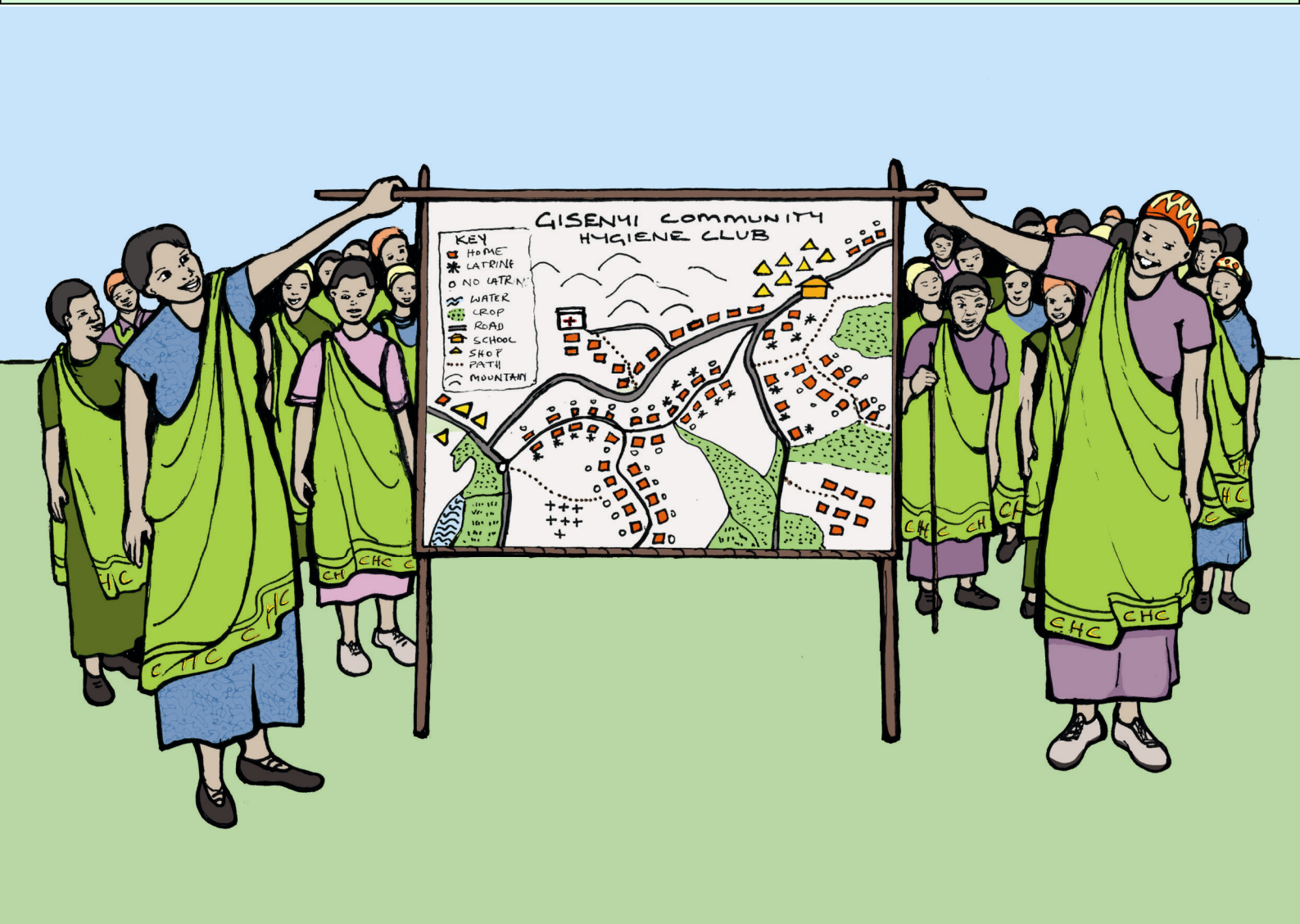
# START-UP OF COMMUNITY HYGIENE CLUBS IN RWANDA

Ministry of Health




## DRAFT MANUAL FOR TRAINERS OF ENVIRONMENTAL HEALTH OFFICERS

Environmental Health Desk

unicef

AFRICA AHEAD

**ACKNOWLEDGMENTS**

The Community Health Club (CHC) Approach was developed and researched by Dr. Juliet Waterkeyn, Director of Zimbabwe AHEAD Organisation in 1995, and first published in 2005 (Waterkeyn and Cairncross). The concept of the CHC Approach is the 'intellectual property' of Africa AHEAD, under a Creative Commons License which allows usage of the material with due acknowledgement (www.africaahead.com).

As this Training Material Package for Rwanda is part of a process of continual adaption in an attempt to refine and perfect the CHC concept, some of the pictures and activities have been adapted from two other manuals previously published by Africa AHEAD in conjunction with Department of Health, Cape Town, Western Cape, South Africa (2008) and Zimbabwe AHEAD Organisation (Zimbabwe, 2010).

