically chosen because it is more similar to neighbouring countries where hygiene levels are lower, resulting in spread of cholera and other communicable diseases across the borders.

At community level, the targeted villages in the programme have been randomly selected by IPA, the evaluation partner, and have been sampled across the district to ensure complete lack of selection bias. The map below shows the villages with Classic CHC villages in dark blue, Lite villages are in light blue and control villages are in red. The challenge for effective project implementation is that the wide geographic spread of individual villages poses significant logistical and supervision challenges as well as concern that CHC innovations will defuse to nearby villages. Taking the Health Centre as the unit of randomization would have been more practical, as the more tightly clustered villages would be around a health centre would also make it easier to see health impact on reported cases.

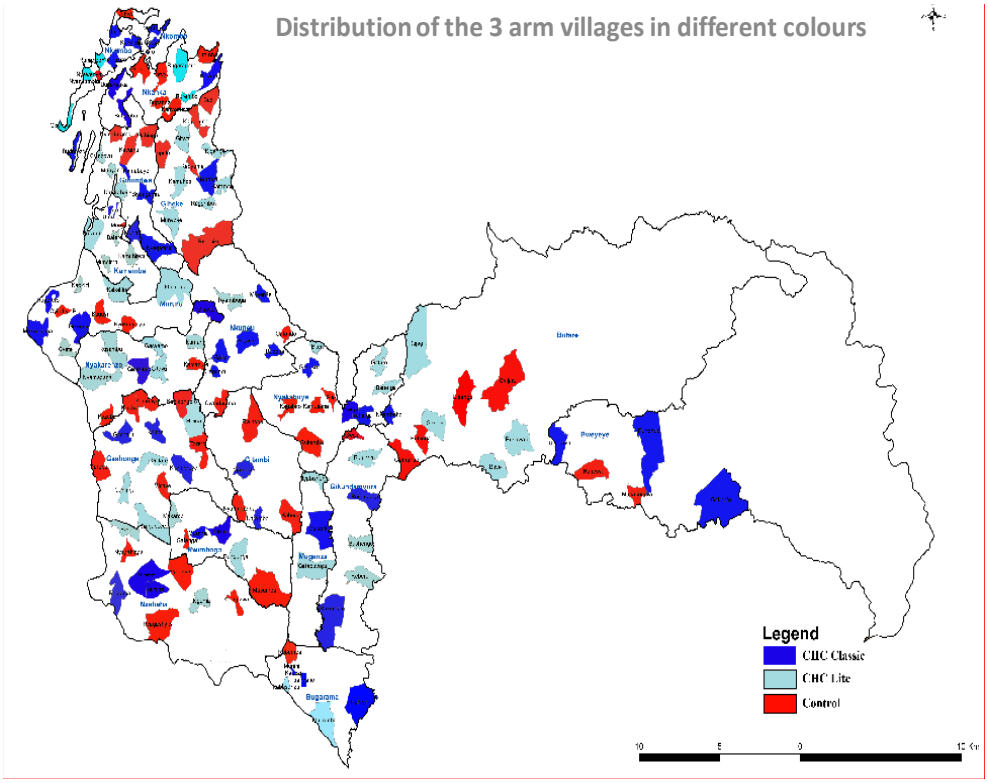

Figure 3 Distribution of Classic, Lite and Control villages as randomized by IPA

1.3 Background information

The start-up in the field has been challenging in some places due to the poor performance of local Environmental Health Officers and the understanding on the importance of improved environmental health practices at household and village levels. That situation led Africa AHEAD team to support MoH in a Training of Trainers on CHC methodology of 19 EHOs for five days using the CHC facilitators training manual with 20 topics on safe water sanitation and hygiene at household and village levels, which was followed by the training of Classic CHC facilitators known as Village Social Affairs (ASOC) for them to start and facilitate CHC 'dialogue sessions' at village level.

1.4 Project Objectives and Summary of Progress

In the agreed project document there are five main objectives for this intervention in 3 years:

1. To build capacity in MoH for cost-effective training of communities for hygiene behaviour change: This will be achieved if, as a result of this intervention, there are organized villages that have benefitted from the enhanced skills of ASOC and EHOs ability to train and impart knowledge effectively.

Progress: Capacity of MoH has been built: 14 EHOs and 7 EHPs were trained to supervise the 100 Community Health Facilitators (known as ASOC) in each village. The M+E Officer at MoH head office has been of great help to the under staffed department.

2. To enable MoH to effectively monitor behaviour change through evidence-based data collection: Reliable information should be readily accessible at village level, through paper-based records and at district and national level through the web-based data base.

Progress: Midline and end-line survey were done using a mobile app 'Mobenzi'. Both have been uploaded onto the CHC website (www.chcahead.com). Village level monitoring is outstanding with CHC committees taking full responsibility for hygiene practices in registration books and reporting weekly through the CHC Facilitator to EHOs from HC to MoH/EHD.

3. To ensure functional and responsible communities exist in 150 villages in Rusizi district: 150 CHCs operational with 80% 'buy-in' and willing to respond to the training and to alter hygiene behaviour at significant levels as per the 10 Golden Indicators, identified in the CBEHPP Roadmap and Health Sector Strategic Plan (HSSP II: 2012).

Progress: 50 CHCs are now fully operational, with active executive committees. To-date average coverage of CHCs household in each village is at 58.4%. The average size of a CHC is 79 members. Of the 9 targeted practices, the uptake is 52.4% (See Annex 2).

