Analysis of the Community Health Club Intervention in Rusizi District, Rwanda

Dr. Juliet Waterkeyn,
Africa AHEAD
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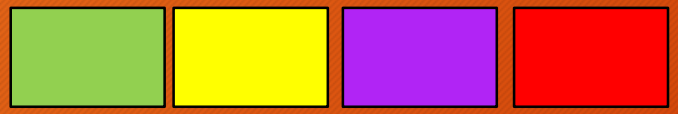
Outline of Presentation

1. BACKGROUND
- Partner Roles
- Area
- Scope
- Village size



KEY: Ranking in 4 categories

2. MOBILISATION METRICS
- Response levels
- Coverage of village
- Duration of Training
- Number of meetings
- Average Attendance
- Completion Rate

3. ANALYSIS
- Highly Mobilised CHCs
- Average
- Poorly mobilised
- Constraints
- Achievements
- Objectives
- Conclusion & Recommendations
- Achieving the SDGs

NB: This does not deal with Hygiene Behaviour Change Indicators

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

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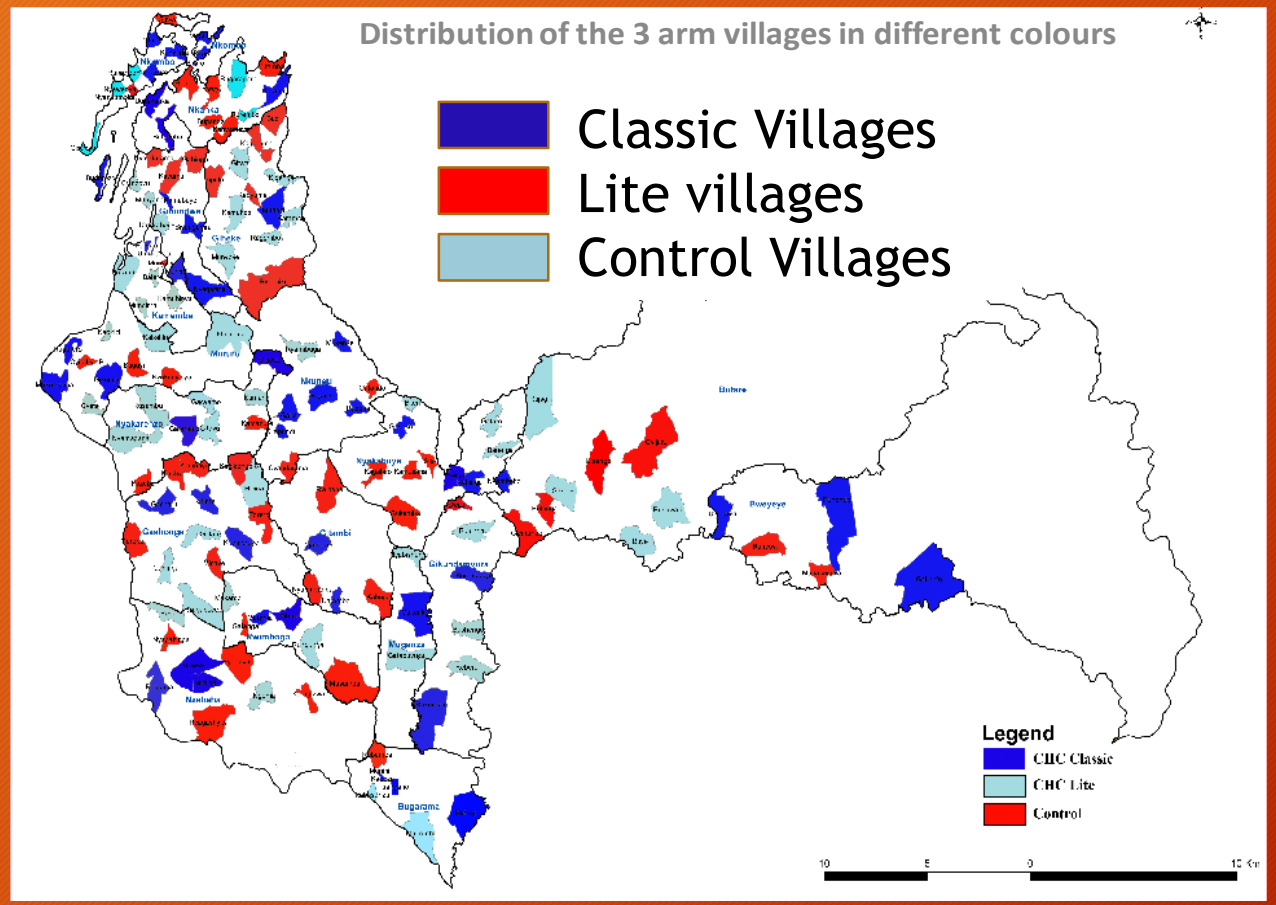
- Mentoring of EHOs
- Design of intervention
- Develop monitoring survey
- Supervise data collection
- Develop monitoring Application
- Develop Monitoring website
- Assist MoH at National level

