Process Analysis of the Community Health Club Intervention in Rusizi District

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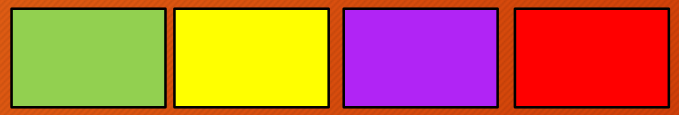
Outline of Presentation

1. BACKGROUND

- Partner Roles
- Why Rwanda
- Why Rusizi
- Randomisation
- Scope / scale
- Village size

2. MOBILISATION METRICS

- Response levels
- Coverage of village
- Duration of Training
- Number of meetings
- Average Attendance
- Completion Rate



KEY: Ranking in 4 categories

Remember these colours for all charts

3. ANALYSIS

- Highly Mobilised CHCs
- Average CHCs
- Poorly mobilised CHCs
- Constraints
- Achievements
- Comparison with DRC
- Objectives
- Conclusions
- Recommendations
- Achieving the SDGs

Why Rwanda? Leadership – Policy - Systemic Programme

LEADERSHIP

- Strong top down leadership
- President Kagame himself endorsed CBEHPP and ordered that it be in every 14,680 villages
- The Minister of Health was behind CBEHPP
- In MoH, The Head of Environmental Health was a champion for CBEHPP

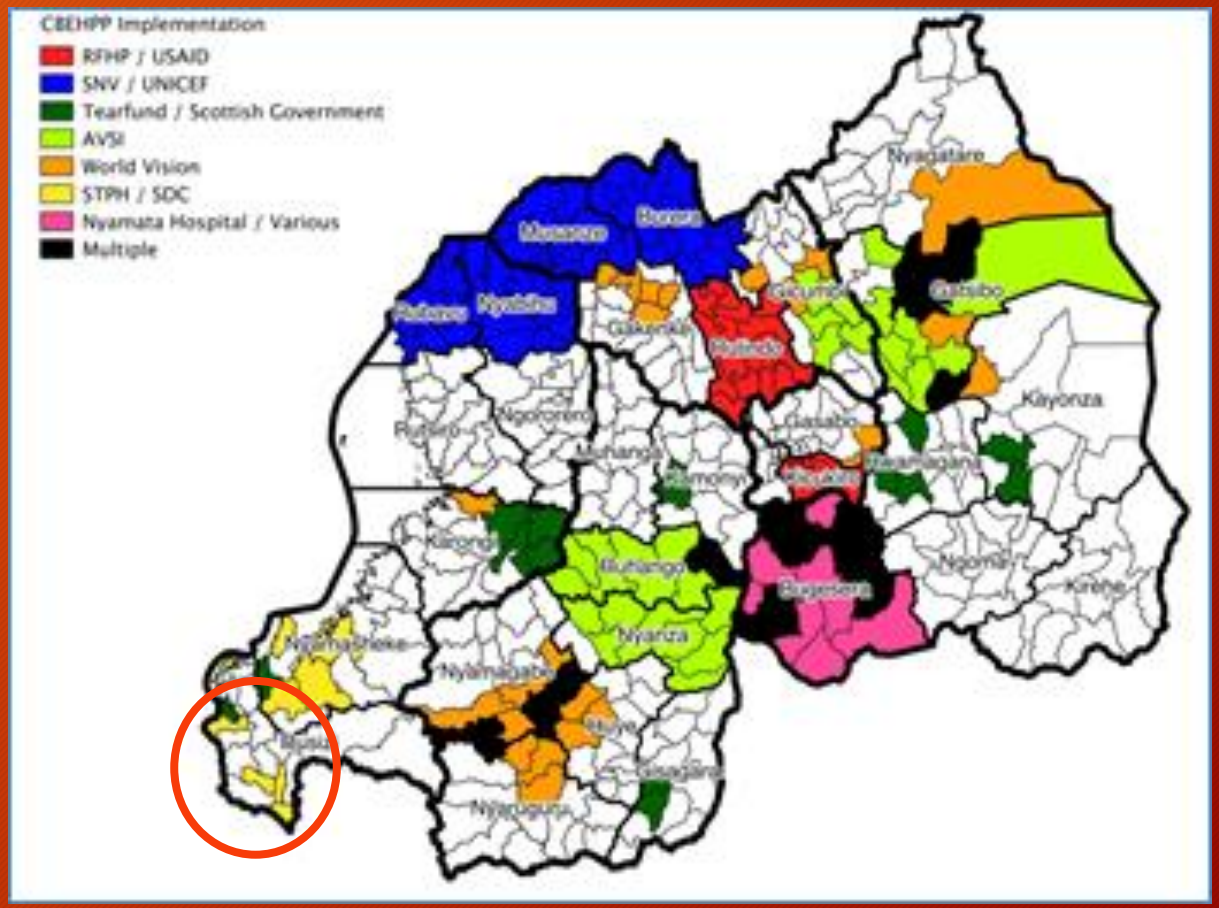
POLICY

- Rwanda was the only country in the world to have adopted the CHC Model at scale.
- Government approved a Road Map for the roll out of the Community Based Environmental Health Promotion Programme
- CBEHPP was endorsed in main Policies and HSSP2

SYSTEMIC

- CBEHPP had a cell structure from national to village level.
- The CBEHPP manual and Training visual aids were developed by Unicef/ MoH and Africa HEAD in 2010.
- Training of core trainers was done in 2011 and it looked like it would take off
- CHC was part of the Imihigo performance contract

Location: Country and District



Partners Roles in the Randomised Control Trial

Implementation

Ministry of Health, Environmental Health Desk

- Mobilise Community
- Start up 150 CHCs
- Train Trainers
- Supervise CHCs
- Keep Project Records
- Conduct follow up
- Competitions
- Graduations

Monitoring

Africa AHEAD

- Mentoring of EHOs
- Design of intervention
- Develop monitoring survey
- Supervise data collection
- Develop monitoring Application
- Develop Monitoring website
- Assist MoH at National level