4. To provide a demonstration on how hygiene behaviour change can be sustained: This will be achieved if the data demonstrates that hygiene behaviour change is taken up and sustained over three years and beyond. Another measurement of such success will be the increase in the number of people living in zero open defecation (ZOD) communities at less than US$5 per person per annum.

Concerns: The baseline shows that there was an exceptional high level of sanitation with 99.9% in classic villages having virtually no open defecation even before start-up of training: 9.5% had no latrine or shared a latrine. 69.3% already had clean latrines with no open defecation. This begs the question whether Rwanda is not too developed to show any significant improvement in latrine coverage? The indicator should be changed to measure the hygienic standard of the existing latrine which should be covered and clean so there is no excreta open to fly access

5. To demonstrate a cost-effective Change Model capable of improving family health at scale: This will be achieved if the evaluation of the CHC Model demonstrates the large scale cost-effectiveness of CHCs in the prevention of most common diseases. One indicator would be to achieve health impacts at less than US$75 per DALY- ***This would be measured by IPA Evaluation Team***

1.5. Project Personnel

In this project, MoH is the implementer through its decentralized units in the District, and Africa AHEAD is the support partner to advise on the process implementation and setting up

systems for monitoring behaviour change in the three arms of the selected villages. The leadership of the project rests with the Mayor in Rusizi, through the Vice Mayor in charge of Social Affairs, the Director of Health Unit, the District M&E Officer and the CBEHPP Officer who supervises the 2 district hospitals covering the two district health zones. There are currently 3 Environmental Health Practitioners (EHPs) in Rusizi District and 16 Environmental Heath Officers (EHOs) (See Annex 3). Mibilizi district hospital supervises 10 EHOs based at 10 Health Centers while Gihundwe district hospital supervises 6 EHOs based at 10 Health Centers, who in turn are in charge of community based facilitators known as ASOC (Affaires Sociale). This cadre is one of the 4 semi volunteer government village field workers, trained in public health and community development. The ASOC has been nominated as responsible for all CHC activities, being primarily concerned with community mobilization and sensitization, and they are supervised by the Environmental Health Officers (EHOs).

As a requirement for international NGOs Africa AHEAD is headed by a local Country Director, who heads the team consisting of a Monitoring and Evaluation (M&E) Officer based with 60% in the Ministry of Health and 40% at AA-R Head Office, a Data Management Officer and a Project Officer in the field, as well as an Administrative Officer. There is also the Programme Manager and Technical Advisor (See Annex 3) on a daily rate as required. The Staff from the international NGO Africa AHEAD are two ex-patriat advisors, the Director of Programmes supporting advocacy and liason with government, and the CEO / Technical Advisor on Research and Training of the CHC approach, who is the architect of the CHC Model. AA-R has its head office in City of Kigali, Kicukiro district in Niboye Sector. This necessitated a security guard and a cleaner.

Figure 4 Africa AHEAD Rwanda staff

Figure 5 Training of Trainers on CHC

1.6 One year journey of CHC implementation and monitoring in Rusizi District

The training of ASOC from 50 ‘Classic’ CHC villages in February 2014 was facilitated by trained EHOs under the supervision of Ministry of Health and Africa AHEAD. With acquired knowledge and skills, trained ASOC have immediately started CHCs and facilitated Community Health Club dialogue sessions and activities in their respective villages. The trained CHC facilitators were given CHC training tools / materials and the dialogue sessions started mid February 2014 after establishment of CHCs in respective villages.

The progress has been good due to the close support supervision, the involvement of District and local leaders with local committees in place to solve arising issues and chain of communication established (see Fig.7. below).

At the time of start-up, the district was only nominally engaged with CBEHPP and had indeed been selected as it had one of the lowest levels of CHC coverage of any district in Rwanda. However the district is now an enthusiastic adherent to CBEHPP and has begun to

appreciate the power of the community mobilization evident even after so few months, district leaders are requesting that the programme should expand in order to cover the entire District systematically.

1.7 Observed Community engagement at Village Level through CHC Model

The way the dialogue sessions are administered using images, sketches/drama, songs and slogans allow for maximum participation and contribution from everybody for better understanding and practice at individual or collective levels. Local leaders recognized the potential of CHCs and have been advocating for them with commitment to work with them after they have got their buy-in. This vital advocacy effort ensures that the village leaders will encourage all the villagers to join the CHCs.

1.8 Current Functionality of CHCs in Rusizi

To ensure standardisation each CHC is limited to 100 households and if there are more than 100 prospective members, a second CHC is formed to meet the demand. When a CHC is formed, a committee of six members is elected and the CHC Committee is charged with monitoring the changes within its own village. They are responsible for ensuring that levels of hygiene are monitored. The executive committee members together with the Village Social Affairs (ASOC) visit each house to conduct a spot observation of the living conditions, known as a 'household inventory'. This information is then entered into an exercise book, thus enabling each CHC to own and identify exactly when the agreed behaviour and lifestyle changes have been made. If a CHC is too large for one CHW to monitor, it is broken into clusters of 10 households, so that a cluster leader (member of CHC Committee) is made responsible for conducting this monthly monitoring. This low-cost, simple and effective method enables communities to track their own progress and to 'own' their own information, and consequently to track hygiene and manage their own health. Any 'challenging' households are soon spotted by the CHC committee and remedial action can be taken locally. Each CHC encourages all members to improve their hygiene through group consensus and positive peer-pressure. House to house visits by CHC members reinforce the selected target practices. People tend to change if they know they are being noticed. In addition, some local leaders may opt to add impetus by providing recognition, rewards and prizes for the best CHC and model homesteads, based on the percentage of behaviour change achieved between start and finish of the six months of CHC training. This was observed in a meeting with local leaders on 22nd January 2015 in which they expressed their commitment to give their own awards to performing CHCs in their Sectors.

