Community-Based Environmental Health Promotion Programme (CBEHPP) in Rwanda

Hygiene Behaviour Change through Community Health Clubs (CHCs)

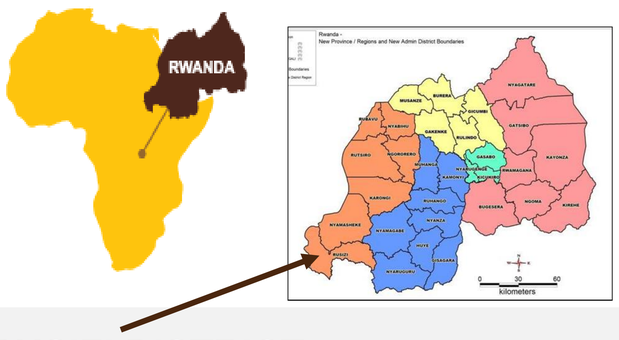
Waterkeyn, Africa AHEAD; Sanitation Partners Workshop, Bill & Melinda Gates Foundation, Hanoi, Vietnam - 2015

- ❑ **Community Health Clubs have been registered in 98% of all villages**
- ❑ **Almost 5,000 villages have received CHC training and meet every week.**

Although latrine coverage is almost universal in Rwanda, low levels of hygiene have persisted. The **Community Health Club** (CHC) model was adopted for the national health promotion campaign (i.e. CBEHPP) because previous research at LSHTM had demonstrated CHCs capable of achieving high levels of cost-effective behaviour change (Waterkeyn & Cairncross, 2006). The MoH (Environmental Health Desk), with TA support from WSP-World Bank & UNICEF, commissioned Africa AHEAD to develop the CBEHPP Roadmap plus training materials to support the scale-up of the CHC model nationwide to all 15,000 villages across Rwanda. To-date, CBEHPP training has been undertaken in 20 out of a total of 30 Districts and 33% of all villages have been trained to conduct health promotion sessions using CHC participatory activities that stimulate hygiene behaviour change. CBEHPP continues to expand with increasing levels of support from many implementing partners. As a result, hygiene is improving in Rwanda, which is one of the few countries in Africa to have surpassed the MDG WASH targets. Neighbouring countries (i.e. DRC and Uganda) are currently piloting similar CHC model.

1. INTERVENTION: "Putting women and girls at the centre of development" (BMGF Grand Challenge Goal: 2014)

INTERVENTION AREA: RWANDA



RUSIZI DISTRICT RANDOMISED CONTROL TRIAL

Rusizi District was selected for a Randomised Control Trial (RCT) sponsored by the Bill & Melinda Gates Foundation and conducted by Innovations for Poverty Action (IPA). The 150 villages in the intervention consist of three arms: 50 'Classic' villages that received 20 sessions as shown in the CHC Membership card above which includes most preventable diseases; the 50 'Lite' villages received much less training, similar to the standard PHAST training with just 8 participatory sessions on WASH related topics; and the 50 Control villages with no treatment for two years. At the end of Y2, the 'Lite' & 'Control' villages will receive the full 'Classic' CHC training. Africa AHEAD was commissioned by MoH to backstop the intervention and ensure that it was carried out according to the 'Classic' recipe as outlined in the Manual designed by Africa AHEAD. There are 8,420 households in the 50 Classic villages of which 60% are represented in a Community Health Club.

This poster does not represent findings from the RCT, which will only be available at the beginning of 2016.

1) Registration : 80% women

CHC Membership Card - The Key to high attendance in the CHC

	Topics	*Recommended 'Homework'*
1	Introduction	Bring friends and family
2	Common Diseases	Know about all common diseases
3	Personal Hygiene	Build a Family wash shelter
4	Hand washing	Hand-wash facility used with soap
5	Skin diseases	Children no skin diseases
6	Diarrhoea	Knowledge of Sugar Salt Solution
7	Infant Care	Correct Immunization of all children
8	Intestinal Parasites/Worms	Children with no Worms
9	Food Hygiene	Clean Drying Rack for pots
10	Nutrition	Good Child Growth Rate
11	Food Security/Safety	Kitchen Nutrition Garden
12	Water Sources	Protected, safe drinking water source
13	Safe Drinking Water	Safe Storage and Usage
14	Adequate Sanitation	Zero Open Defecation / Hygienic latrines
15	The Model Home	Waste Management and Greening
16	Good Parenting	Clean Children
17	Respiratory Diseases	Good Ventilation of kitchens
18	Malaria	Use of Treated Bed Nets
19	Bilharzia	Treatment for Bilharzia
20	HIV/AIDS	VCT and PMTCT