Evaluation

Innovations for Poverty Action

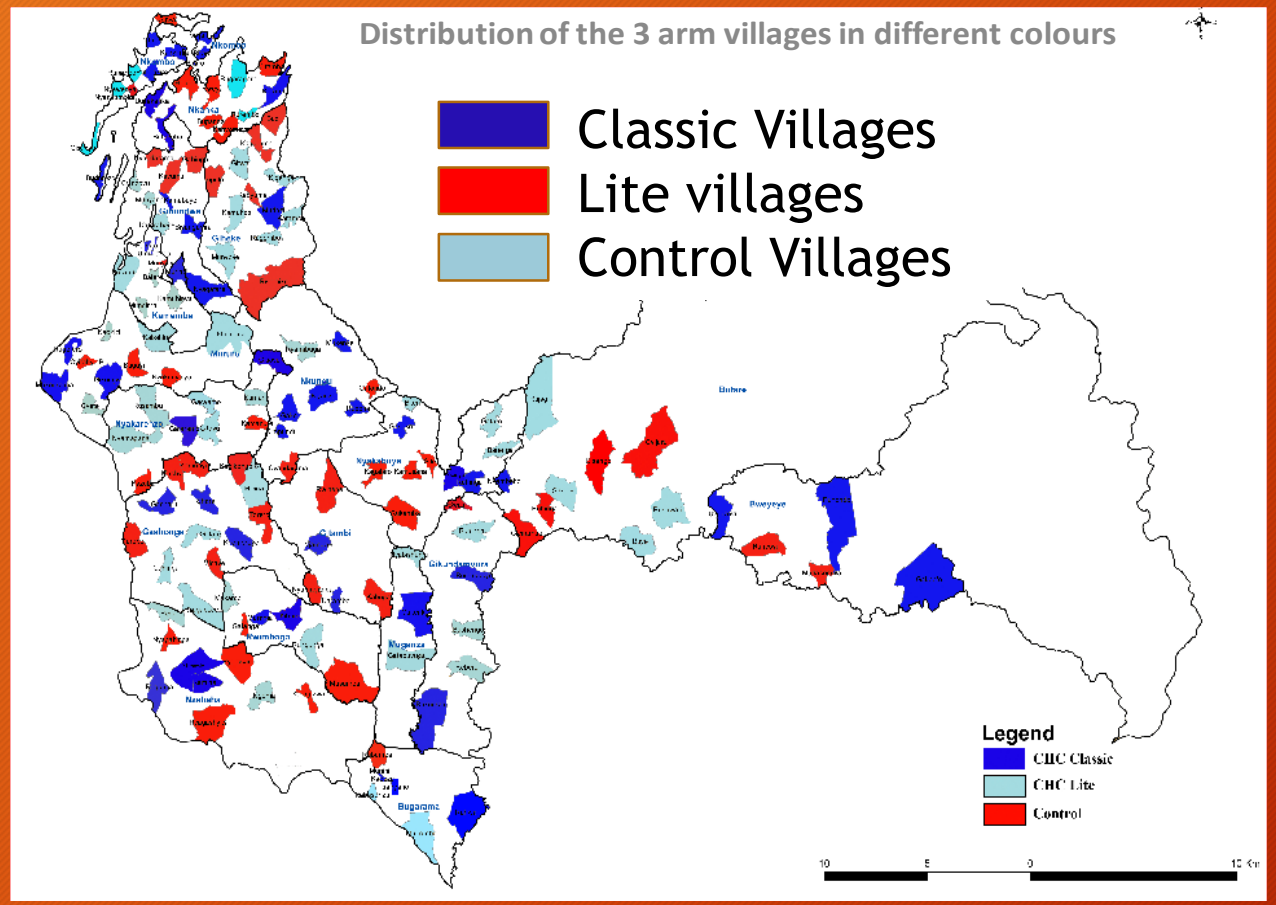
- Design of RCT
- Baseline of villages in Rusizi
- Randon selection of RCT villages
- Process Evaluation
- Measurement of Hygiene change
- Measurement of disease reduction
- Publication of findings

Why Rusizi District? –Remote, under developed

- One of the most remote districts in Rwanda
- Bordering DRC and Burundi, therefore replication more likely
- Little WASH intervention before, and no current WASH projects
- The district has least CHCs prior to our intervention
- Difficult to manage – 6 hours drive from Kigali on bad roads
- Population is diverse and openborder with lake
- Local Government disorganised and lacking commitment
- Few EHOs and low need to achieve

We made it difficult for ourselves : this context needs to be understood

Distribution of Classic villages in Rusizi district



Source: Innovation for Poverty Action

INTERPRETATION:

No villages shared a common boundary

REASON:

To avoid contamination between arms of RCT

IMPACT:

This interfered with the 'normal' CHC model which relies on group consensus through shared experience, and multiplier effect of emulation

Scope of the Intervention: Classic Arm only

Total number of households in 50 villages : 6,144 households

Total number of CHC members in 50 villages: 3,746 CHC members

Average number of CHC members per CHC: 65 members

Average % of members completing 20 sessions in 5 months: 52%

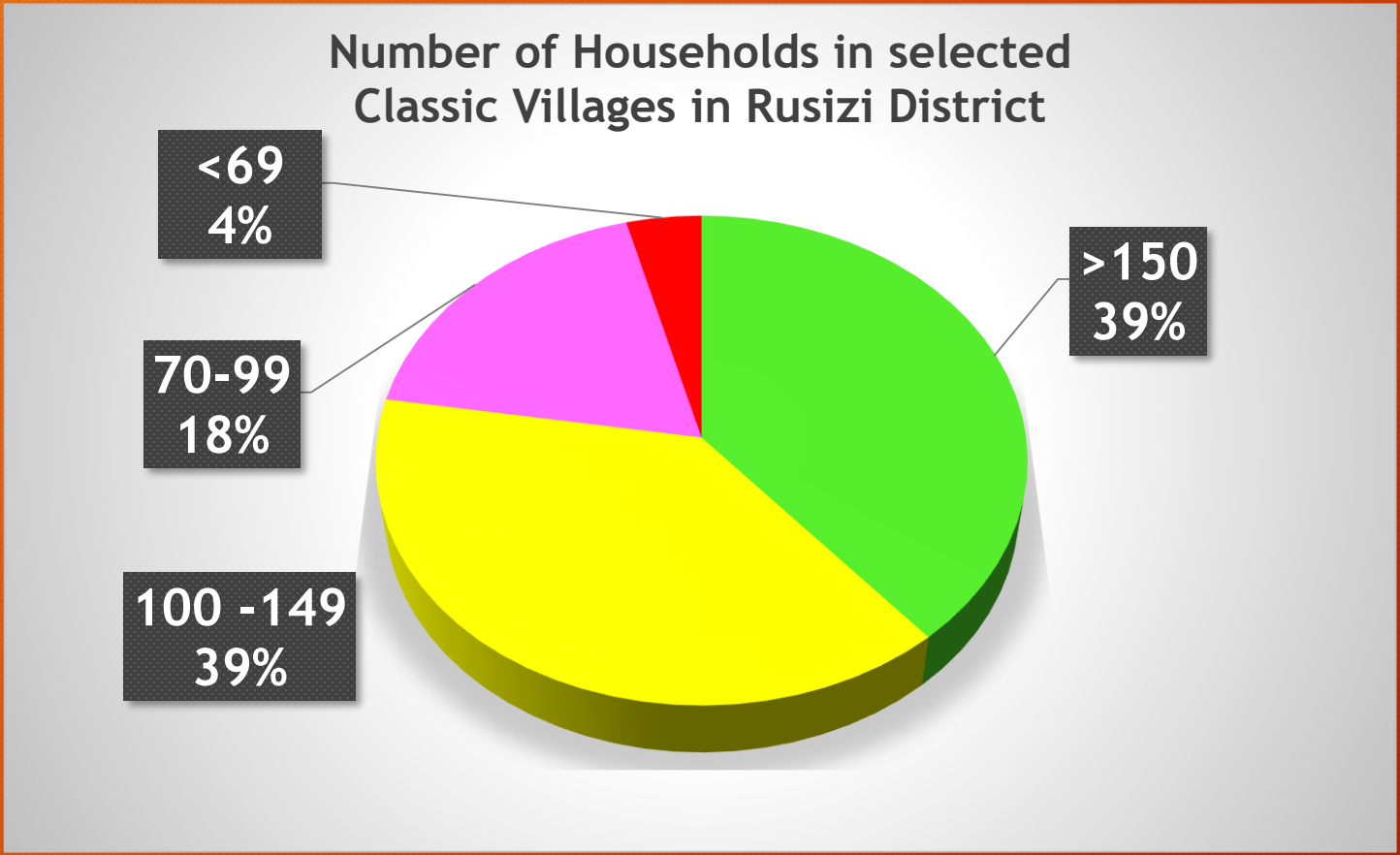
Number of CHC Members who have completed 20 topics: 2,000