1.9 Established Community based monitoring and MoH/Africa AHEAD inputs

The community based monitoring can be summarised as follow: The CHC committee ↔ Village level/leader ↔ Cell level/SEDO ↔ Health center level/ EHT ↔Sector Leader ↔ Hospital level/EHO↔ District level/Health unit/M&E ↔ MoH level/ M&E/EHD. At CHC level, the CHC committee is charged with monitoring the changes within its own Village (households).

In order to ensure that the project is running as planned in all villages, three motorbikes were donated to the district of Rusizi to ensure the mobility of Environmental Health Officers for project monitoring, who are considered one of the ways hygiene is reinforced in the Classic CHC Model.

Figure 6 Three motorbikes donated to Rusizi district to support EHO in M&E activities

These three motorcycles were delivered by the Country Director of Africa AHEAD on behalf of MoH and received by the District authority on 6th February 2015.

1.10 The community based monitoring can be summarized as shown by the chart below

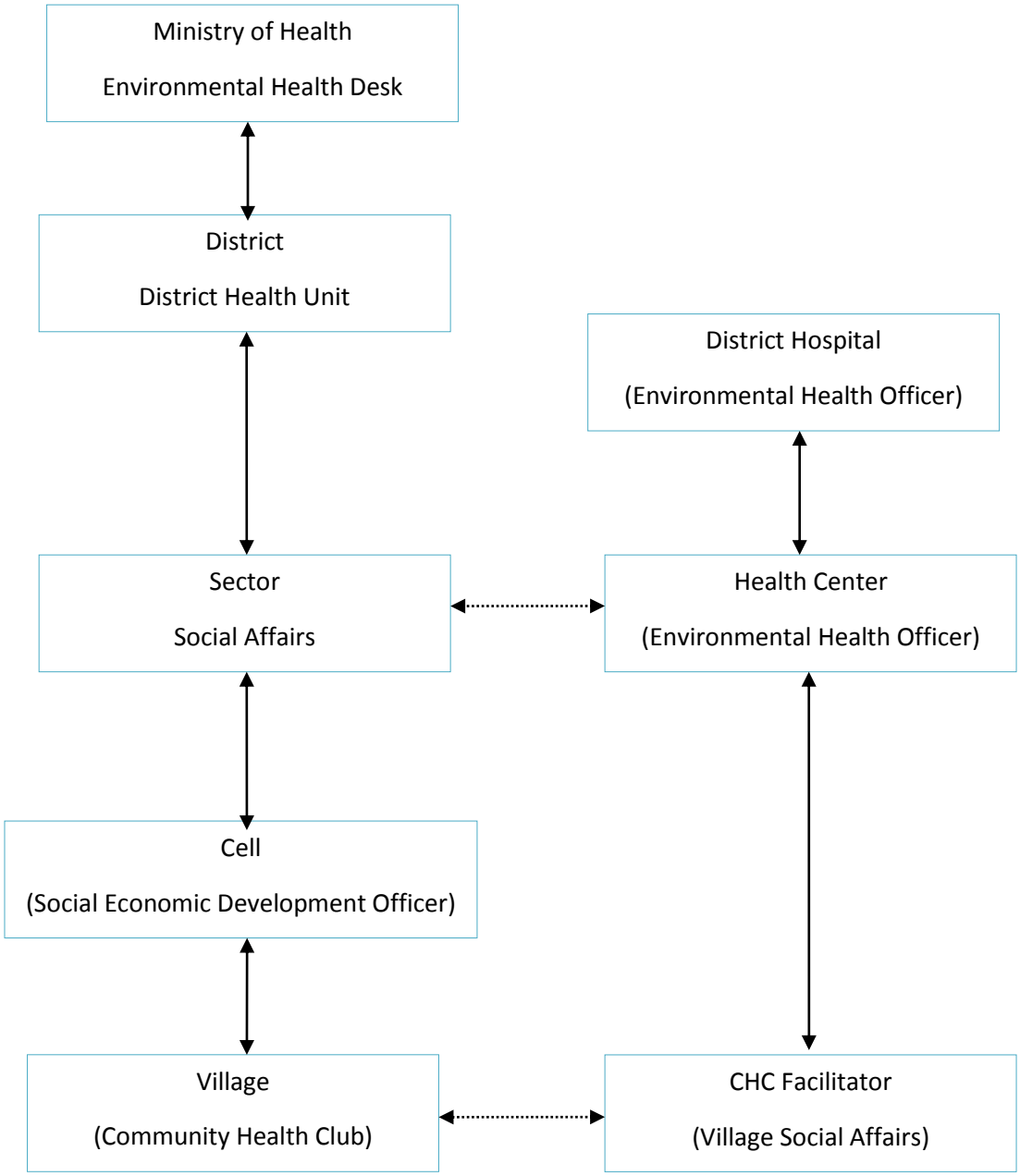

Figure 7 Chart showing the close monitoring of CHC activities by district

The head of the village collaborate with the CHC committee monitored by the Cell (Social Economic and Development Officer, SEDO), monitored by the sector level/ ASOC and EHT at Health centre level, monitored by the District/ Health Unit and report sent to MoH. Hygiene and sanitation indicators are established and are used from CHC level (membership card, household inventory booklets) to MoH level-Africa AHEAD.