2) Training CHC Members in six months: 20 weekly health and hygiene sessions with corresponding 'homework'

Participatory Activities: *Discuss hygiene challenges*

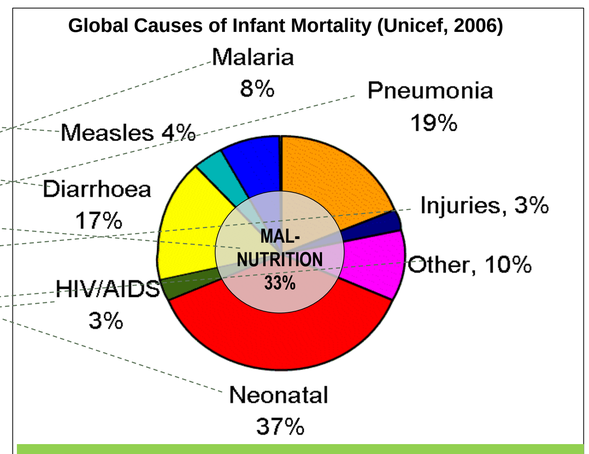
Song and Dance: *Reinforce key health messages*

Behaviour Change: *Home improvements*

3) Community Graduation: Certificate of full attendance with compliance of many recommended practices

HOLISTIC CONCEPT OF HEALTH

As 88% of these deaths are preventable, training in CHCs target ALL diseases not just diarrhoea (17%)



Our Target is to reduce all these deaths through CHCs

Intervention Activity in Rusizi

2013 October: **Base line survey conducted**
November: Training of the MoH Trainers by AA

2014: January: CHC facilitators trained by MoH trainers
February: CHC weekly training started
May: 50 Classic had completed 10 sessions.
Mid term Survey conducted
Training of 50 Lite Villages begins
September: Classic completed all 20 sessions
October: Graduation ceremonies for Classic
December: **End line survey conducted**

2015: Model Home Competitions for 50 Classic villages

2016 March: Training of Control & Lite Villages to reach full 'Classic' level
Sept. Completion of Lite & Control villages
December: End of Intervention (150 villages)
Post Intervention Survey