Average number of CHC members at each topic: 43 members

TARGET

+100

Size of Classic Villages in Rusizi District



INTERPRETATION:

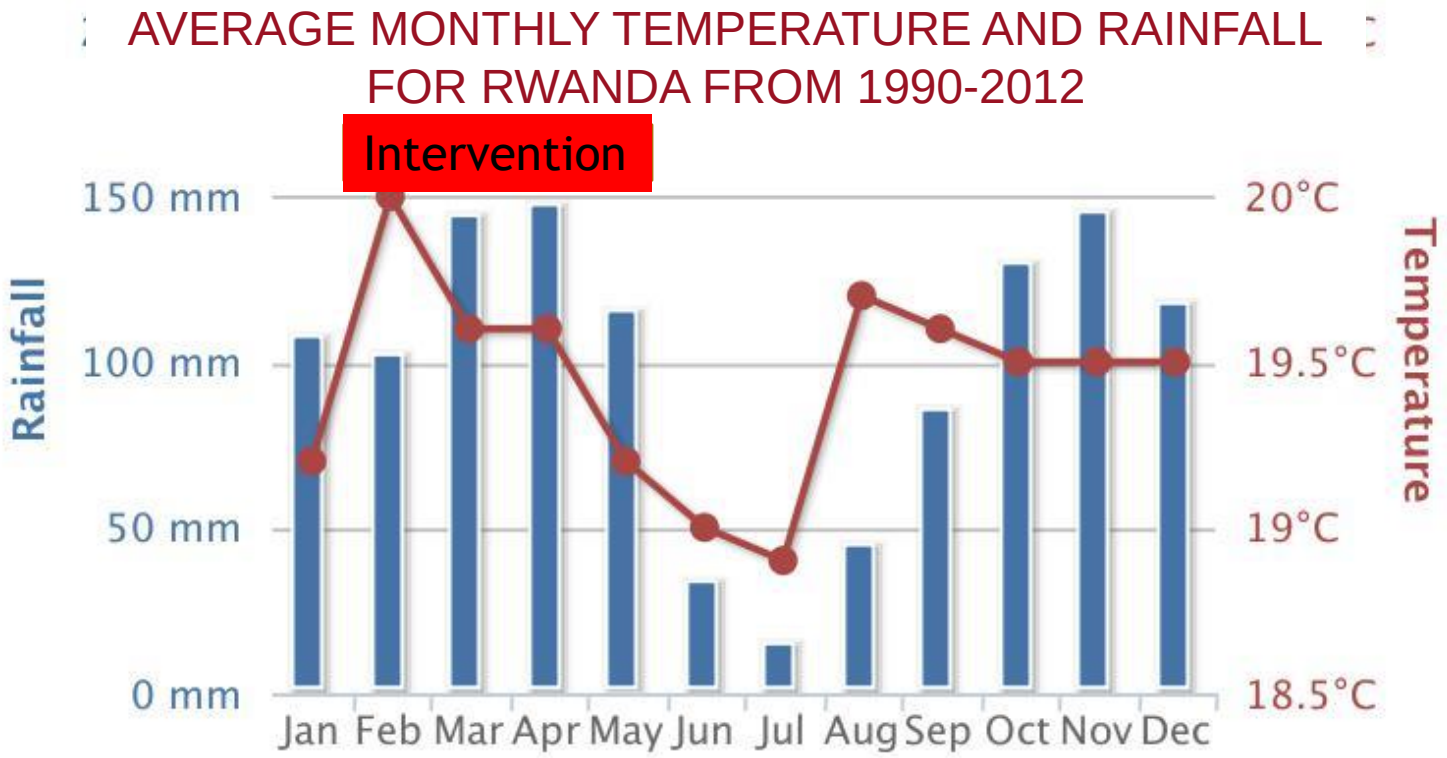
- 22% of villages were too small to provide 100 members.

REASON:

- **Sampling was NOT purposeful**

Poor Seasonal Timing of Intervention

Dry Season: May - October



Source: www.sdwebx.worldbank.org/

INTERPRETATION:

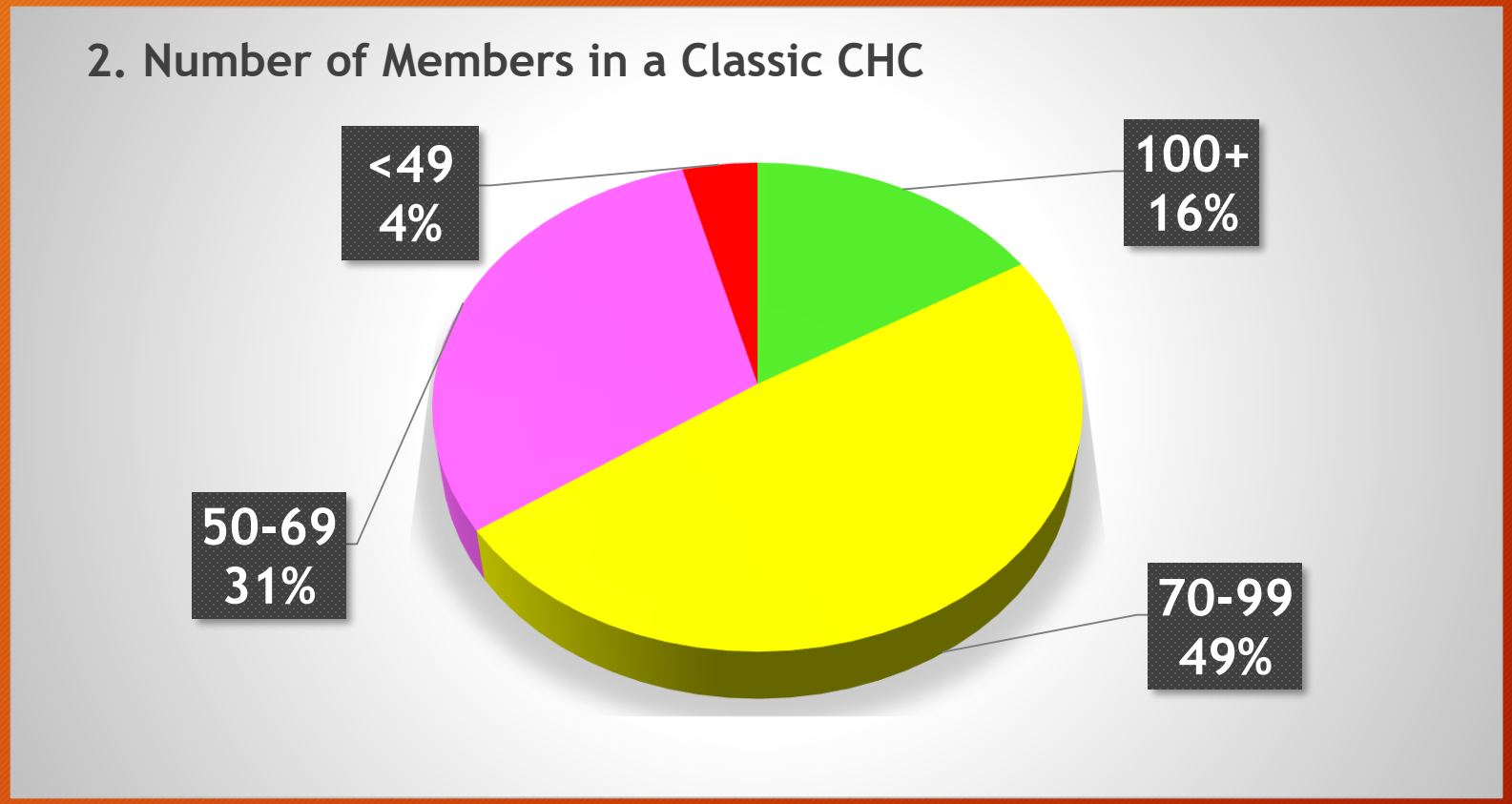
The intervention took place in the long rains with nearly 150 mm rain falling per month.

IMPACT: Reduced attendance as people had to be very keen to walk through torrential rain as it pours in most afternoons.

TARGET

Community Mobilisation & Response

+100



INTERPRETATION:

The CommunitIES did responded well to the call to join a CHC

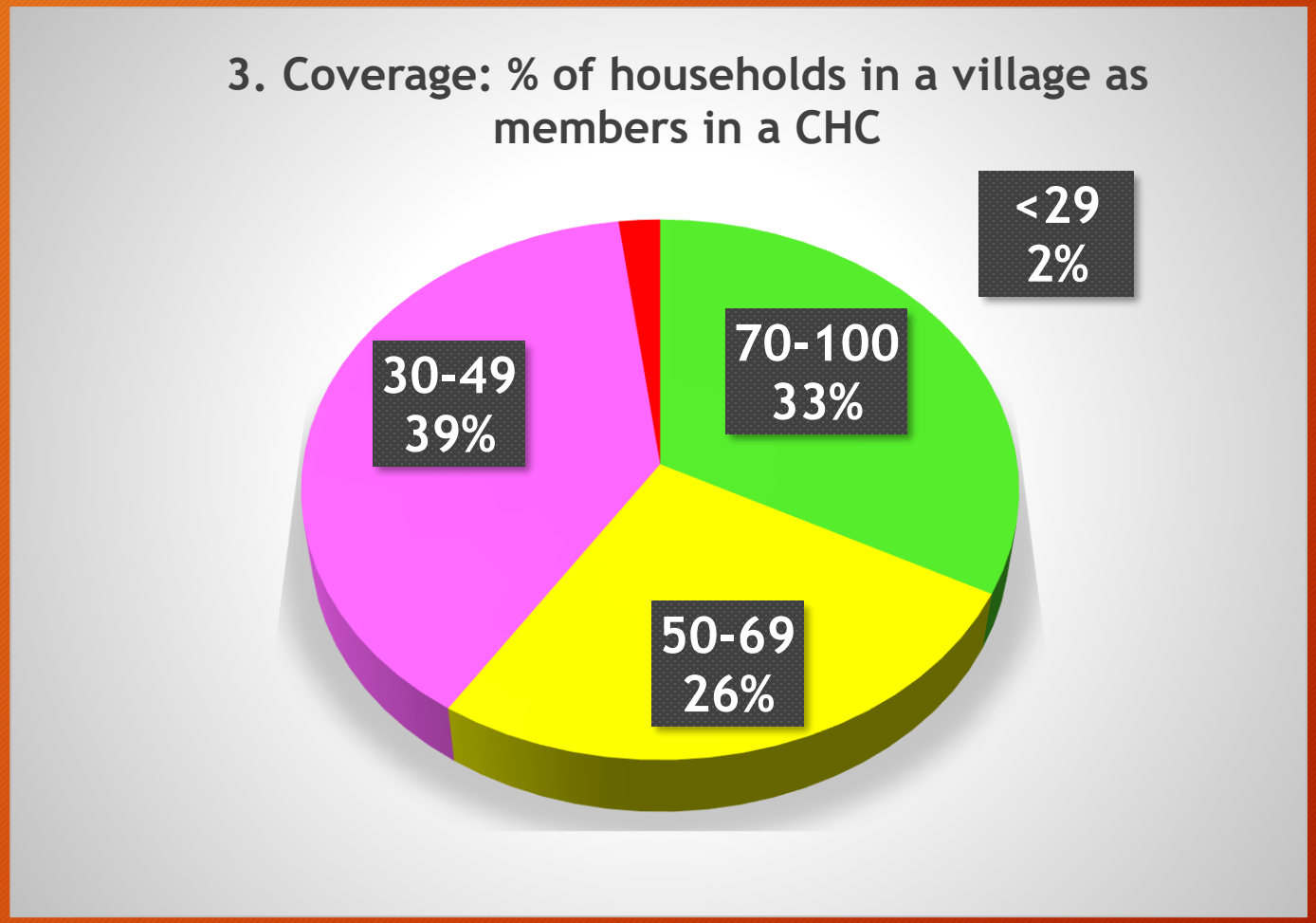
IMPACT: The CHC model succeeds in mobilising community but CHCs were smaller than expected

REASON: poor timing, & not enough time

TARGET

COVERAGE: What % of the households in a villages are in a Community Health Club?

+80%



INTERPRETATION:

Only 33% of villages were adequately covered.