1.11 District lead coordination meeting

From the beginning of the classic CBEHPP implementation through CHC model in Rusizi, quarterly coordination meetings have been conducted for project partners for updates, exchange and way forward. The practice helped to get all key actors to be involved and play own role for the success of the project.

1.12 Graduation ceremonies: Not an end of the story but an evidence of CBEHPP effectiveness and sustainability

As part the process implementation of the CBEHPP programme through CHC Model, the graduation started in November 2014 for all CHC members who participated fully in organised dialogue discussions and completed recommended practices by March, 4th 2015. Of the 4,056 HH registered in the 51 CHCs 52.4% have graduated having attended every one of the 24 sessions (Annex 2). While some may be sceptical of the sustainability of the programme the commitment revealed by the villagers themselves in different speeches by the representatives of CHCs as well as local leaders present in the graduation ceremonies, indicated the programme has strong buy-in by the community. As earlier described by the CHC pioneers (Waterkeyn J and Waterkeyn. A, 2013), the CHC model is a long term development model whereby this is the first phase, so that health promotion is an entry point to the community resulting in poverty reduction. An additional benefit is the increase in social capital built by being together for community actions/enterprises.

Motivated and very happy to belong to a CHC, members at the graduation ceremonies proudly acknowledged their improved knowledge and practices as reflected in their drama, songs and speeches. CHC members together with local leaders testified that they will continue with dialogue sessions as refresher for old members but also for new comers since the households are joining the CHCs gradually, so that everyone in the village completes the training eventually. The local leaders invited the CHC members to be more involved in development activities of their households and villages in addition to their hygiene and sanitation activities and promised them a strong partnership.

The following pictures show graduation ceremonies in some of the villages.

Figure 8 Pictures showing CHC graduation ceremonies in different villages (Mukenke, Kamina, Murinzi, Nyambeho, Rubona, Rugunga, Budorozo and Rukuraza)

In all graduation ceremonies held in respective villages, all local leaders were present from district, sector, health centre, cell and village including journalists from Radio Rwanda.

In Rukuraza Village as well as in other villages like Kamina and Rubona, Heads of village and in charge of socio economic and development at cell level participated in CHC dialogue sessions and graduated among other CHC members.

In addition to hygiene and sanitation achievements that were envisaged in the project other extra non targeted things have been achieved by the community. For example all of the 50 CHCs have established a 'tontine strategy' where each CHC member contributes weekly an amount ranging from 50 to 500 Rwf. and benefit from the total amount from the CHC alternatively for responding to any financial need. With this strategy, all CHC members have Community Based Medical Insurance at 100% since there is a mutual assistance to insure even the poorest of the poor are assisted. The table below summarizes identified initiatives and elements for sustainability with facts/indicators from visited CHCs.

1.13 Elements of effectiveness of CHC methodology and sustainability

Table 1 Summary of identified initiatives and elements for sustainability with facts/indicators

Elements of effectiveness and sustainability	**Concerned CHCs/ Villages among 22 systematically sampled**	**Indicators**
Building / rehabilitating own latrines voluntarily	Njambwe, Ruhinga, Karambo, Isangano, Kabeza, Nyambeho.	30 new pit latrines for Njambwe, latrine covers for CHC members in Ruhinga, Isangano, Kabeza and Nyambeho villages
Established tontine strategy	Nyambeho, Kiremereye, Nkanga, Badura, Nyagatare, Uwinzovu, Gakopfo, Mukenke, Njambwe, Karambo, Rukuraza, Gako, Kimpundu, Rugunga, Kamina, Murambi, Ruhondo, Murinzi, Rubona, Ruhinga, Isangano, Kabeza	From 50 Rwf before but now 100 Rwf per week and above Common funds for self-assistance Bank Accounts
Mutual assistance for Medical insurance	Nyambeho, Kiremereye, Nkanga, Badura, Nyagatare, Uwinzovu, Gakopfo, Mukenke, Njambwe, Karambo, Rukuraza, Gako, Kimpundu, Rugunga, Kamina, Murambi, Ruhondo, Murinzi, Rubona, Ruhinga, Isangano, Kabeza	All household members of CHCs have Community Based Medical Insurance
Mutual assistance for students school fees	Gako, Nyambeho	Sent 3 students to secondary school
Mutual assistance for beddings	Ruhinga, Mukenke	4 Mattresses bought (2 per CHC)
Mutual assistance for latrine building	Kimpundu, Ruhinga, Njambwe, Karambo, Isangano, Kabeza, Nyambeho.	30 Latrines have been built
Mutual support among club members in poultry rearing	Rukuraza	Six (6) chicken were given to club members during the celebration of achievements
Loans and credits	Nyambeho, Kiremereye, Nkanga, Badura, Nyagatare, Uwinzovu, Gakopfo, Mukenke, Njambwe, Karambo, Rukuraza, Gako, Kimpundu, Rugunga, Kamina, Murambi, Ruhondo, Murinzi, Rubona, Ruhinga, Isangano, Kabeza	CHC members get loans and credits from their servings as they want.
Accounts and bank deposits	Kamina, Rubona, Mukenke, Murinzi, Rukuraza	About 200,000 Rwf each sometimes in kind or in cash
Development projects	Mukenke, Murinzi, Isangano	Soap making and Body lotion products making (Mukenke) Production of local sanitation and hygiene products (Murinzi and Isangano)
Accountability	Rubona, Mukenke, Murinzi,	Clear and detailed reports on

		finance and activity management
Road building	Uwinzovu	Road now being used
Saloon project	Gako	Near to start
Communal farming	Karambo, Rukuraza, Kiyanza	In progress and functioning
Conflict resolution including domestic violence	Badura	2 cases of conflict resolution including domestic violence

The cases above confirm the capacity of communities to solve their own problems which differ from a community to another and contribute to their own as well as overall development if well organized and supported like under the Community Health Club Model.