2. HYGIENE BEHAVIOUR CHANGE : Average 41% change of 14 indicators in 3 months

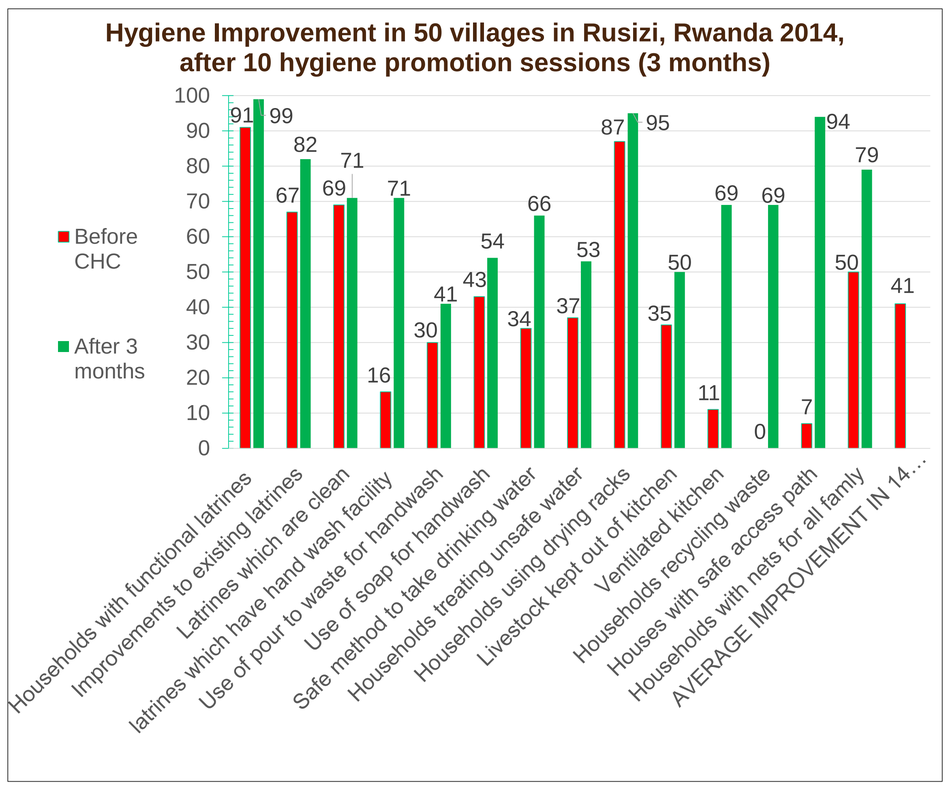
MONITORING THE INTERVENTION

Africa AHEAD is responsible for backstopping Ministry of Health and building capacity to monitor the CBEHPP nationally.
This is being done at three levels:

1. **Village Level:** Training the community health workers to make routine visits and record levels of hygiene according to 10 Golden Indicators (GI) of Good Hygiene as defined in the CBEHPP Road Map.
2. **District Level:** Demonstrating the use of mobile phones to monitor hygiene behaviour change, done by Environmental Health Officers as a base, mid and end line survey using the same 10 Golden Indicators
3. **National Level:** Development of an online registry of CHCs which can be used to record long-term changes in every village and provide MoH with a national monitoring tool. www.chcahead.org

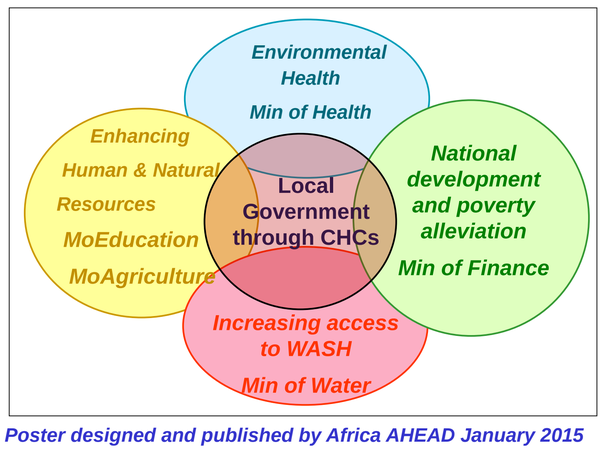
Mid Term Survey, May 2014 Demographic Information	Percentage n =621
Respondents registered in CHC	100%
Average household size	5.3
Households with Children under 5	100%
Household's of Christian religion	96%
Main carer in Household is Mother	93.7%
Average age of main carer	41.49 years
Carer with only primary education	72.2%
Carer with no education at all	20.6%
Average CHC sessions done	10

	BEHAVIOUR CHANGE
SAFE SANITATION	
99% of households have a latrine	8%
82% made improvements to latrines	15%
71% have *clean* latrines	2%
SAFE HANDWASHING	
71% have tippy taps at latrines	55%
41% use 'pour-to-waste' method	9%
54% use soap with hand washing	11%
SAFE HOME HYGIENE	
66% now take drinking water safely	32%
53% are treating unsafe water	11%
95% use drying racks for pots	8%
50%% keep livestock out of kitchens	15%
69% now have ventilated kitchens	58%
SAFE ENVIRONMENT	
69% are now recycling solid waste	69%
94% now have safe paths to home	87%
79% use mosquito nets for all family	29%



3. CHC POTENTIAL : Integrated & Inter-sectoral Community Development

Collaboration between Ministries at Local Government level



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Community Health Club = An Engine for Change

The programme in Rusizi to-date, as described above, is only the 1st stage of a 4 year process of development which could - if the CHC Model is used to its full extent - proceed into other Sectors so achieving 'Applied Health Education and Development' – AHEAD. The CHC becomes the engine for change, a structure at community level which can be used to address most development challenges. In Zimbabwe, CHCs have been used for Water, Sanitation, Nutrition, Livelihoods and Energy saving programmes. They are useful for saving/loans schemes and empowerment of women generally. For more information on this integrated and holistic approach to development using health promotion as an entry point to full community development. www.africaahead.com