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

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%

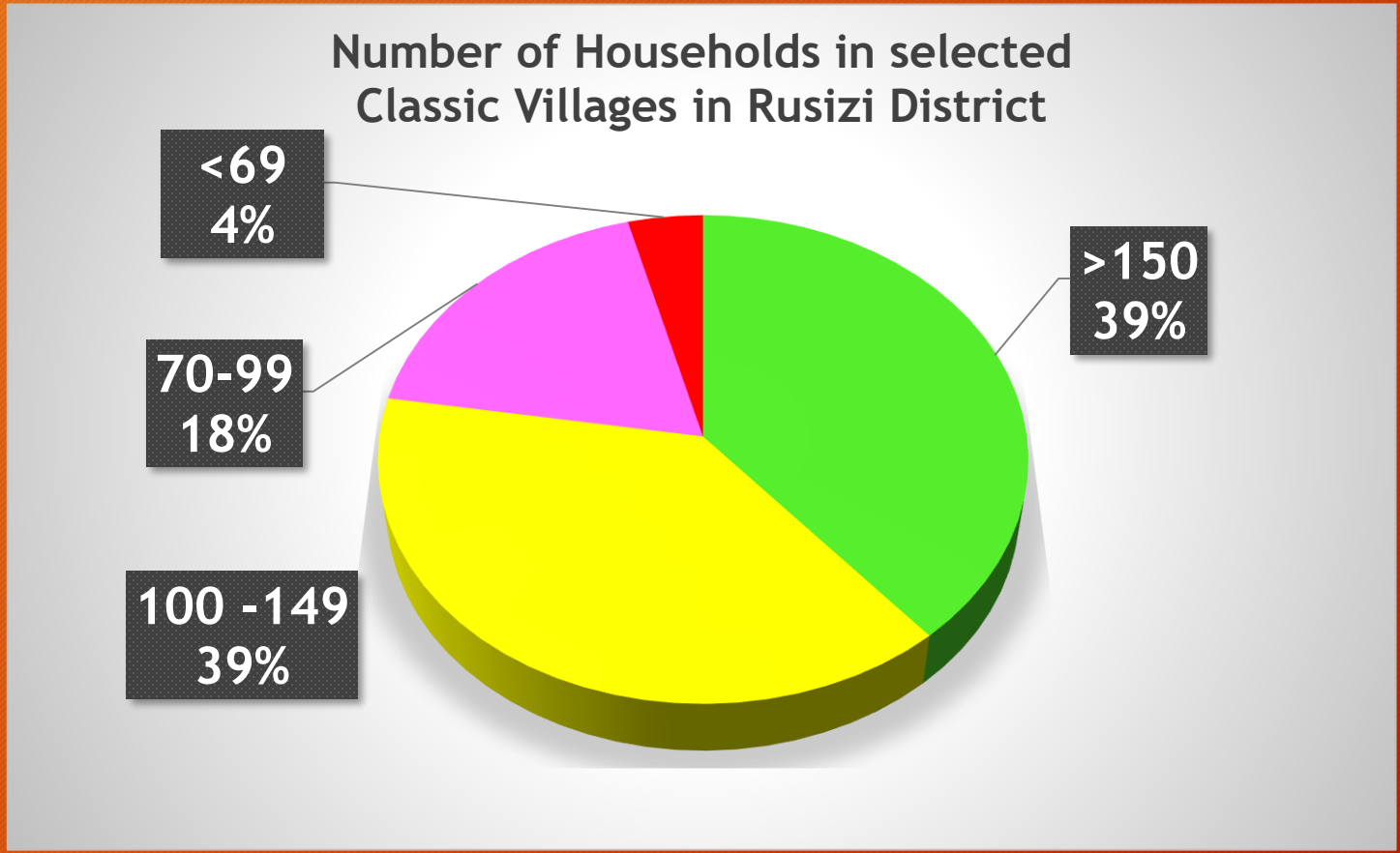
Number of CHC Members who have completed 20 topics: 2,000

Average number of CHC members at each topic: 43 members

TARGET

+100

Size of Classic Villages in Rusizi District



INTERPRETATION:

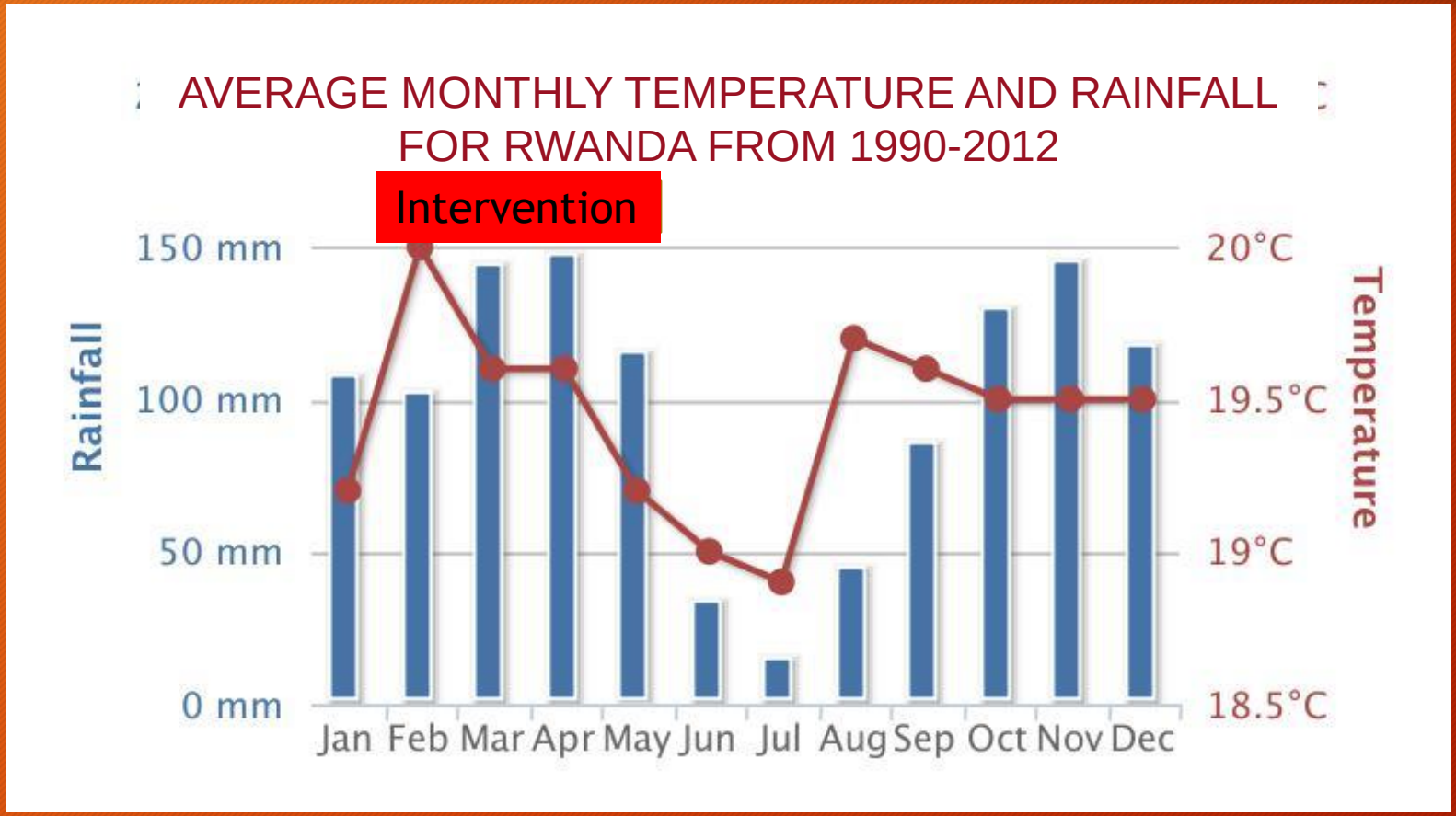
- 22% of villages were too small to have the size of CHC targeted - ie enough households to provide 100 members.

REASON:

- Sampling was NOT purposeful

Poor Seasonal Timing of Intervention

Dry Season: May - October



Source: www.sdwebx.worldbank.org/

INTERPRETATION:

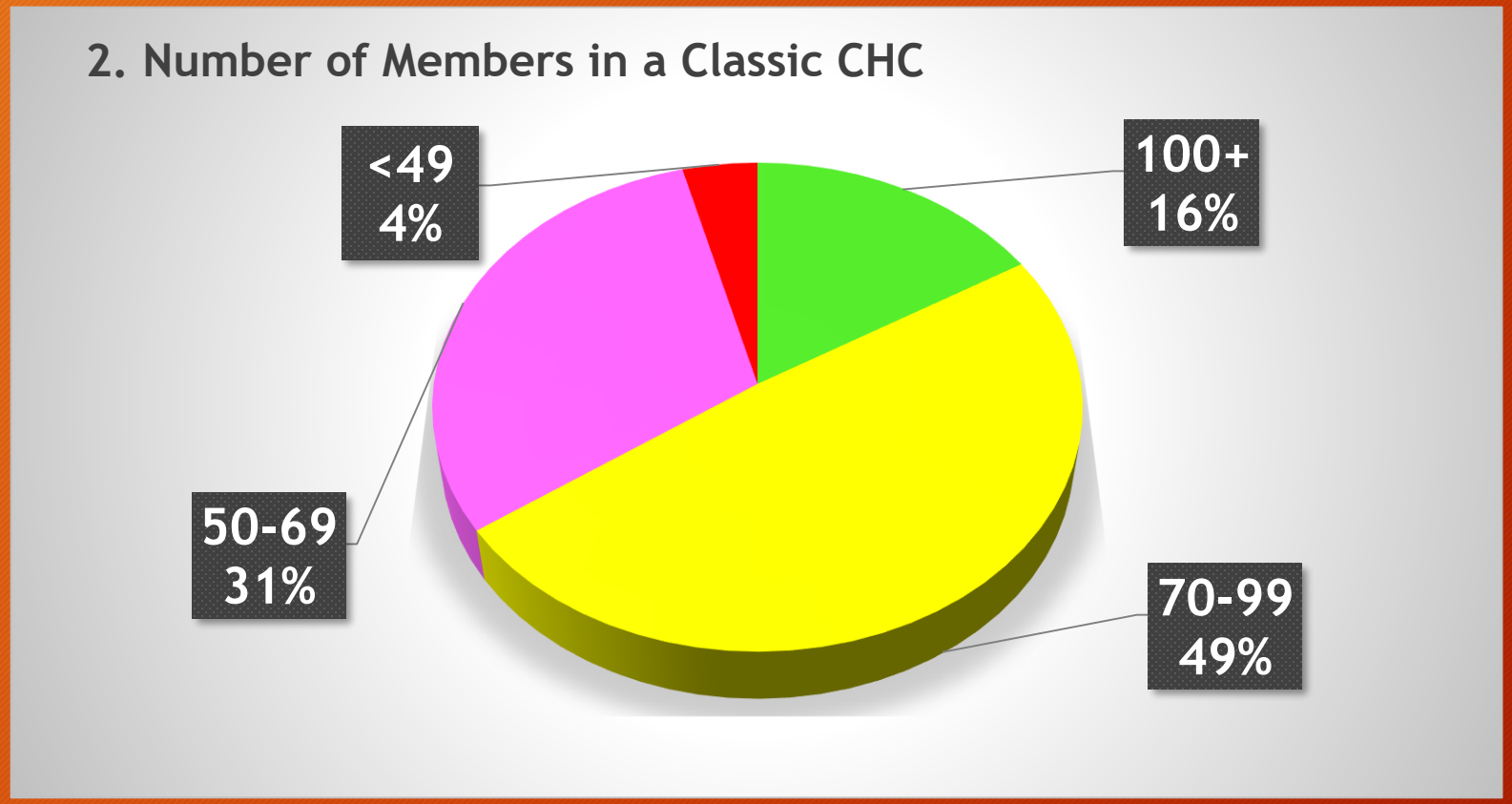
The intervention took place in the long rains with nearly 150 mm rain falling per month.

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 Community responded well to the call to join a CHC

But only 16% were over 100 members

Only 4% were below 50 members

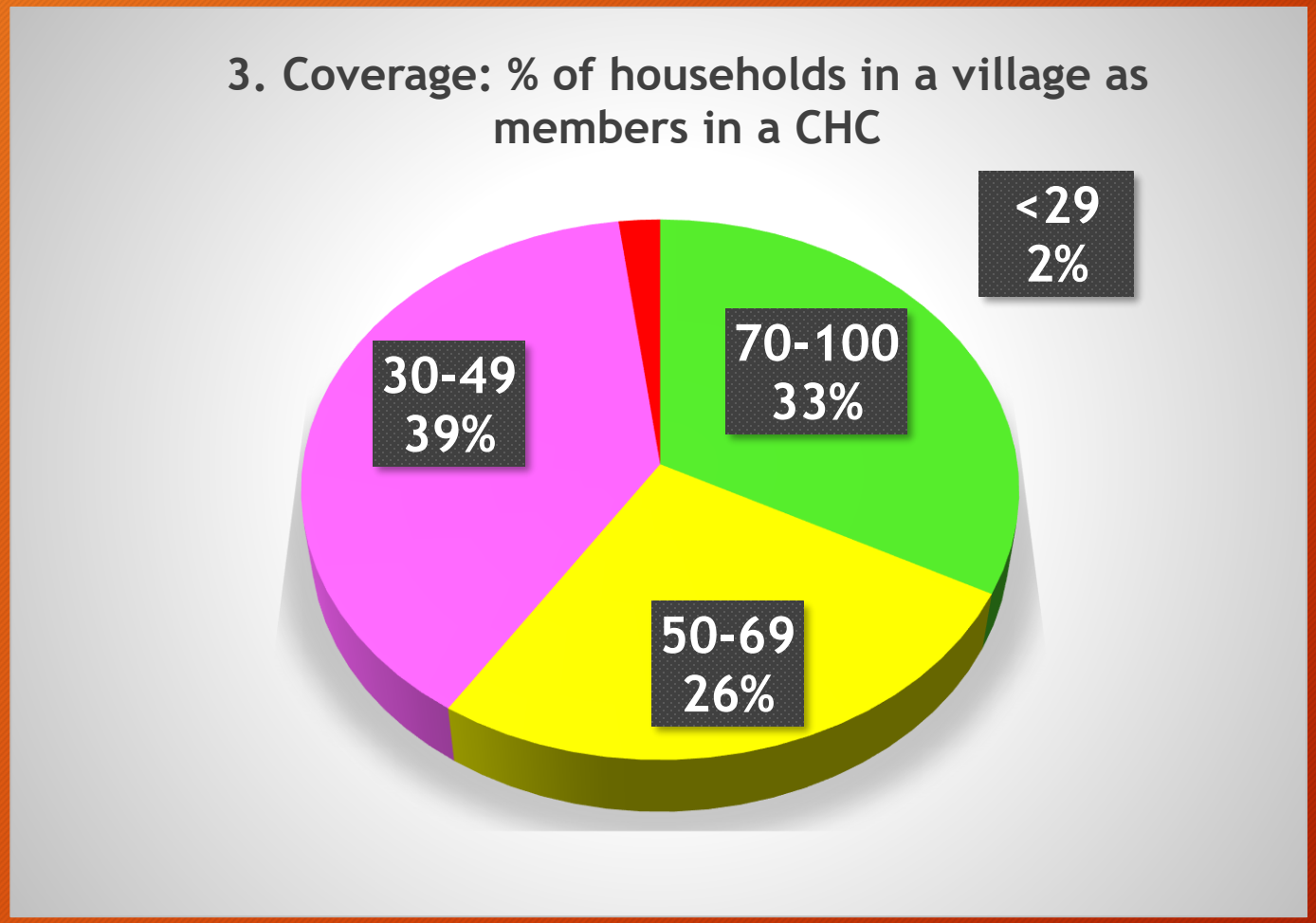
The CHC model succeeds in mobilising community but CHCs were smaller than expected