Local leaders revealed that CHCs are their partners for development and encouraged them to register as cooperatives and start more initiatives with income greeting activities (cases of CHCs of Rasano, Ruhondo, Uwinzovu, Rubona, and Kiremereye). In addition CHC activities ease the work of local leaders and contribute to the government programme for development (cases of Nyambeho village leader, Kiremereye, Ruhinga, Ruhondo, etc).

1.14 Declaration of local leaders

In a meeting conducted on 22nd January 2015, local leaders including sector, cell and village leaders, declared committed to participate actively in the implementation of CHC activities and resolved that CHC activities be adopted in the performance contracts. In the same line the local leaders have expressed the wish of the community based monitoring learnt for the established monitoring of CHC activities to be supported continuously.

The local leaders suggested that CHCs to have statute regulations and register at Sector level to have the status of cooperatives.

Finally, the District leaders appreciate the CBEHPP programme implemented through CHC methodology and thanked Africa AHEAD as a District development partner.

1.15 After graduation, surprises from CHCs

Some days after graduation ceremonies, some of the Villages have organized day parties demonstrating their satisfaction and enthusiasm about their performance in CHC activity implementation and to celebrate their achievements and have invited AA-R, the district and journalists as well to join them.

Another success story is that some CHCs including Kiyanza CHC are organizing sensitization of other villages on CHC activities through community radio using related drama and songs and the Mayor of Rusizi District supports them as he signed them a recommendation letter for the valuable activity.

Last but not least, Rukuraza CHC organized a party to celebrate the achieved results from CHC activities and invited the District authorities as well as Africa AHEAD leaders to be with them on that occasion and this mobilized Radio Rwanda to visit the village and to cover the event.

Figure 9 Celebration of achievements in Rukuraza village from CHC activities with keen knowledgeable children on some basic hygiene and sanitation questions

1.16 Monitoring

During the implementation of the CBEHPP in Rusizi District, data on CHC recommended practices were collected as part of monitoring the performance of households within the Community Health Clubs. The survey tool was developed, refined and approved by Ministry of Health.

Base Line

The data for the base line was conducted by the ASOC, manually (i.e.. not using Mobenzi) in the previous year. The standards of the data was questionable as the skill of the enumerators was low and therefore we are we are not using it in this report. An older version was used for the baseline. During the period of this report, between June 2014 and June 2015, there were two rounds of monitoring i.e. midline survey and end-line survey.

Midline Survey

The Midline survey data were gathered when the Community Health Clubs (CHCs) was halfway through their training i.e. 10th session between May and August 2014. There was a total of 6,721 HH in the 50 CHC villages, of which 3,811 HH (Data from weekly report, June 2015) were registered members of CHCs (56.7%) and 2,174 HH attended regularly the dialogue sessions. A total of 1,254 HH (32.9%) were surveyed.

The ***End-line survey data*** were collected after the classic CHCs had completed all 20 dialogue sessions from November 2014 to January 2015.

Method of data collection

The Midline and Endline surveys were conducted by 16 EHOs from 14 Health Centers (As Enumerators) and 2 District Hospitals (as Supervisors) with the help of a mobile phone (Nokia ASHA 201) equipped with a data collection application 'Mobenzi'. The Mobenzi app had a questionnaire in English and Kinyarwanda which had been refined further after the base line.

A two day orientation workshop on the Mobenzi system was conducted twice and how to conduct the survey using the mobile phones was organized for the enumerators (EHOs) accompanied by District Health unit staff.

The surveys were conducted in all of the 50 Classic CHCs villages. Data was collected from 1,398 households. In order to obtain the sample for survey, 25 household's members of a CHC were randomly selected and surveyed. The EHT would begin at any point in the village and select a HH after which skip 4 and take the 5th and gradually until 20 HH were surveyed per village.

Data collection at household level took 30min per household once the enumerators became familiar with the Mobenzi application. After the questionnaire was filled on the cell phone it was sent automatically to the Mobenzi website. This required the handset to have a cellular network and ample airtime. On the Mobenzi website the data was downloaded in a CSV file and saved in Excel for treatment (completeness and accuracy) and analysis.

End-line Survey

For the endline survey, from a total of 7,021 HH in the 50 CHC villages, 3,859 HH (54.9%) were registered members of CHCs and 1,514 HH attended regularly the dialogue sessions. (Data from weekly report, October 2015). This fall in attendance compared to the first survey is not relevant as it was due to the fact that some members had already completed the 20 dialogue sessions.

Results

From the data analysis of the midline and end line surveys, the membership increased as follows: The figure shows the increase in number of households' members of CHC with time.