Rwandan Toolkit developed and manuals written by Dr. Juliet Waterkeyn

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# CONTENTS

# ABOUT THE CBEHPP TRAINING

**The training for CBEHPP is designed at three levels:**


**Module 1: Advocacy for the CBEHPP**

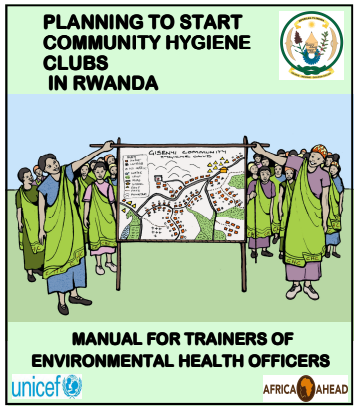
**Target audience:**

Opinion leaders in government and Development Agencies

This one day Orientation Workshop is conducted by MoH for stakeholders at National and District level, based on the Road Map for CBEHPP launched in Nov. 2009.

**Module 2: Planning to start up CBEHPP in Rwanda using Community Hygiene Clubs**

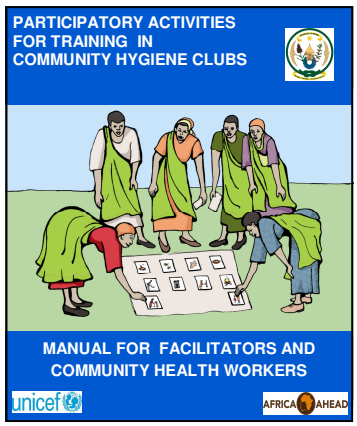
**Target Audience:** District Environmental Health Officers




The workshop is a 3 day training in all aspects of the CHC Approach to be used in CBEHPP, which is contained in this manual. As it is largely theoretical to enable planners to have an understanding of the CHC approach, it is not designed to be passed on to Community Health Workers in the village.

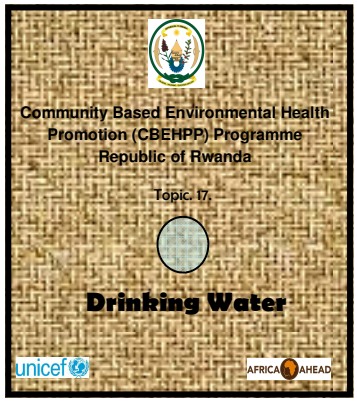
**Module 3: Participatory Sessions for Community Hygiene Clubs**

**Target Audience:** Community Health Workers at Village level




This is a 5 day workshop, to enable Environment Health Officers and Community Health Workers to effectively facilitate the 24 topics which comprise the CBEHPP training, in the weekly sessions held within the Hygiene Club. This is a practical rather than theoretical training on the methodology, and not the health knowledge which is also needed for effective facilitation of Public Health.

**CBEHPP Tool Kit for the Participatory Sessions in CHCs**




**Target Audience**: semi-literate and illiterate villagers in Rwanda
This is a Kit of 24 topics, each with 20 illustrated cards, which is used by the facilitator and CHC in the 24 sessions, in a participatory approach to training. The cards are visual aids with no written text, and can therefore be used at every level of education. They are culture specific to Rwanda and have been pretested in the field to ensure over 80% comprehension by the .

# TRAINING WORKSHOP : PLANNING TO START CHCS

| Time | Day One | Day 2 | Day 3 |
|---|---|---|---|
| | **CHC THEORY** | **PLANNING / MANAGMENT** | **PRACTICAL** |
| **8.30** | 1.Introduction | 6. Management Structures | 9. Training Methodology |
| **9.30** | 2. Health Promotion | 7. Targets and Challenges | 10. Exit Strategy and Sustainability |
| **10.30** | 3.The CHC approach | 8. Where to start CHCs | |
| **12.30** | Lunch | Lunch | Lunch |
| **1.30** | 4. Monitoring: the | Mapping your area | Field trip to use household inventory, participatory activities or pre-test visual aids. |
| **2.30** | 5. Measuring Hygiene Behaviour Change | Feed plan and planning session | |
| **4.30** | End of day | End of day | End of day |

| | **Topic** | **Objective** |
|---|---|---|
| **1.** | **Introducing CBEHPP** | To understand the Programme, methodology and targets |
| **2.** | **Health Promotion** | Compare the levels of **hygiene behaviour change** with other methodologies so as to understand why it has been chosen |
| **3.** | **The CHC Approach** | Understand the **CHC Approach** and become familiar with some sociological concepts |
| **4.** | **Monitoring** | Understand the reason for the **Membership Card** and how to use it |
| **5.** | **Measuring behavior change** | Learn how to measure hygiene behaviour using the **Household Inventory** |
| **6.** | **Management Structures** | To know the **roles and responsibilities** of everyone involved in the CBEHPP |
| **7.** | **Targets & Challenges** | Plan realistic targets to ensure an achievable plan of action |
| **8.** | **Where to start CHCs** | Understand how to choose the **right place** to start CHCs |
| | **Mapping your area** | Provide a **careful plan** of where the CHCs will be started |
| **9** | **Training Methodology** | To understand participatory activities and visual aids |
| **10.** | **Exit strategy and sustainability** | To discuss the more long term holistic potential of CHCs |
| | **Field work** | Practice in conducting the household inventory and pretesting the Toolkit. |

**EVALUATION:** The participants will be asked to complete the evaluation form at the end of each sessions, which will be collected and results included in each workshop report. The participants may remain anonymous to encourage accurate response. ***See Annex 3. for Evaluation Form***

# 1. INTRODUCTION: WHAT IS CBEHPP?

## 1.1. THE COMMUNITY BASED ENVIRONMENTAL HEALTH PROMOTION PROGRAMME

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, in so doing, will contribute significantly to poverty reduction outcomes. CBEHPP will strengthen the capacity of all **45,000 Community Health Workers** (CHWs) who are located throughout 15,000 villages, through the adoption of the holistic **Community Hygiene Club (CHC)** methodology as a means to rapidly achieve hygiene behaviour change that is both sustainable and cost effective.