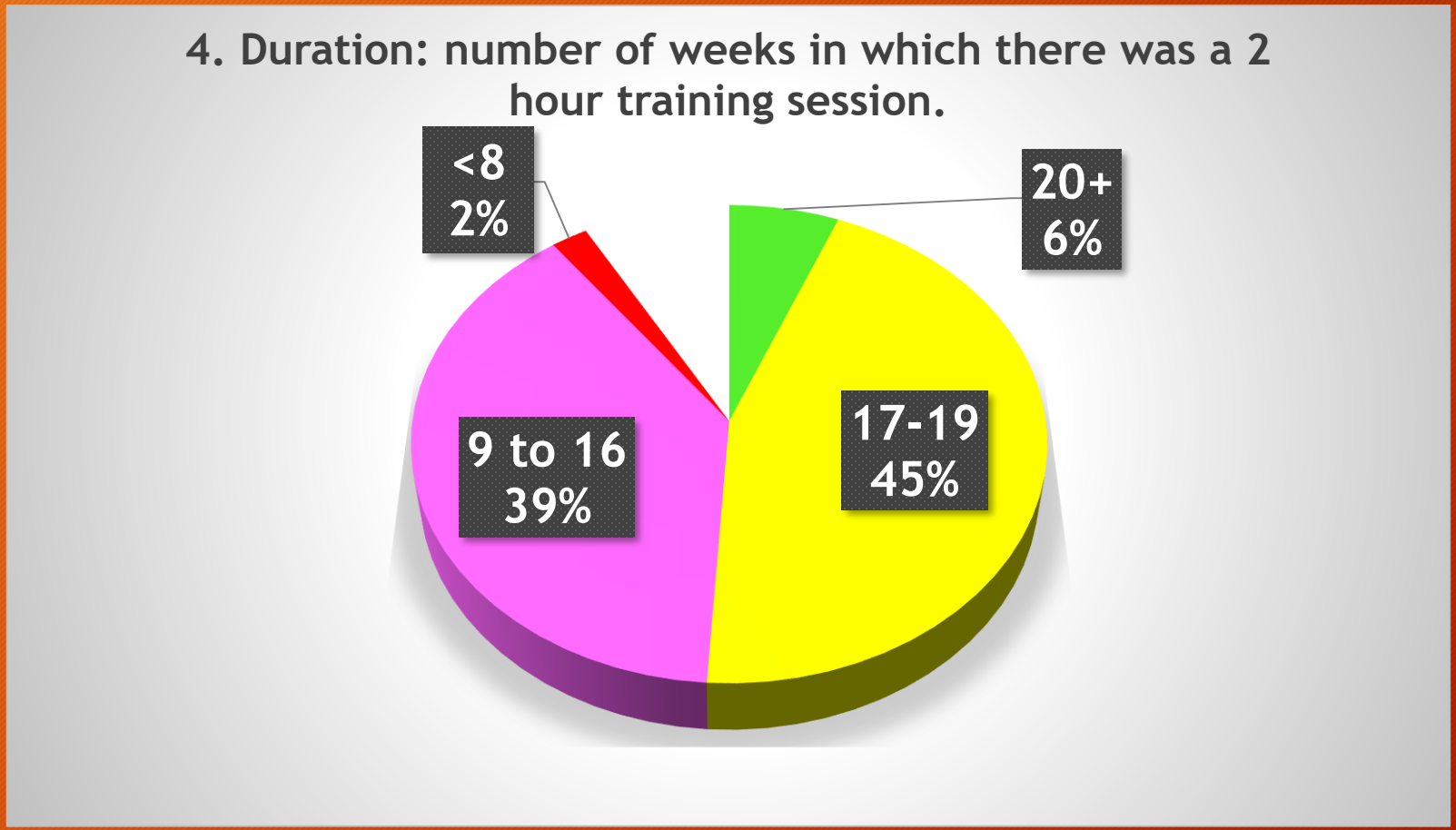
IMPACT: Too thinly covered to expect diarrhoea to reduce

REASON: Not enough time for mobilisation and training

DURATION:A Classic Training should have at least 6 months of weekly meetings

TARGET

24 weeks



INTERPRETATION:

The training lasted only 5 months.

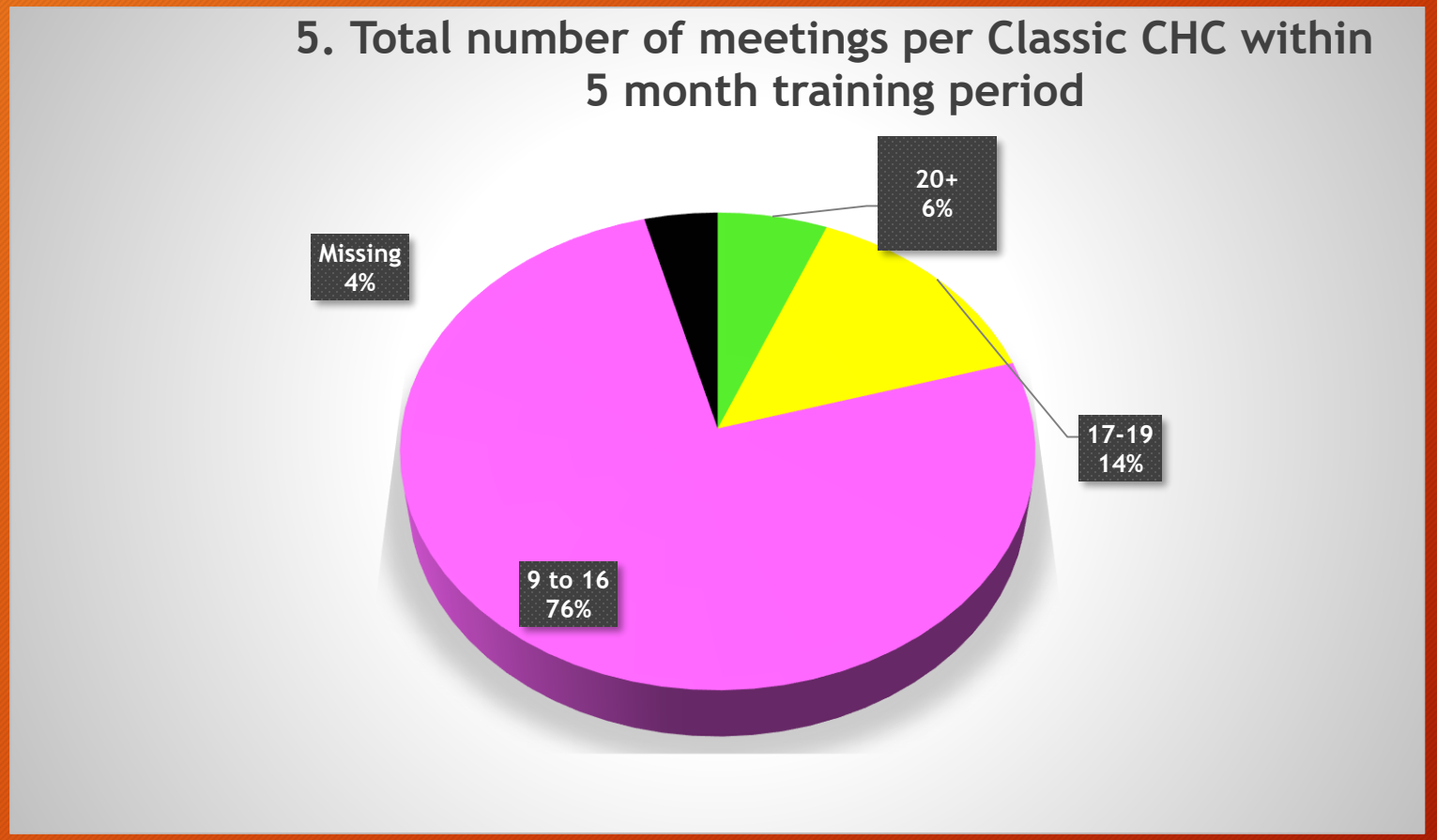
IMPACT: Lack of time for reinforcement of key messages - Insufficient understanding and time for change

REASON: Late start due to delays in selection of villages

How many times did each CHC meet?