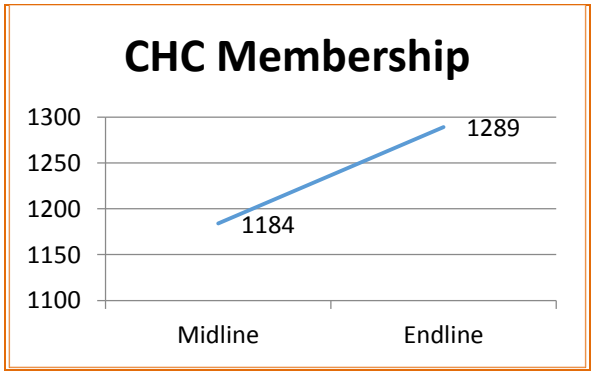

Figure 10 CHC membership club increase

According to the following 17 main indicators, the tables bellow give the status of change

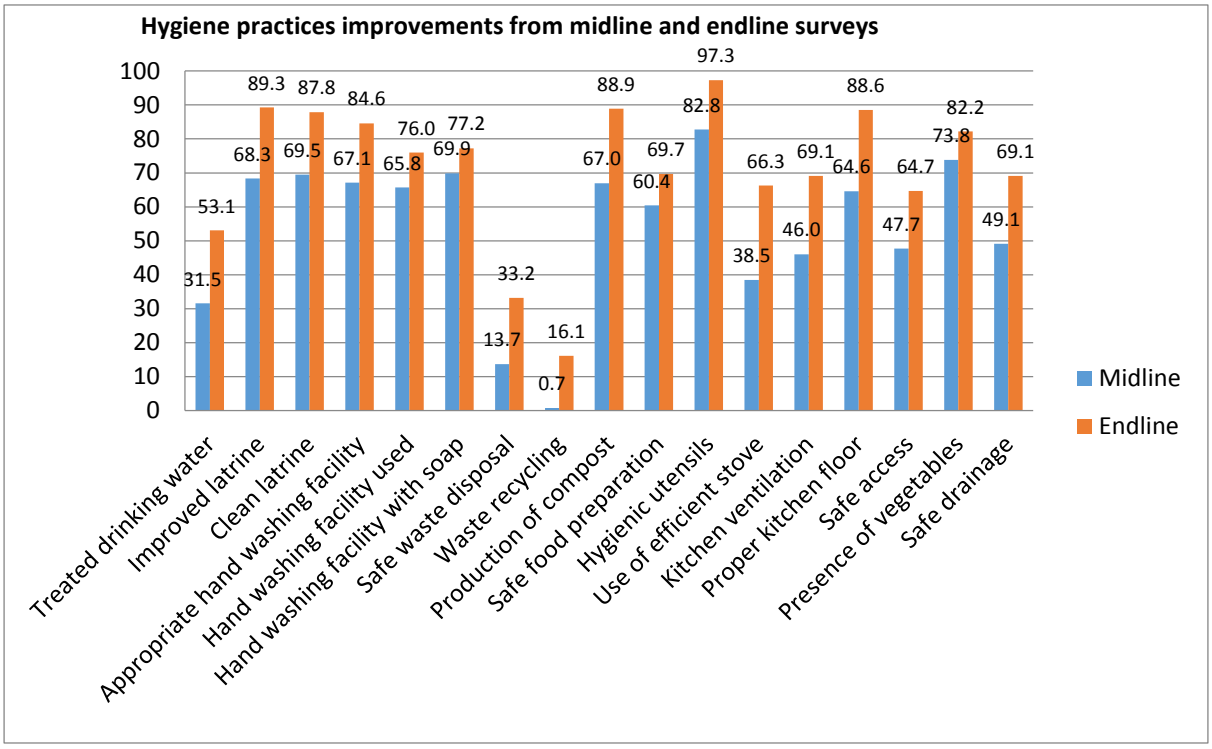

Figure 11 Hygiene practices improvements from midline and endline surveys

1.16.1 Comparison between the mid-line and end-line survey

Comparison between the midline and end-line surveys within the 50 Classic CHC villages shows improvements in 17 indicators. The highlights are around drinking water which has improved significantly with a 21.6% increase in treatment of drinking water. Latrine coverage is high with only 68.3% improved latrines and only 69.5% clean. Sanitation upgrading took place with 21% having made improvements on existing latrines and there are 18.3% more clean latrines and 87.8% maintained them clean. Households with appropriate hand-washing facilities increased to 17.1% of which 76% are used and 77.2% have both water and soap. The community is practicing safe waste management with 15.4% more recycling and 88.9% using it for compost. Safe food preparation has also seen a change with 9.3% adhering to clean surfaces and 14.5% increase in storage of utensils (using pot/dish racks) while 27.8% have changed to use fuel efficient stoves. Kitchen hygiene is improving with 23% of them having better ventilation in the cooking area while 24% more have proper kitchen floors. The promotion of kitchen gardens as a means to increase the vitamin uptake by the community has led to more 8.4% households creating them in their backyards. Safe drainage of waste water also increased to 20%. Overall the response from the community in the implementation of homework given after each dialogue session has been exceptional.

1.16.2 Challenges in data collection

- Some of the phones were either lost or stolen making it hard to complete on time due to handset sharing between the enumerators.
- The lack of cellular connectivity and airtime led to late uploading of data collected and thereby late analysis to correct the information on time while the enumerators were still in field.
- All CHCs were not advancing at the same pace which made it not easy to time them at once for the data collection thereby taking long (approximately 2 months for each survey).
- Geographical inaccessibility, bad weather and HH which were locked (with occupants being away) are among the factors that also hindered data collection.
- Misunderstanding and misusing of codes made it hard and sometimes impossible to monitor data collection and analysis.