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

### Why is CBEHPP also vitally important to the Water & Sanitation Sector?

Whilst safe water can reduce diarrhoea by 15%, health promotion can reduce diarrhoea by 35% and frequent hand-washing with soap is estimated to reduce diarrhoea by 47% (Curtis & Cairncross, 2003). It is for this reason that hygiene behaviour change is now considered 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 the women, to take responsibility for village-level operation, maintenance and management (VLOMM) of rural water facilities like hand-pumps, protected springs and piped supplies, thus ensuring their long-term sustainability. CBEHPP thus complements the efforts of **MININFRA** to provide safe drinking water and sanitation.

### Why is CBEHPP also 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 that will result in increased synergies through efficient mobilisation and use of existing human and material resources. CBEHPP focuses on basic development right down at the level of the family and 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 all 45,000 Community Health Workers (CHWs) under close mentoring and supervision by Environmental Health Officers (EHOs) who are based at Health Centres. The CHWs will facilitate formation of Community Hygiene Clubs (CHCs) in every village in order to achieve practical hygiene behaviour change in every homestead. Institutions (schools, clinics and prisons) will be especially targeted under this programme that seeks to change hygiene behaviours and place Environmental Health firmly on Rwanda's Development Agenda.

# 2. HEALTH PROMOTION STRATEGIES

## 2.1. A CHALLENGE: THE MILLENNIUM DEVELOPMENT GOALS

**In 2000 MDG goals were set with the aim to halve the 2.4 billion people (40% of the people in the world) without adequate sanitation by 2015 .**

But how can we suddenly make 1.2 billion people change their ways unless we have new strategies that are more successful than those used in the past to mobilize people's energy? With one of the most densely populated countries in Africa, Rwanda's challenge involves nearly the whole population of 11 million, as less than 8% in the rural areas are estimated to use hygienic latrines. Therefore the target for the next 5 years, is to convert over 5 million people or around 1 million

## 2.2. THE RESPONSE: DIFFERENT BEHAVIOUR CHANGE STRATEGIES

**1. SOCIAL PLANNING: people need authority to make them change**

Social Planning means that those officially responsible for public health, identify the problems and provide the solutions and then enforce them by law.

**2. HEALTH BELIEF MODEL – People need to understand why they should change**

The Health Belief Model of development assumes that if information is given to people, they can easily understand and will therefore change.

**3. DEMONSTRATION MODEL APPROACH: People need to see in order to change.**

It is a practical method based on the **'Diffusion of Innovation'** model or the 'trickle down' theory, which assumes that people will 'naturally' copy a good idea.

**4. PHAST– People need to get involved if they are to change**

The Approach felt that for change to work people have to participate fully, to get involved right from the beginning, so that they 'own' the ***process*** not only the ***outcome*** of their actions.

**5. SOCIAL MARKETING: People will change if they think it is smart or progressive**

Social marketing focuses on getting people to change their behaviors by appealing to their desire to be smart and modern, as they think that knowledge plays little part in behavior change.

**6. COMMUNITY LED TOTAL SANITATION (CLTS) : people shamed by peer pressure**

CLTS, in its original form, aims to put an end to open defecation by shaming each community into good behavior through public exposure of less hygienic individuals.

**7. THE COMMUNITY HEALTH CLUB APPROACH (CHC): people change best as a group.**

Developing group consensus through informed decision making and developing a '*Culture of Health'* which then guides all hygiene behavior.

# 3. THE CHC APPROACH

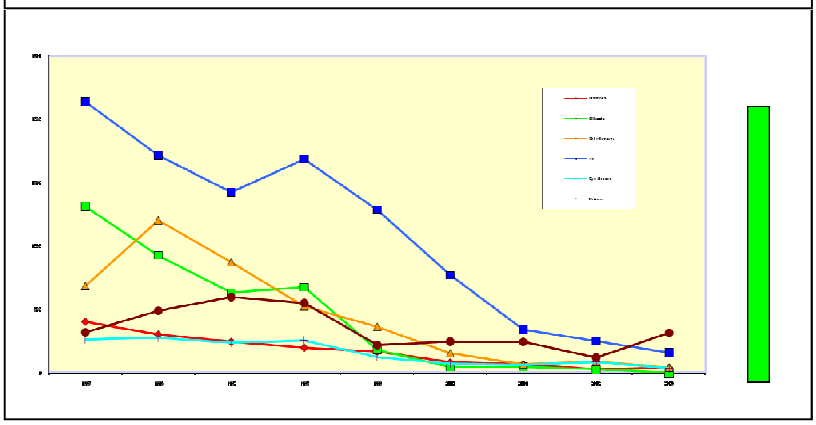
## 3.1. WHAT IS THE CHC (COMMUNITY HYGIENE CLUB) APPROACH?

There is no difference between a Community **HYGIENE** Club and a Community **HEALTH** Club Approach that is now recognised as one of the most cost-effective methodologies for achieving hygiene behaviour change in Africa (WSP-World Bank, 2005)

The Community Health Club Approach was originally started in Zimbabwe by an indigenous NGO called Zimbabwe AHEAD organisation. It was subsequently disseminated to many parts of Africa and has now been successfully tried and tested in many countries (Sierra Leone (2003), Uganda (2005), Guinea Bissau (2007), South Africa (2005), and more recently in Asia (Vietnam, 2009).