TARGET

+20 sessions



INTERPRETATION:

Only 6% of CHCs met the required number of 20 times.

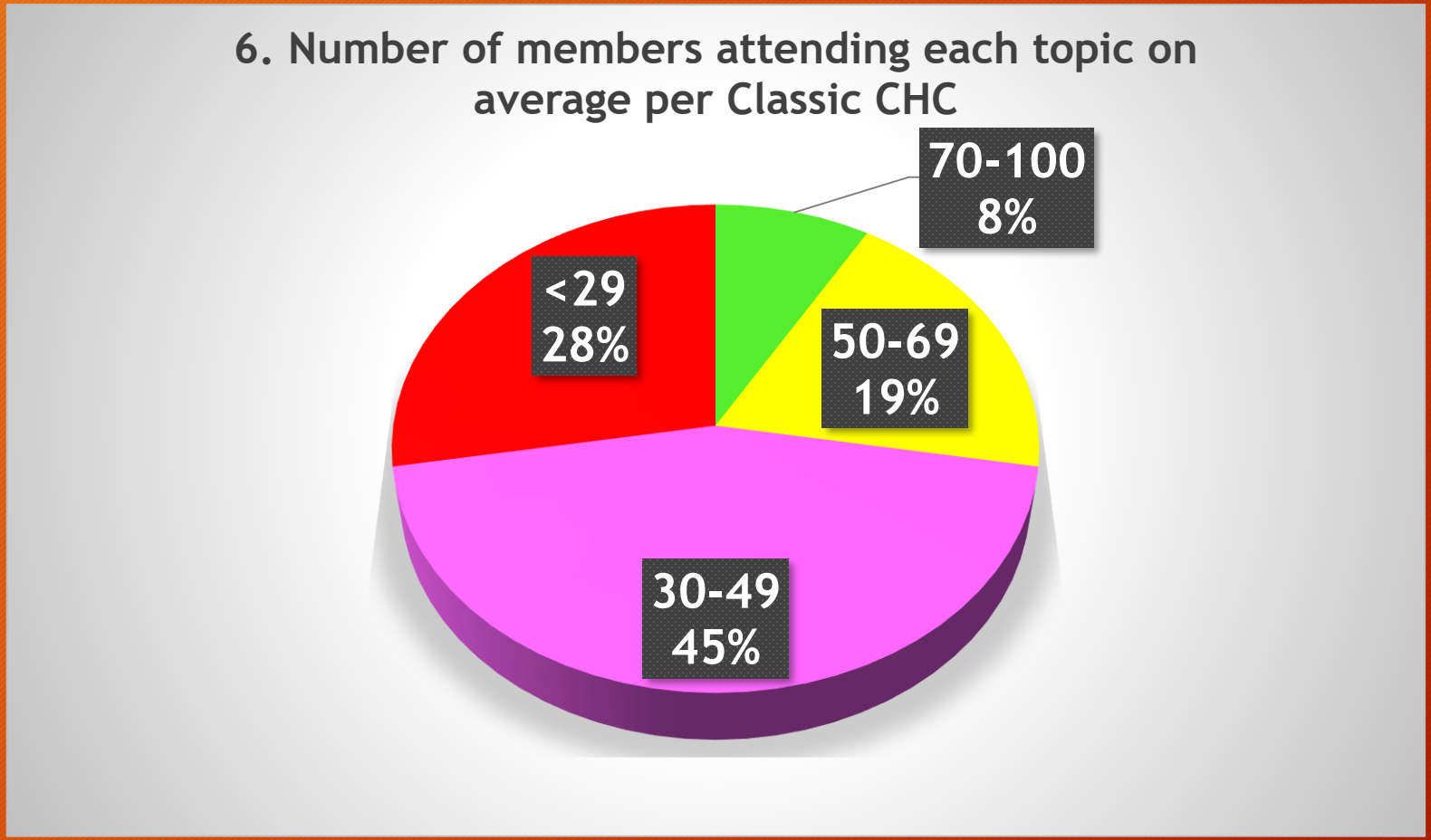
IMPACT: too many topics were done in one session.

REASON: Late start due to delays in selection of villages

TARGET

Attendance of training topics: average number of members attending topics in each CHC.

+50%



INTERPRETATION:

27% CHC had average attendance of over 50%

73% of CHC was below target.