1.17 National Level Monitoring: Web Based

Africa AHEAD has been piloting a website for CBEHPP which will enable data to be collected directly from the CHCs themselves and uploaded by EHOs at HC and DH with a direct link by the district and MoH. Given the expense of the Mobenzi system and how difficult it is to process data from each village in Rwanda, this website is likely to be the easiest system of reporting for the CBEHPP once ASOC are provided with reporting tools and EHOs are properly trained. The website enables each CHC to have its own profile, highlighting whether individual CHCs are active, the number of households, vital demographic information about the village, and number of CHC members and levels of appropriate hygiene practices implemented. It also allows visitors to the CHC to write their own comments as a means of peer review and register a partner/donor/project to a specific CHC. In this way it will be possible for MoH and Africa AHEAD to provide 'verification' if CHCs are functioning should there be interest by investors or donors to sponsor CHC activities enabling a system of 'quality control'.

At present, the website has been presented to the Environmental Health Specialist within the MoH/EHD after data was uploaded by the Data Officer with supervision from the Monitoring Officer. Her comments were helpful in shaping the website for presentation and approval by the MoH.

Rusizi district EHPs (3) were trained on its use as information can be accessed anywhere and at any time. The M&E Officer is the main supervisor for the website at present, managed by Africa AHEAD pending training and hand over to MoH/EHD once it has been approved. It is currently active online at www.chcahead.org and can be accessed only with a user name and password from the website administrator. All the CHCs in Rusizi District have been registered and CHC reports have been uploaded, based on the information from the base-line, mid-line and end-line survey.

1.18 Conclusion

After one year of implementation and the second year for monitoring, we have evidence that the CBEHPP implementation through CHC Model is a cost effective

approach to reach all communities and empower them to identify their personal and domestic hygiene and environmental health related problems and actively participate in the process of solving them. This case study reflects that CBEHPP implementation through CHC Model will contribute to significantly reduce the debilitating national hygiene and sanitation related disease burden that currently exists and, at the same time, contribute significantly to poverty reduction outcomes. Only some local leaders are not aware of what is happening but they should know how to take advantage of the existing instrument to overcome challenges like the community based health insurance coverage at 100% and others. Note that first villages in terms of district performance contracts are the classic CHCs villages.

1.19 Way forward

Roll out with the remaining 100 villages of the RCT (50 control and 50 lite villages). This activity includes preparation of training materials and plan for training of facilitators and actual implementation of the programme with related budget.

Annex 1: Action Plan & Timeframe of CHC activities to September 2016

The following is the timetable of CHC activities as agreed in February 2014 by District Authorities, MoH, IPA and Africa AHEAD:

N°	MONTHS	OCT				NOV				DEC				JAN				FEB				MAR				APR				MAY				JUN				JUL				AUG				SEP			
	ACTIVITIES / WEEKS	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	CHC DIALOGUE SESSIONS																																															
1	Printing CHC membership cards																																															
2	Printing CHC graduation certificates																																															
3	Purchase 100 ASOC kit (Hat, bag and T-Shirt)																																														
4	CHC Training of EHOs																																														
5	CHC Training of ASOC in 100 villages (Lite and Control)																																														
6	Adaptation of Control and Lite villages to Classic village CHCs																																														
7	Election of CHC committees																																														
8	Mapping of CHC villages																																														
9	Registration of members																																														
10	Naming of CHC Health slogan and song																																														
11	CHC dialogue sessions																																														
12	Graduation in all 100 villages																																														
	MONITORING & REPORTING																																														
13	Bicycles for 100 ASOC																																														
14	Baseline data collection																																														
15	Endline data collection																																														
16	Presentation of findings District and MoH																																														
17	Quarterly coordination meetings																																														
18	Preparation of Annual Report																																														
19	Annual Report Submission																																														
20	Approval/Launch of Website by MoH																																														
21	Preparation of Conference paper																																														

Annex 2 Ranking of 50 'Classic' CHC villages on membership

Village	CHC Name	N° HH in the village	N° of HH members in CHCs	% of CHC membership compared to HH in village	N° of HH that graduated and awarded certificates	% of HH graduated compared to HH registered in CHC
Nyambeho(c)	TUGIRUBUZIMA	111	111	100	101	91.0
Busarabuye(c)	GIRA ISUKU MUNYARWANDA	80	80	100	47	58.8
Isangano(c)	DUKUNDE UBUZIMA	93	93	100	39	41.9
Shara(c)	TWITE KW'ISUKU	93	93	100	37	39.8
Uwinzovu (c)	TURWANYE UMWANDA	80	80	100	59	73.8
Gasharu(c)	GIRISUKU	74	73	99	56	76.7
Karambo (c)	TURWANYE UMWANDA	77	75	97	28	37.3
Ruhondo (c)	TWIYUBAKE	128	124	97	107	86.3
Gakopfo (c)	TUBEHO NEZA	76	69	91	56	81.2
Kimpundu(c)	TWITABIRE ISUKU	62	56	90	14	25.0
Isangano(c)	TWITE KU BUZIMA	93	83	89	26	31.3
Kanyinya(c)	TWIRINDUMWANDA	85	66	78	18	27.3
Ruhinga(c)	TURWANYE UMWANDA	111	86	77	62	72.1
Rukuraza(c)	TUGIRE ISUKU	192	148	77	120	81.1
Kibare (c)	TUBUNGABUNGE UBUZIMA	99	76	77	38	50.0
Mapfura(c)	TWITE KU BUZIMA BWACU	98	75	77	13	17.3
Mukenke(c)	ABATARUSHWA MWISUKU	113	86	76	53	61.6
Gako(c)	NKORE BANDEBEREHO	123	90	73	37	41.1
Ruhwa (c)	GIRA ISUKU MUNYARWANDA	134	98	73	46	46.9
Gaseke(c)	INTWALI KW'ISUKU	50	36	72	14	38.9
Murambi (c)	TURENGERE UBUZIMA	151	102	68	68	66.7
Rugunga(c)	ABAKUNDA ISUKU	150	100	67	75	75.0
Kiremereye(c)	ISOKO Y'UBUZIMA	120	80	67	62	77.5
Kiyanza (c)	GIRA UBUZIMA BWIZA	144	90	63	36	40.0
Njambwe (c)	GIRA UBUZIMA MUNYARWANDA	151	92	61	46	50.0
Kamina(c)	TUGIRE UBUZIMA	143	86	60	80	93.0
Gataramo(c)	TWITE KU BUZIMA	179	107	60	25	23.4
Biraro(c)	TWITE KU BUZIMA BWACU	129	77	60	27	35.1
Gisovu(c)	DUHARANIRE ISUKU	143	83	58	51	61.4
Murinzi(c)	IMBANZIRIZABIGWIZA MURINZI	149	80	54	26	32.5
Badura(c)	TWITEKUBUZIMA	76	40	53	26	65.0
Budorozo(c)	HARANIRA KUBAHO	133	68	51	28	41.2
Murama (c)	GIRA ISUKU	173	86	50	70	81.4