The CHC Approach has been found to achieve high levels of change in rural and urban, Christian and Muslim, as well as semi-literate and illiterate communities. The results from Zimbabwe have been researched and published showing the increase of knowledge and improved hygiene as well as corresponding reduction in preventable disease (Waterkeyn, 2010).

*Fig 1. Decrease in reported cases of communicable disease at a Clinic in Ruwombe, Makoni, Zimbabwe 1995-2003. (Waterkeyn.2005)*



The chart (right) shows the sustained decrease between 1995 - 2003, in the top diseases (Diarrhoea, Bilharzia, skin Diseases, ARI, Eye disease, Malaria) within one ward of Makoni District, Manicaland, Zimbabwe, where 18 CHCs were in 80% of the clinic catchment in a ward of 1,777 households (Waterkeyn 2005).

Research of 1,200 household showed a significant difference between community health club areas and non CHC areas in terms of knowledge and non risk hygiene practices (below left)

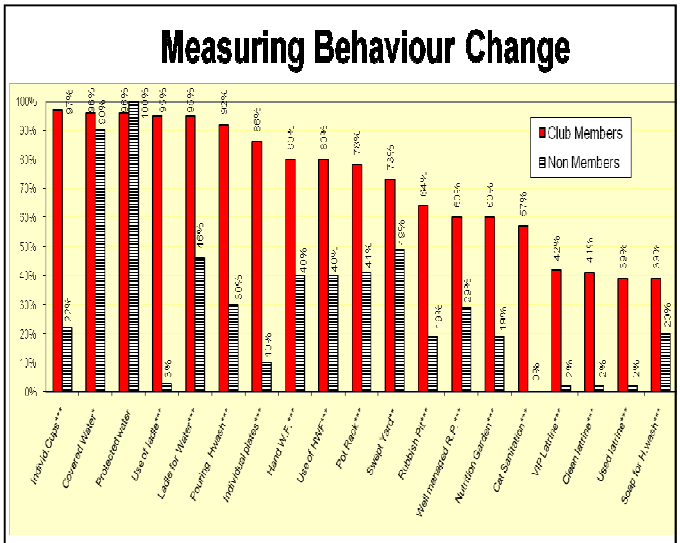
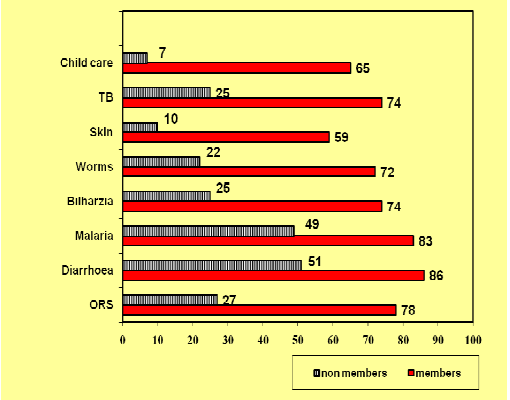



*Fig.3. Difference in observable proxy indicators of safe hygiene between CHC and non CHC in Tsholoto, Zimbabwe (Waterkeyn.2005)*

The Bar chart (lbelow) shows how the knowledge of critical health issues such as child care, TB, Skin disease, worms, Malaria, Bilharzia and Diarrhoea, have changed in the community afer only six months of CHC training, compared to communities with no training.

The link between the need to learn, and love of achievement and behavior change has been well established and this has resulted in an average of 47% change in some areas.

*Fig. 2. Difference in health knowledge between CHC and non CHC in Tsholoto, Zimbabwe*




This manual is based on 20 years of research and field work by Africa AHEAD Association and is written and presented to the Ministry of Health, by Dr. Juliet Waterkeyn, the initiator of the Community Health Club (CHC) Approach.

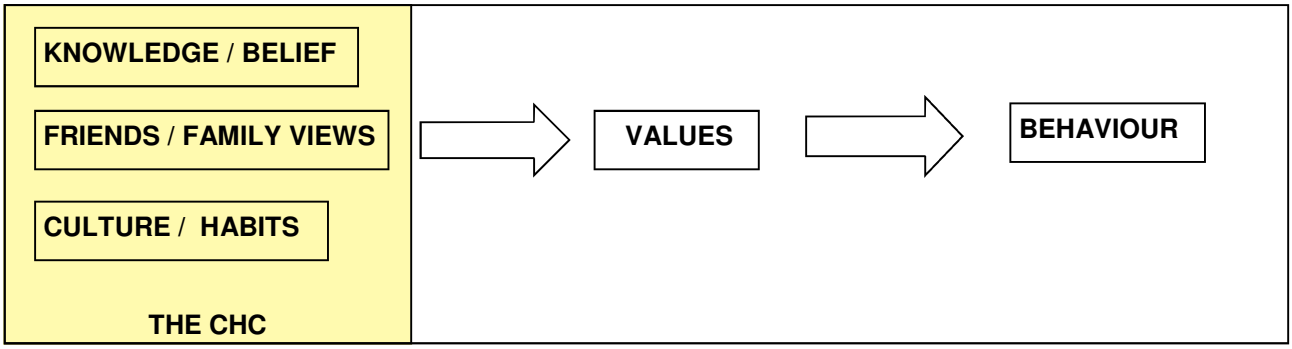
## 3.2. UNDERSTANDING HOW THE CHC METHODOLOGY WORKS

The CHC Methodology is based on a 'Theory of Development' that recognizes a combination of factors is involved in making people change. We cannot just expect them to change their behavior without understanding what makes them behave in a certain way.