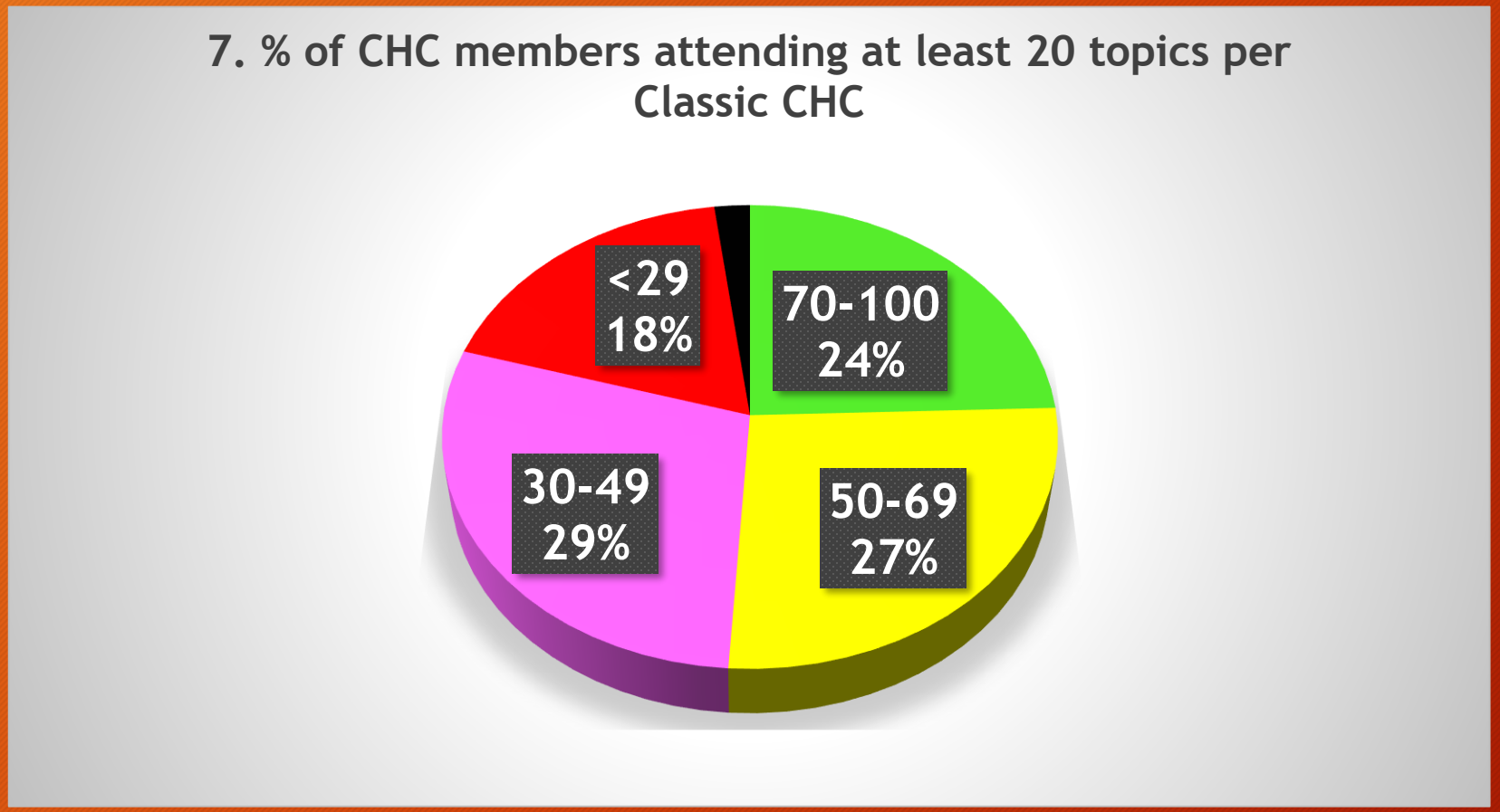
IMPACT: knowledge is not universally shared

REASON: Sessions were held in the rainy season

TARGET

Completion: % of full attendance of the 20 topics in each CHC

+70%



INTERPRETATION:

24% of CHCs had over 50% completion rate of members.

IMPACT: Training was incomplete and behaviour change was slower than expected

REASON: Wrong season for maximum attendance. Heavy rain daily.

RANKING of Classic CHC: 1. Highly mobilised

Classic villages	HH in village	HHs in CHC	coverage of CHC hhs	Graduated/CHC	Graduated members	Average Attendance
2014	Number	number	%	%	number	number
Rukuraza	192	148	77	81	120	103
Ruhondo	128	124	97	86	107	99
Gakenke	345	167	48	64	107	35
Nyambeho	111	111	100	91	101	87
Kamina	143	86	60	93	80	53
Rugunga	150	100	67	75	75	35
Murama	173	86	50	81	70	48
Murambi	151	102	68	67	68	72
Isangano 1+2	186	176	94	73	65	67
Ruhinga	111	86	77	72	62	58

RANKING of Classic CHC: 2. Average mobilised

Classic villages 2014	HH in village Number	HHs in CHC number	coverage of CHC hhs %	Graduated/CHC %	Graduated members number	Average Attendance number
Kiremereye	120	80	67	78	62	33
Uwinzovu	80	80	100	74	59	62
Gasharu	74	73	99	77	56	49
Gakopfo	76	69	91	81	56	51
Mukorazuba	187	85	45	66	56	11
Gisovu	143	83	58	61	51	29
Mukenke	113	86	76	62	53	52
Busarabuye	80	80	100	59	47	26
Njambwe	151	92	61	50	46	31
Ruhwa	134	98	73	47	46	67
Rugerero	154	61	40	64	39	39
Kibare	99	76	77	50	38	50
Shara	93	93	100	40	37	60
Gako	123	90	73	41	37	57
Kanyinya	85	66	78	27	36	45
Umuganda	220	70	32	50	35	31
Rubona	153	63	41	54	34	36
Karambo Gitambi	77	75	97	37	28	48
Budorozo	133	68	51	41	28	29
Bisanganira	132	50	38	54	27	33
Biraro	129	77	60	35	27	12
Nkanga	190	83	44	29	24	50
Murinzi	149	80	54	33	26	29
Gataramo	179	107	60	23	25	22
Kamabuye	178	63	35	38	24	25

RANKING of Classic CHC: 1. Poorly mobilised

Classic villages	HH in village	HHs in CHC	coverage of CHC hhs	% Graduated per CHC	Graduated members	Average Attendance
2014	Number	number	%	%	number	number
Bahemba	152	53	35	38	20	33
Kiyanza	144	90	63	40	18	33
Nyagatare	120	50	42	36	18	38
Busekanka	132	60	45	28	17	38
Rutarakiro	137	63	46	24	15	29
Gaseke	50	36	72	39	14	17
Kimpundu	62	56	90	25	14	33
Mapfura	98	75	77	17	13	21
Karambo	137	56	41	20	11	35
Mbuga	170	73	43	11	8	32

Constraints: What went wrong?

Policy: Environmental Health Desk was abolished leaving CBEHPP without direction.

Trainers: CHWs but this was changed to 'ASOC' (Social Mobilisers) without health training

Champion: CBEHPP lost all friends in high places

Funding: funding through MoH didn't always reach the District – still US$40,000 un-used!

Transport: Motorbikes were given to EHOs one year late, after the intervention

Implementation: AA ended up running the programme with one project officer

Coordination: **Poor** coordination and alignment of targets between IPA and AA .

Achievements: What went right?