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. Doubtful if this coverage is dense enough to improve hygiene throughout village.

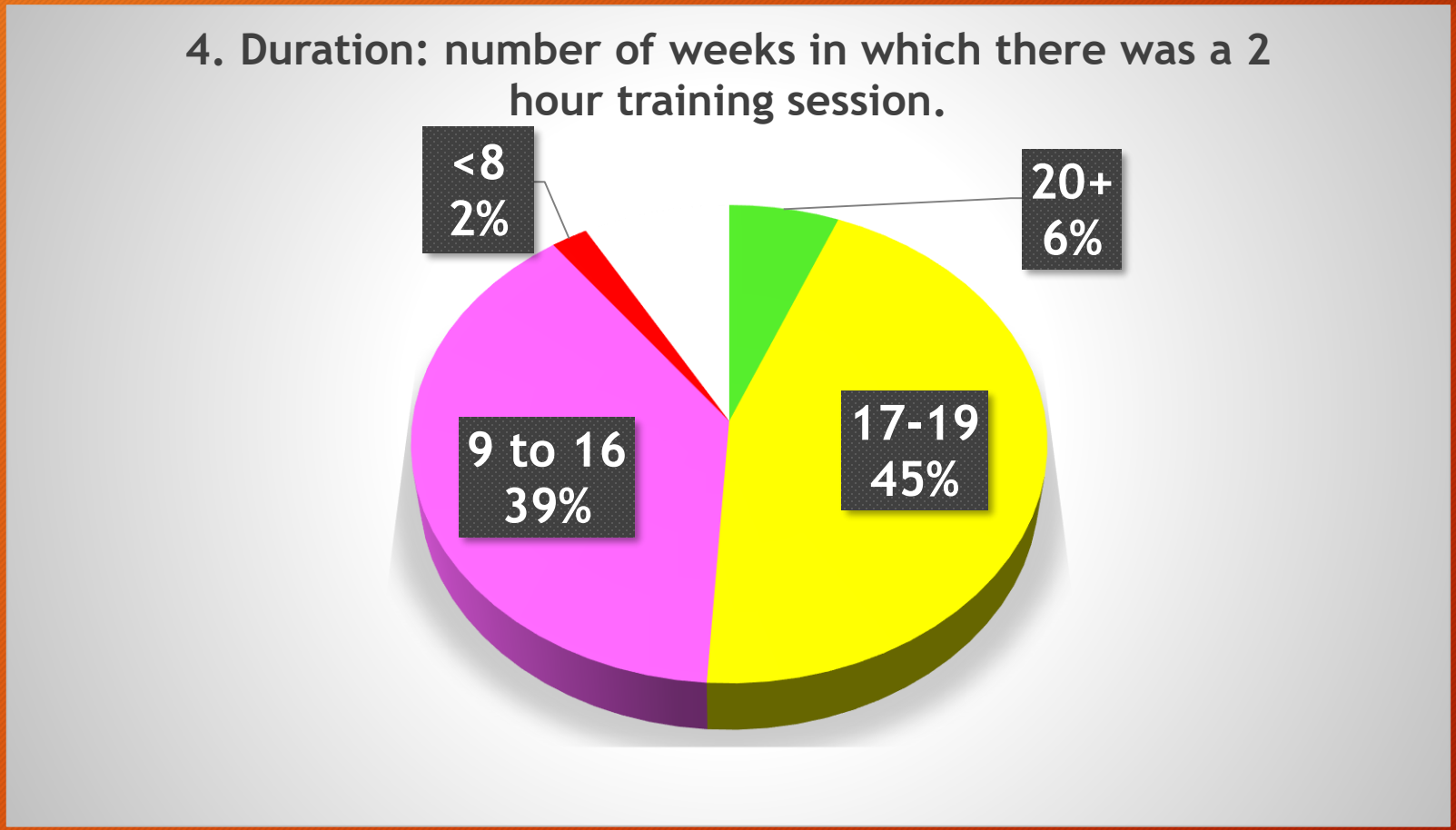
CONCERN: Too much to expect much impact on diseases such as diarrhoea

REASON: Not enough time for mobilisation and training

TARGET

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

24 weeks



INTERPRETATION:

The training lasted from Feb - June 2014, only 5 months. Lack of time for reinforcement of key messages

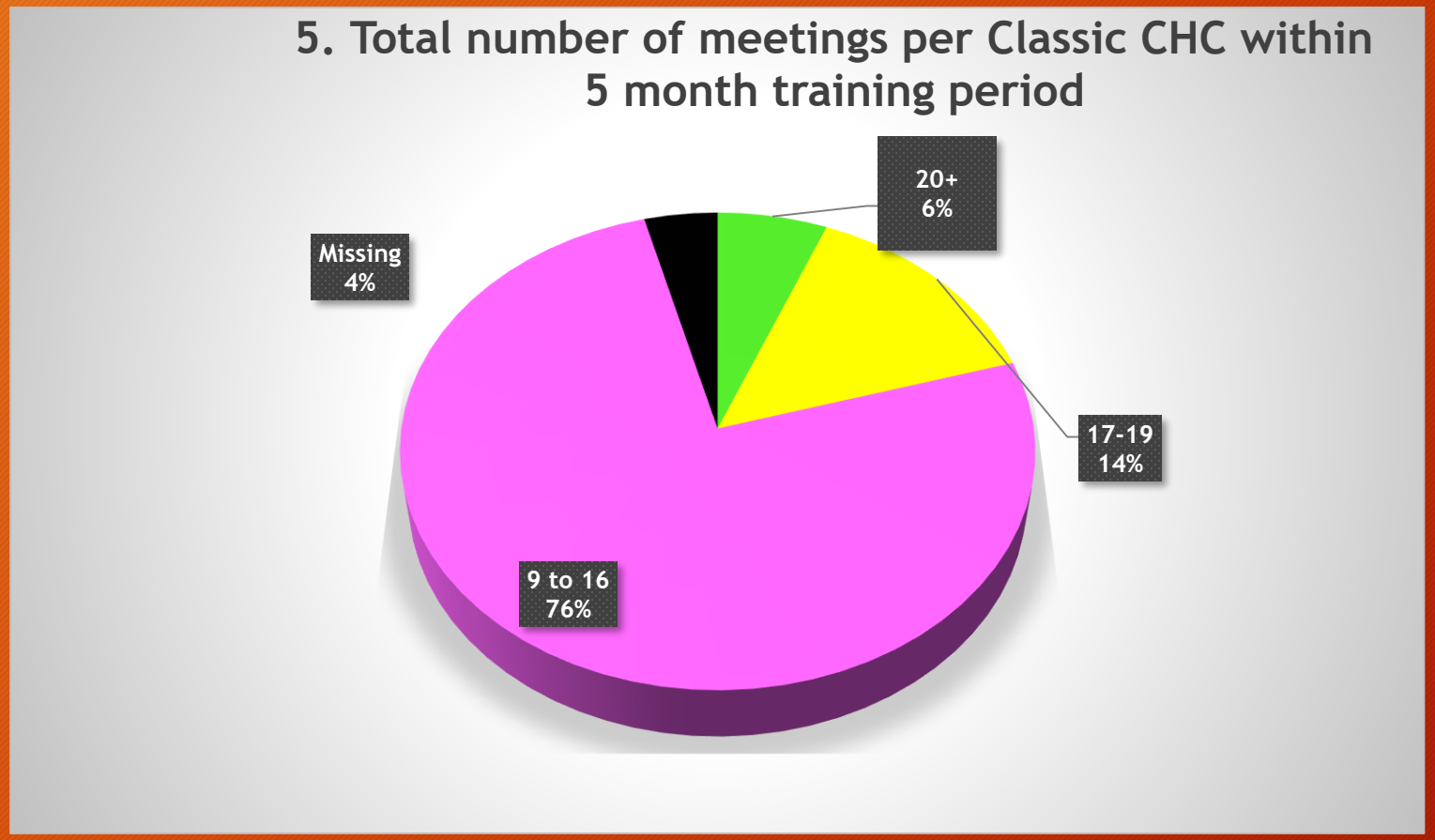
REASON: Late start due to delays in selection of villages

IMPACT: Insufficient understanding and time for change

TARGET

+20 sessions

How many times did each CHC meet?



INTERPRETATION:

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

REASON: Late start due to delays in selection of villages

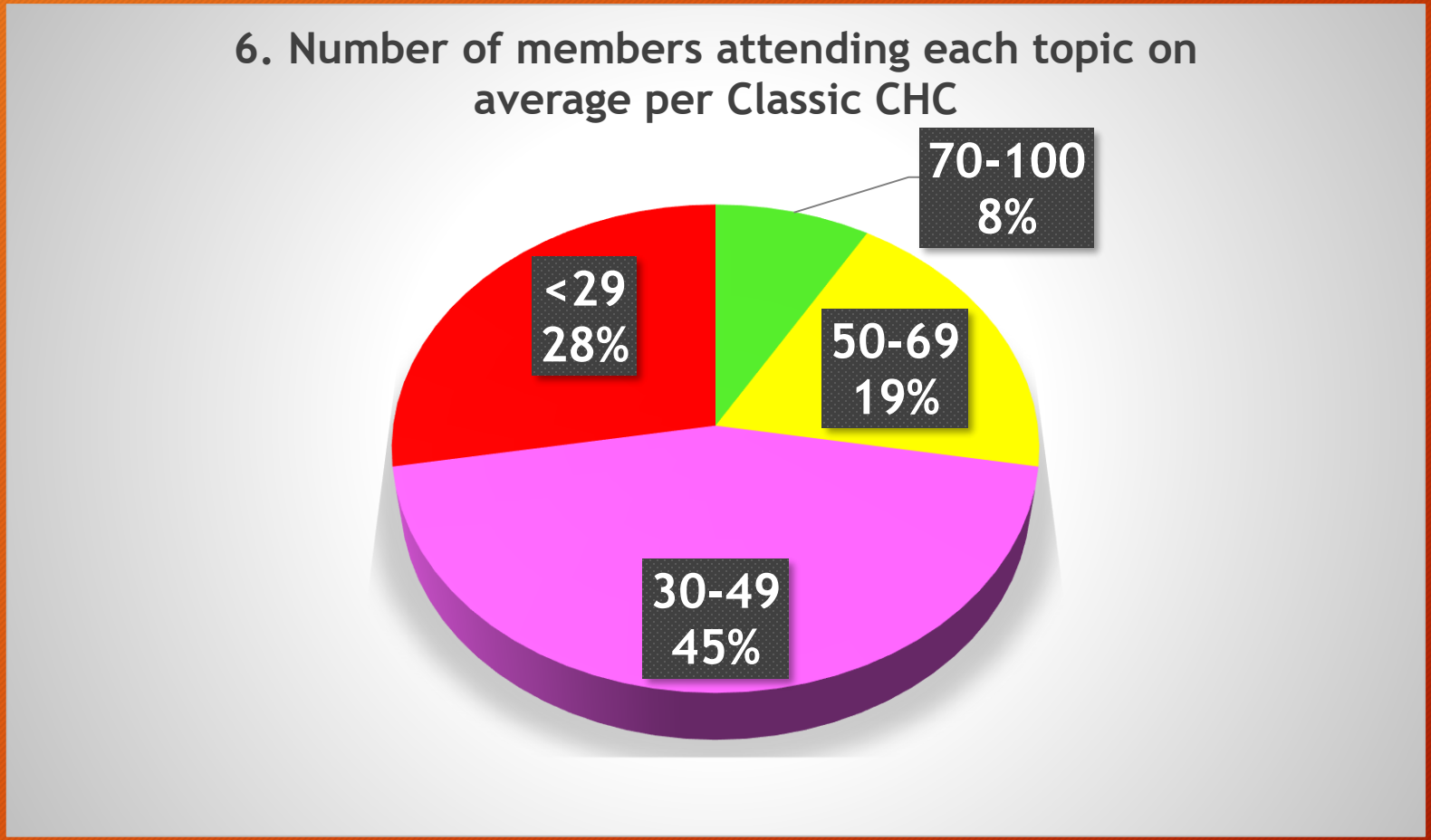
IMPACT: To complete training before end of June many topics were done in one session.

Lack of reinforcement

TARGET

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

+50%



INTERPRETATION:

27% had over 50% of members on average attending each topic. 73% of CHC was below target.