We find that it is a combination of factors: their knowledge and understanding of something, combined with their will to change. This desire to change is usually driven by their ***need*** to change. Their need is often conditioned by their ***peers*** (friends and family) , and their culture. Particularly in less educated communities, people don't like to be different. Therefore if most the people in the village decide to do something, supported by the leaders, the chance is that the rest will also follow, by peer pressure in a positive way.

Therefore rather than appeal only to each individual as was done in the past (Health Belief Model), we appeal to the group, and build their capacity and understanding so that they can make informed decisions and learn to manage their health through safe hygiene. So the CHC strategy tries to change people's **values**, which are based on their knowledge and peers and culture, and once this happens they will change their behavior automatically.

Change takes time to happen and this is the reason the CHC training takes at least six months of weekly meetings. It is 'little but often' that helps people to understand. Just like to get well we take vitamin pills, we do not swallow the whole bottle at once, we take one pill a day. In the same way information must be taken slowly, drop by drop if the knowledge is to truly sink in.




Within the CHC friends and family have time to talk and decide what needs to be done, and together they decide as a group to make changes and improve their lives. This is known as **Group Consensus.** The CHC Members changes their **values** and when everyone decides to do something this is known as the **norm** (normal behavior). It is more comfortable to be like other people therefore people change rather than to remain different (**Peer pressure**). After a while everyone follows and a new Culture is established - a '**Culture of Health'**. Once this is the norm, then all the details of daily living will be dictated by the **values** that the group has decided to adopt. This is a very positive way to progress because nobody feels excluded, and everyone is welcome to join the group.

This positive way of living can be compared to belonging to a church group, which lays down certain ways to behave. If you accept to be part of the group, you **conform** to the ways of the group, and this makes you stronger and happier because you have support. The friends and support that you develop are sometimes referred to as **Social Capital**, because (like money in a bank) you can draw on these people in times of need. Therefore the CHC is more than just a way to improve your hygiene, it is a way build trust and love within a community: **Common Unity.**

## 3.3. DEFINITIONS OF THE CHC METHODOLOGY

**The following are some important definitions which help us to share an understanding of what makes a Community Hygiene Club Approach different from other strategies of development.**

**COMMUNITY HYGIENE CLUB (CHC)**
A CHC is a community based organisation, made up of voluntary men and women dedicated to improving the health and welfare of the community through **common knowledge**, **common understanding** and the practice of safe hygiene in the home leading to **common unity** and **common welfare**.

**COMMUNITY** comes from the two words Common and Unity. This is the ideal 'community', where all households share a common culture: beliefs, attitudes and behaviour. In other words they understand each other and share a 'Culture of Health'.

**HEALTH** is often used to mean the opposite of disease. If someone is not ill they are healthy. However in this programme we understand health as being not only being strong in body but also in mind: that means unstressed and able to cope with our lives successfully.

**COMMUNITY HEALTH** is when a community can manage all preventable diseases and has a healthy environment: i.e. safe water, Zero Open Defecation (ZOD) and safe hygiene practices.

**NORMS :** how you usually behave

**VALUES :** what you believe is good

**ATTITUDES:** the way we think

**BELIEF:** What we decide is true for us

**BEHAVIOR:** the way we conduct ourselves physically

**GROUP CONSENSUS**: agreement within a group on a certain issue

**PEER PRESURE:** people conform to the expectation of the group because they are admired

**SOCIAL CAPITAL:** a level of trust and mutual help in a community based on social networks

**HOUSEHOLD INVENTORY:** spot observation to record facilities and hygiene behavior

**OBSERVABLE INDICATOR:** a tangible, visible object that gives evidence that a certain behaviour is being practiced

We will use many of these sociological concept in the following pages, so it is important to understand their meaning, and get used to using this terminology when explain this approach.

# 3. THE CHC APPROACH

## 3.4.CONCEPTS THAT ARE IMPORTANT FOR THE CHC APPROACH

**The key aspects of the CHC Approach can be summarized as follows:**

- **TARGET GROUP**: A club is a registered group of members that make progress together.
- **INCLUSIVE:** CHC Members are both men and women of all ages, stages, education and religion.
- **STRUCTURED:** Members receive a membership card outlining the training.
- **REINFORCEMENT**: Members meet every week for at least six months to discuss health issues.
- **PARTICIPATORY:** Members use fun activities to promote open discussion and debate.
- **GROUP CONSENSUS:** Members make a group decision to adopt certain hygiene standards.
- **HOMEWORK:** Every member is challenged to adopt a set of recommended practices.
- **CERTIFICATION:** Members who complete the whole training of 24 topics are awarded a certificate.
- **QUANTIFYING BEHAVIOUR CHANGE:** Community is monitored with a household inventory.
- **FAIRNESS** : Only those with a certificate qualify to go to the next stage of the programme.

### 3.5. ACTIVITY: UNDERSTANDING THE VOCABULARY OF THE CHC APPROACH

**METHOD: GROUP DISCUSSION**

**How is a Community Hygiene Club different from a Woman's Group?**

.....

.....

**Make up a definition of a Community Hygiene Club?**

.....