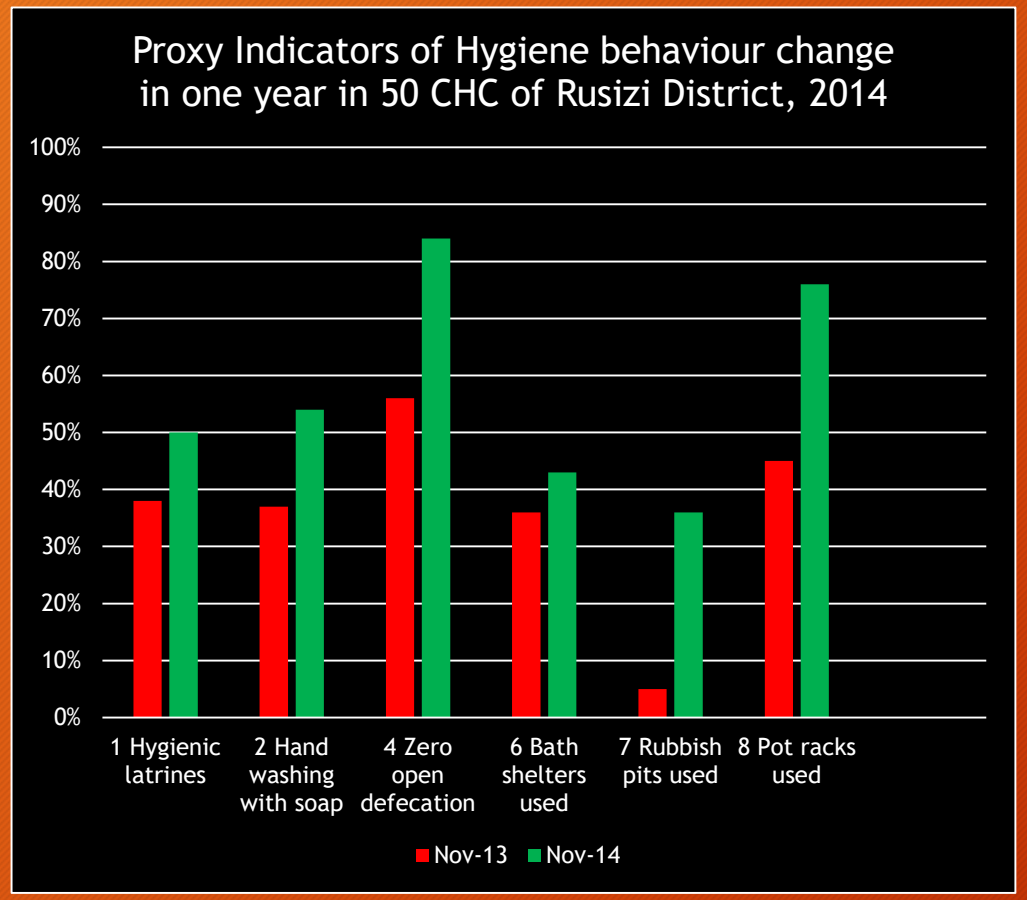
Rusizi District was greatly enhanced: Rusizi moved from 27th to 4th place (2016) for Imihigo

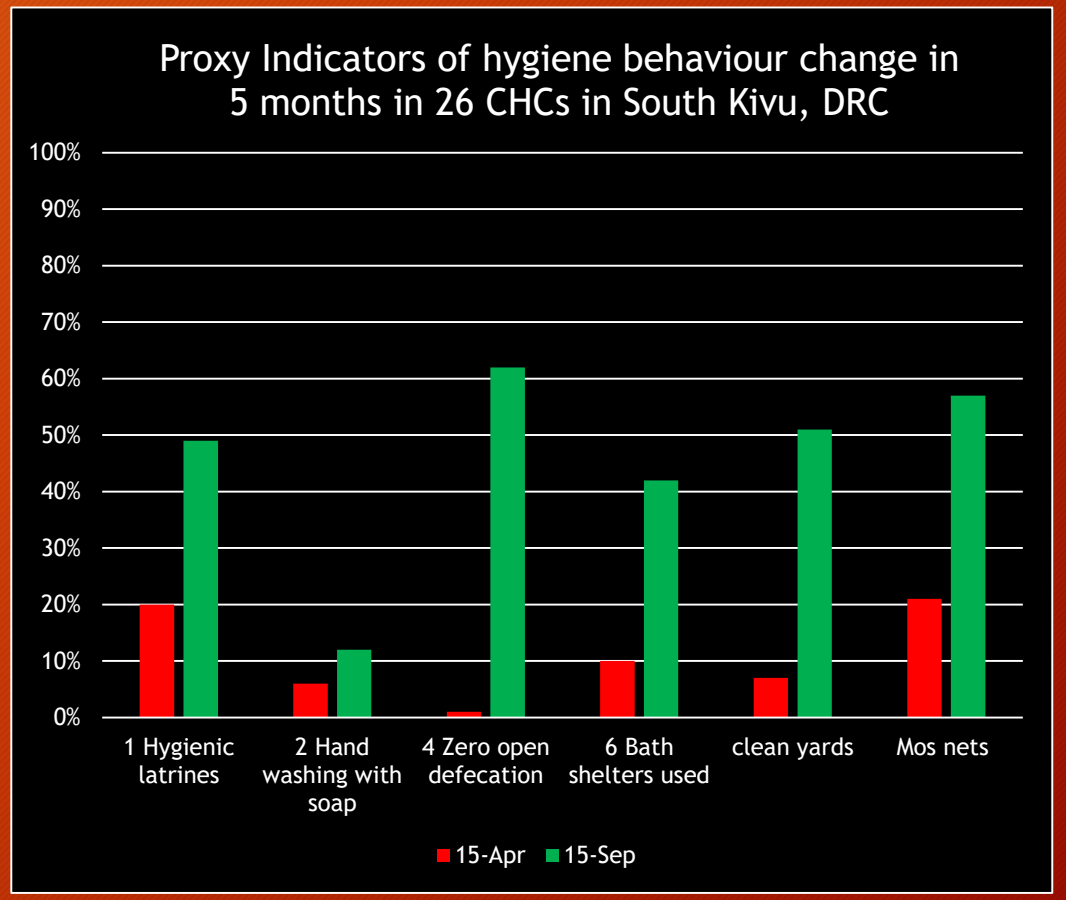
Capacity of Village Leadership was greatly enhanced: CHC are owned by the villages and are sustained

CHC Model adopted and extended: Agencies (USAID/Unicef) in combined Integrated Nutrition and WASH (INWA) programmes which have been scaled up to 8 Districts.

Regional replication: CHC Model used in Uganda and DRC more successfully than in Rwanda

Comparing outputs of proxy indicators between Rusizi, Rwanda & South Kivu (DRC)





Achievements: Monitoring Component

1. We have built capacity in MoH for training of communities for hygiene behaviour change.

2. We have enabled MoH to effectively monitor behaviour change through evidence-based data collection

3. We have ensured functional and responsible communities exist in 150 villages in Rusizi district with 150 active CHCs to 60% coverge - outstanding 20%.

4. We have provided a demonstration on how hygiene behaviour change can be sustained - but still needs a longer time frame .

5. We have demonstrated a cost-effective Change Model capable of improving family health at scale- to be assessed by IPA

Conclusion: The CHC Model is a very successful tool for high community mobilisation BUT….

1. **PROPER TIMING** is essential for high community response
2. **MORE TIME** (1 year) is needed to trigger behaviour change
3. **MORE REINFORCEMENT** is needed to sustain behaviour change
4. **HOLISTIC DEVELOPMENT** in order to prevent poverty & disease

There are NO short cuts to sustainable development

How to Alleviate Poverty and Disease

Mobilising through Community Health Clubs

An obvious way to meet the Sustainable Development Goals

Mobilising Village Leaders

Building local capacity / training

Safe Hygiene Behaviour

Safe Water and Sanitation

Environment: Climate Resilience

Improved Gender Equity

Community Organisation (start up Health Club)

Improving Health Knowledge

Hygiene Competitions

Good Nutrition and Food Security

Maternal and Child Survival

Resulting in sustainable Livelihoods

Recommendation: Adopt the full 4 year holistic AHEAD Model for Genuine Sustainable Development

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For more information please see www.africaahead.com