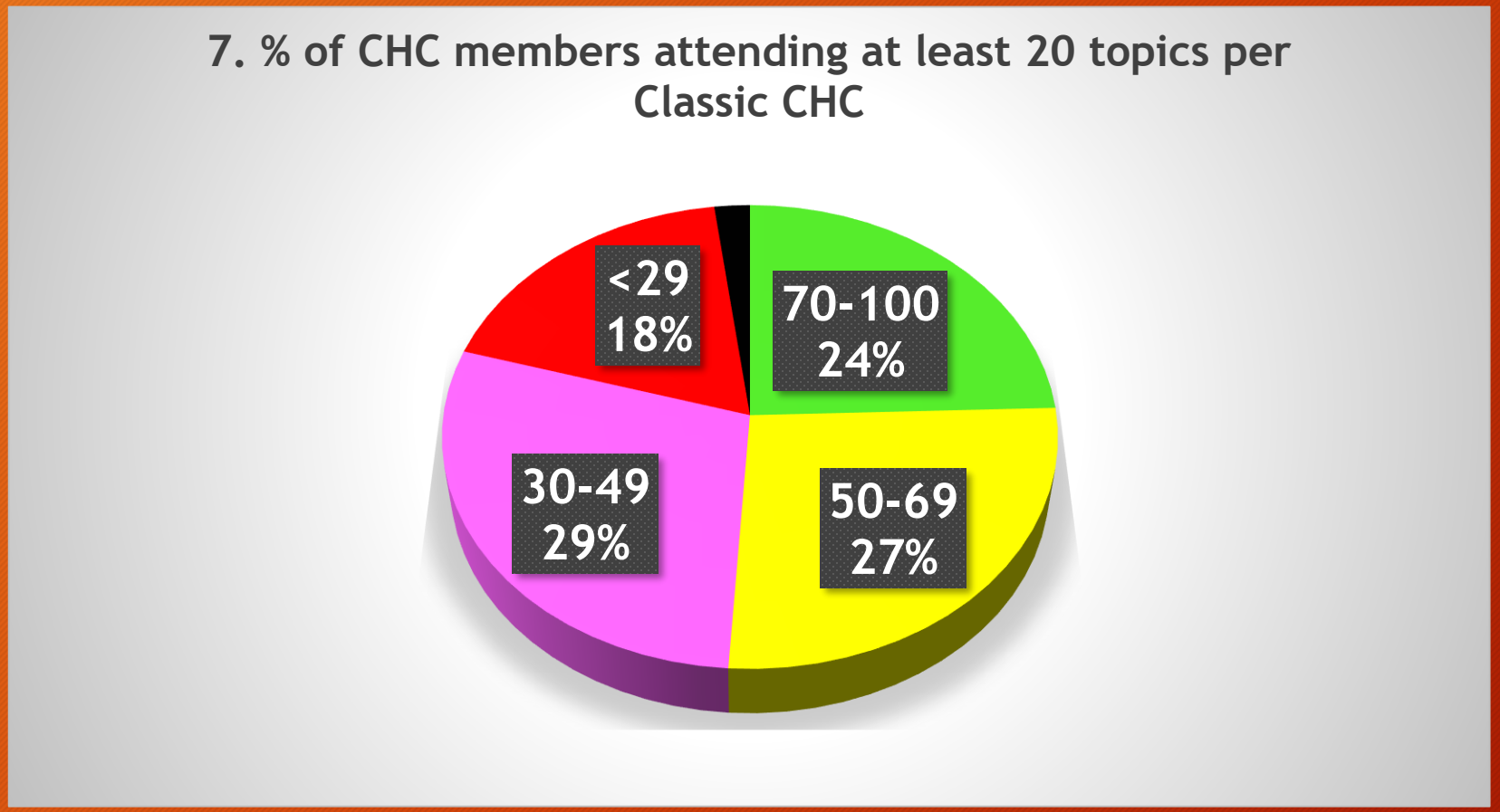
REASON: Sessions were held in the rainy season

IMPACT: knowledge is not universally shared and behaviour change is slower than expected

TARGET

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

+70%



INTERPRETATION:

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

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

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

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?

1. **Policy:** Whilst CBEHPP was firmly part of Rwandan Policy at the beginning of the RCT, there was a reshuffle of MoH during the intervention period and Environmental Health Desk was abolished leaving CBEHPP without direction.
2. **Trainers: CHC Model designed to be facilitated by CHWs but this was changed to 'ASOC' (Social Mobilisers) without health training**
3. **Champion:** At the start of the RCT, the CBEHPP had a champion in MoH but he was made redundant and all CBEHPP staff left MoH.
4. **Funding:** Indiret funding to to the District through MoH head office which never reached district, therefore EHOs were not properly funded or supervised
5. **Transport:** Motorbikes were given to EHOs one year late, after the intervention, therefore EHOs did not monitor as much as they should have done
6. **Implementation:** the intervention should have been implemented by MoH, and although not properly resourced AA ended up running the programme with one project officer, no transport and 150 CHCs scattered throughout the district.
7. **Coordination:** There was no coordination between IPA and AA, which led to lack of understanding by IPA of the methodology and indicators were not aligned with training manual.

Achievements: What went right?

Rusizi District was greatly enhanced through this intervention and there is wide recognition that the CHC approach has had a great impact on development. Rusizi moved up the District Ranking from 27th (2013) to 4th place (2016) for meeting performance contracts

Capacity of Village Leadership was greatly enhanced through this training and are taking strong measures to improve hygiene locally, even through there is no AA presence on the ground – the CHC are owned by the villages and are sustainable

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

Regional replication of the CHC Model in Uganda and DRC

Achieving our Objectives: Monitoring Component

1. **To build capacity in MoH for training of communities for hygiene behaviour change.**
   Organized villages that have benefited from the enhanced skills of CHWs and EHOs and EHTs ability to train and impart knowledge effectively.

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 (this website).

3. **To ensure functional and responsible communities exist in 150 villages in Rusizi district with 150 active CHCs.**
   The target is to achieve 80% 'buy-in' and willingness of households to respond to the training and to alter hygiene behaviour at significant levels.

4. **To provide a demonstration on how hygiene behaviour change can be sustained.**
   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.

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

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

PROPER TIMING is essential for high community response

MORE TIME (1 year) is needed to trigger behaviour change

MORE REINFORCEMENT is needed to sustain behaviour change

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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Our Africa AHEAD Team in Rwanda
Technical Advisors: Anthony and Juliet Waterkeyn
Regional Representative: Zachary Bigirmana
Country Director: Joseph Katabarwa
Programme Manager: Amans Ntakarutimana
Monitoring Officers: Andrew Ndahiro, Julia Pantaglou
Zonal Coordinators: Fausca Uwingabire, Vincent Habimana, Emmanuel Bwimana
Field Officer: Mercy Mbirira
All Community Health Club Facilitators and **Committees**

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