.....

**What is a Culture?**

**Think of some things which define the Rwandan culture?**

**Food** .....

**Proverb** .....

**These habits, preferences, and ideas are what make a Culture**

**CULTURE** means shared **KNOWLEDGE, ATTITUDES AND BELIEF.**

Shared **Knowledge** creates a common understanding
Common Understanding makes similar **attitudes**
Similar attitudes ensures there is a **Group Consensus**
Group consensus means a shared set of **beliefs**
This ensures accepted ways of **hygiene behavior**

**GET INTO PAIRS AND DISCUSS THE FOLLOWING:**

What is the Culture of a Community Hygiene Club?
What do we mean by a **CULTURE OF HEALTH**?
If every one shares the same **norms** and **values** what does this mean?
How do Health Club Members develop their own **Culture of Health?**
All they do is based on **principles of good hygiene** and care of their own health.
Members will be recognised by others as a **Health Conscious** person.
They are enlightened and their family will prosper because they are healthy.
A family with a **Culture of Health** will be a Healthy Family

## 3.6. OBJECTIVES AND TARGETS OF A COMMUNITY HYGIENE CLUB PROGRAMME

**The main objective a Community Hygiene Club Programme is as follows:**

1. To build capacity of local community to sustain their own hygiene clubs.

2. To empower families to effectively prevent disease through good hygiene.

3. To encourage all Rwandans to build their own latrines and hand washing facilities

4. To increase Social Capital by enabling a strong social network through CHCs

4. To enable existing Community Health Workers to manage their workload better through CHCs.

5. To measure behavior change so there is information on results of the programme.

6. To alleviate poverty through organised communities

Then CHCs can be used as a vehicle for change in whatever form it takes, and all Ministries and development agencies are invited to work through them wherever possible.

### 3.8. WHAT HAPPENS IN A COMMUNITY HYGIENE CLUB?

The main activity within a community hygiene club is to meet every week to debate on health and hygiene issue and to improve family living standards

However, in addition CHCs can undertake many other productive activities for self improvement:

- Singing, quiz, debates and drama competitions
- Visits to members homes to advise/assist
- Assistance to local schools, health posts
- Voluntary counseling, support networks
- Training in domestic skills and crafts
- Training in literacy and management
- Home based care for the vulnerable
- Revolving funds and savings groups
- Income generating groups and trading
- Nutrition and cooking classes
- Sewing, knitting, other home industries
- Village clean ups and recycling
- Sanitation improvements, latrine construction
- Catering for funerals and weddings

## 3.9. FREQUENTLY ASKED QUESTIONS

Here are some of the most common concerns with some of the answers: If you have any other questions, please consult the website (www.africaahead.com) which providing facts and figures.

**WHY DO WE NEED COMMUNITY HYGIENE CLUBS? Because...**

- CHCs helps organise people effectively and makes a functional community.
- Public Health is an issue that must involve everyone in the neighbourhood.
- A woman on her own is powerless, but women together are a real force for change.
- A club is the forum for decision making and group action.
- Members support each other to make positive improvements for the good of all.

**WHY WOULD PEOPLE WANT TO JOIN A COMMUNITY HYGIENE CLUB? Because...**

- Members join a club because they want to be with like-minded progressive people.
- All members share a common interest to learn and improve family health.
- Members enjoy being together because they share a common vision.
- The club provides a safety net and reliable friends in time of need.
- The meeting each week is a time of fun and socialising as well as learning.

**WHAT ABOUT NON CLUB MEMBERS? Because…**

- There are no qualifications to becoming a member so there is no reason they cannot join
- Anyone can join at any time, so it does not prevent people joining late
- The health club is free of charge, so it does not exclude the poor
- It is open to men and women of all ages, as everyone is part of the community
- People of all levels of education can join as none of the activities involve reading and writing
- People of all religions can join, because religious issues are not discussed
- If people do not join it is because they do not want to join and that is their choice
- There are always non adaptors but they may get ideas from their neighbours

**HOW DO YOU GET SO MANY PEOPLE TO JOIN THESE CLUBS? Because ...**

- The membership card a gives a guarantee that the programme is serious
- The reward of a certificate encourages people to keep on coming to the sessions
- People are eager to learn and they get a sense of self achievement .
- People love using pictures and they continue come to the health sessions
- Women in particular are attracted because CHC sessions are fun and sociable.

# 4. MONITORING : THE MEMBERSHIP CARD

## 4.1. MONITORING WITH THE MEMBERSHIP CARD

Look at the Membership Card. You will see there are 24 separate topics as well as 24 recommended practices. Each time a member attends a session the membership card is signed by the facilitator of that session. Every 3 months the CHW or CHC Chairperson/Secretary must visit all CHC members and check which of the recommended practices have been adopted and sustained in each household. When those practices are observed the membership card can be signed against the practice observed. When the membership card is completely signed, the member qualifies to receive a certificate.

## 4.2. WHY DO YOU NEED A MEMBERSHIP CARD?

The membership card provides a structure to a programme as it not only outlines the topics, but also establishes the key recommended practices which are the indicators used for monitoring in the household inventory. If the Membership Card is not appropriate for the area it can be adapted as required by the programme. The content may be varied according to area, depending on the health issues that relate to each context. Topics can be done in any order also depending on the seasonal priorities.