Gakenke(c)	GIRA ISUKU MUNYARWANDA	345	167	48	107	64.1
Rutarakiro(c)	TUGIRE UBUZIMA BWIZA	137	63	46	15	23.8
Mukorazuba(c	TWITE KU BUZIMA	187	85	45	56	65.9
Busekanka(c)	TUGIRE ISUKU	132	60	45	17	28.3
Gikungwe (c)	DUKUNDUBUZIMA	179	79	44	34	43.0
Nkanga(c)	TWITE KUBUZIMA	190	83	44	24	28.9
Mbuga(c)	TWITE KU BUZIMA	170	73	43	8	11.0
Kabeza (c)	DUHAGURUKIRE ISUKU	129	55	43	37	67.3
Nyagatare(c)	INYENYERI ZA NYAGATARE	120	50	42	18	36.0
Rubona(c)	TWITE KW'ISUKU	153	63	41	34	54.0
Karambo(c)	HARAMBE ISUKU	137	56	41	11	19.6
Rugerero (c)	TUBUNGABUNGE UBUZIMA	154	61	40	39	63.9
Munini (c)	TUBUNGABUNGE UBUZIMA	250	98	39	27	27.6
Bisanganira(c)	TURWANYE UMWANDA	132	50	38	27	54.0
Kamabuye(c)	ISUKU MURI KAMABUYE	178	63	35	24	38.1
Bahemba(c)	ABAHEMBURANA	152	53	35	20	37.7
Umuganda(c)	GIRA ISUKU MUNYARWANDA	220	70	32	35	50.0
Murindi(c)	TUGIRE UBUZIMA BWIZA	164	38	23	0	0.0
		6,942	**4,056**	**58.4**	**2,124**	**52.4**

Annex 3 List of personnel in the project

No	Names	Position	
•	Dr.NGABO, Fidele	Director of Maternal Child and Community Health Unit	
•	MUKAMUNANA Alphonsine	Head of Environmental Health Desk	
•	NSIGAYE Emmanuel	Vice Mayor in charge of Social Affairs	
•	GATERA Egide	Director of Health	
•	MUTURUTSA, Patrick	District M&E Officer	
•	HABIMANA, Vincent	CBEHPP Officer	
No	**Names of EHOs**	**Health Center**	**Names of EHPs**
1	TWAGIRAMUNGU Joel	Bweyeye	UWAMARIYA Jeannette Gihundwe Hospital 0788639615
2	UWIMANA Alphonse	Giheke	
3	AYINKAMIYE Marie Redempta	Gihundwe	
4	HANYURWIMFURA Sabin	Nkanka	
5	MUKESHIMANA ROSINE	Nkombo	
6	UWAMAHORO Hyacinthe	Rusizi	
7	NYIRAMUBERA Suzanne	Nyabitimbo	
8	NYIRANDAYISHIMIYE Vestine	Mashesha	NTAKIRUTIMANA Zacharie Mibilizi Hospital 0788755976
9	KARAMAGA Jean Damascene	Bugarama	
10	HAKIZIMANA J. Paul	Islamic	
11	NZUMVIRYUMUGABO Alfred	Mushaka	
12	UWIZEYIMANA Odette	Nyakarenzo	
13	NGIRINSHUTI Valens	Mibilizi	
14	MUKANTWARI Berthilde	Nkungu	
15	RUHORIMBERE Charles	Gikundamvura	
16	HAKIZIMANA Clement	Rwinzuki	

Africa AHEAD Staff 2014- 2015

N°	Name	Position
•	KATABARWA T. Joseph	Country Director
•	NDAHIRO Andrew	Monitoring and Evaluation Officer
•	GASENGAYIRE Jeanne	Administrative Officer
•	HAVUMIRAGIRA Etienne	Data Officer
•	ABANABASE MBIRIRA Mercy	Field Officer

CONSULTANTS

N°	Name	Position
•	BIGIRIMANA Zachary	Regional representative
•	NTAKARUTIMANA Amans	Programme Manager
•	WATERKEYN Anthony	Programme Director
•	WATERKEYN Juliet. Dr.	Chief Executive Officer