The membership card is the hallmark of a CHC programme and its importance can be summarized as follows:

- **Accountability:** The cards makes the CHC facilitator accountable as there is no chance that they claim they have been training when in fact they have been skipping sessions.

- **Achievement:** Once the membership card has been completed the member is entitled to a certificate of full attendance. The number of members who have earned this can be verified so that there is no unfair advantages though favoritism or corruption.

- **Contract:** When people see the printed card they realize that this is a serious programme and are convinced that the programme is going to be done properly and it is not all promises and no action.

- **Fairness:** Those who have completed the training of the first module are entitled to continue to the next grade. If there are any material benefits to be gained, the first to be rewarded will be those who have completed the training. This is a just system which prevents those who have not given their time to gain unfairly when they do not deserve to benefit.

- **Identity**: It provides a sense of identity and belonging and makes people feel they are important.

- **Mobilisation:** The cards should be given out at the first meeting or when the household is visited because it encourages other to join when they see the cards that their friends have been given.

- **Monitoring:** Because the card is signed every time a member attends a session, it enables the attendance of the community to be properly monitored, both by the facilitator and the managers.

- **Structure:** The membership card gives the members a list of topics so that they know what they are going to be doing and this is a common politeness in most meetings - we tend to want to know our agenda before starting a meeting.

- **Target:** There is also a list of the recommended practices that should be undertaken by all serious members, and so this sets targets and gives a set of behaviours which is standardized.

# 4. MONITORING : THE MEMBERSHIP CARD

| No. | Topic | Date | Signature of Facilitator | Weekly Homework | Signature of Facilitator |
|---|---|---|---|---|---|
| 1. | Introduction | | | Bring friends and family | |
| 2. | Common Diseases | | | Knowledge of Causes | |
| 3. | Personal Hygiene | | | Family Wash Shelter | |
| 4. | Skin Diseases | | | Children no Skin Disease | |
| 5. | Hand washing | | | Hand Wash Facility / Soap | |
| 6. | Infant Care | | | Correct Child Immunisation | |
| 7. | Worms | | | Children no worms | |
| 8. | Diarrhoea | | | Use of soap in home | |
| 9. | Nutrition | | | Good Road to Health chart | |
| 10 | Child care | | | All children at school | |
| 11. | Kitchen Hygiene | | | Good food storage | |
| 12. | Solid Waste | | | Rubbish management | |
| 13. | Food Security | | | Nutrition mounds | |
| 14. | Water Sources | | | Water Source cleanup | |
| 15. | Water Storage / usage | | | Covered water and ladle | |
| 16. | Improved Sanitation | | | No open defecation/ Clean safe latrine | |
| 17. | Respiratory Disease | | | Individual cups and plates | |
| 18. | Malaria | | | Use of treated bed nets | |
| 19. | Bilharzia | | | Treatment for Bilharzia | |
| 20. | HIV / AIDS | | | Voluntary Council & Test | |

| | | | |
|---|---|---|---|
| | CHC Member No. | | COMMUNITY BASED ENVIRONMENTAL HEALTH PROMOTION PROGRAMME |
| i. | Introduction to CHC | | |
| ii. | Registration | | COMMUNITY HYGIENE CLUB NAME |
| iii | Village Mapping | | MAIN MEMBER |
| iv. | Committee Election | | 2ND MEMBER |
| v. | Household Inventory | 1. | ENVIRONMENTAL HEALTH OFFICER |
| vi. | Household Inventory | 2. | COMMUNITY HEALTH WORKER |
| vii. | Model Home | | PROVINCE |
| viii | Health Song | | DISTRICT |
| ix. | Health Drama | | SECTOR |
| x. | Graduation | | IMIDUGU |
| xi | Community Duties | | START DATE |
| xii | Office Bearer | | COMPLETION DATE |

# 5. MEASURING HYGIENE BEHAVIOUR CHANGE : The Household Inventory

## 5.1. OBSERVATION VS REPORTED BEHAVIOUR:

The Household Inventory is a spot observation of the facilities that indicate the hygiene behaviour of each household. It is very important that the CHW actually ***observes*** the facilities and does not rely on the householders ***report*** on such things. This is because respondents often try to save face by claiming that these facilities or behaviours are done, when in fact this is not the case. We need to get a true picture of the situation in the village; otherwise when we check after the program, it will seem that the situation has hardly improved, because the base line was artificially high (due to incorrect information). All CHWs must have a good training in how to observe the indicators for the Household Inventory, so that standards are agreed that are the same throughout the project. EHOs must do at least three test observations with each CHW.

## 5.2. SAMPLING FOR THE BASE LINE AND END-LINE SURVEY

If the time and resources permit the enumerators should complete the following Household Inventory for ***all*** the members of the Community Hygiene Club. If time is short then in at least 30 households in each Club, (where pretesting was done), using every 2nd CHC member on the sampling frame.

## 5.3. TIME PER SURVEY

It is estimated that the time taken for this preliminary introduction (including pretesting pictures and household survey) should be about one hour per household, and that five households can be done per day. That means that at least six days should be allocated to this base line survey with one day for training.

## 5.4. DEFINITION OF THE OBSERVABLE INDICATORS

An observable indicator is a tangible object and empirical evidence that shows that a certain behaviour is being practiced.

All the indicators that are used in the household survey have been chosen because they represent one of the recommended practices on the membership card. The objective is to be able to produce a simple bar chart for each CHC, Village and District showing before and after the training. ***See page 7, 'Measuring Behavour Change" Chart.***

The Code Sheet for the responses should be laminated to ensure it is more durable. The respondent's demographic details are filled in on the Registration Form. On the Response Form the values for each of the questions are recorded using the codes from the code sheet.

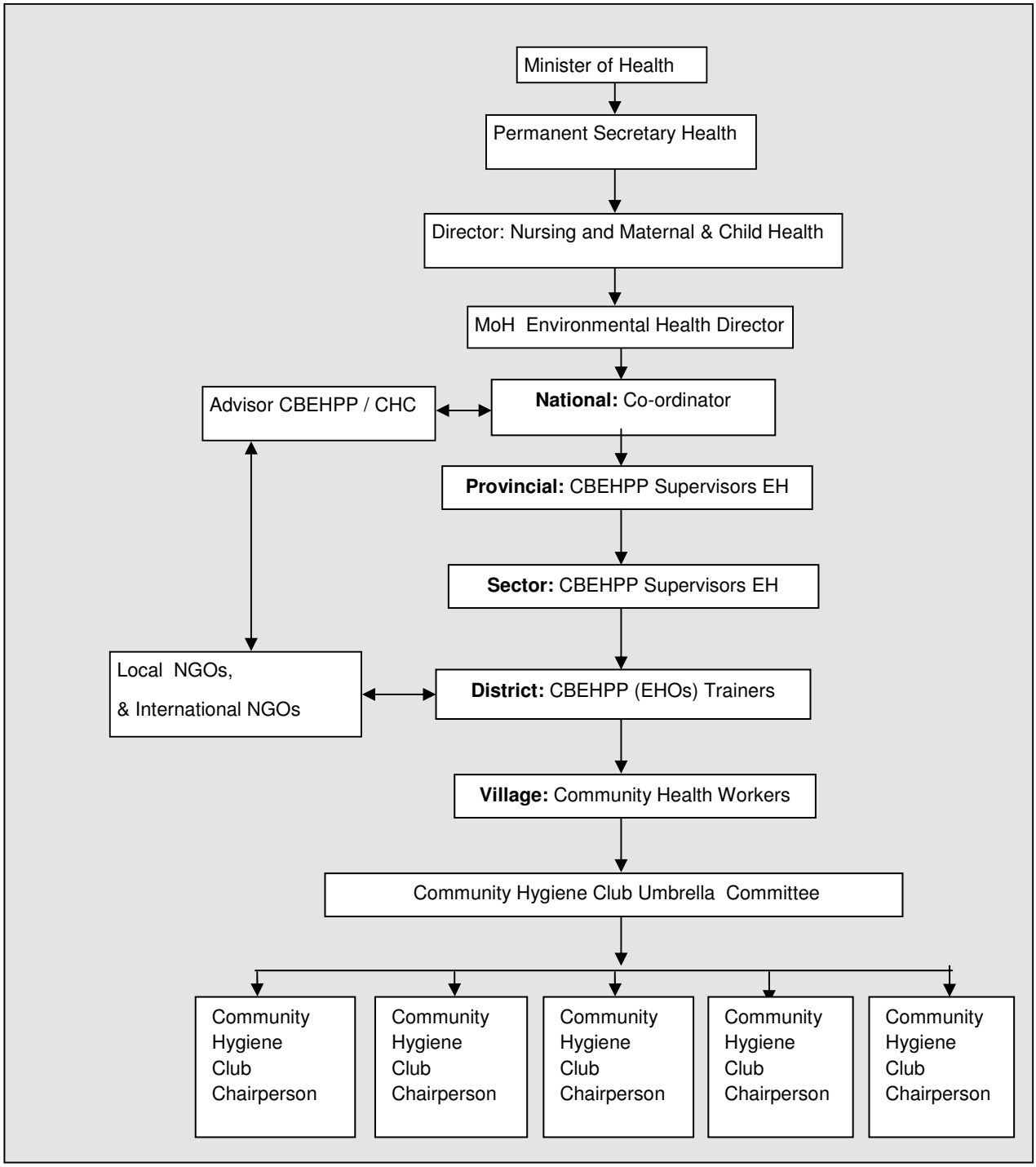
# 6. MANAGEMENT STRUCTURE OF CBEHPP

## 6.1. Organogram of the CBEHPP Programme

**Who needs to be involved to ensure that the CBEHPP is a success?**

CHC is established under the direction and management of Ministry of Health: the Department of Environmental Health, in conjunction with other Ministries (MINRCOFIN, MINEDUC, MININFRA, MINALOC) who will take be associated with certain aspects of the programme.

Experience shows that a strong political leadership and commitment is the key to CHC success and sustainability. Therefore, CHC establishment and existence need special support commitment from the health sector, local leaders at Provincial, district and commune level as well as from other mass organizations.



# 6. MANAGEMENT STRUCTURE OF CBEHPP

## 6.2. ACTIVITY: Roles and Responsibilities of Stakeholders

**METHOD: GROUP DISCUSSION**

If the following stakeholders are present divide into groups according to the following:

National, Provincial, District, Sector, and Village.

If not then simply divide all participants to represent these different groups.

Provide each with a flip chart paper and markers.

Give each group the job to brain storm and summarise some of the following:

1. **What are the duties of the Community Health Worker and who do they report to?**
2. **What are the duties of the Village Head in relation to the CHC and who do they report to?**
3. **What role do the officials have related to the CHC?**
4. **Should there be a CHC Umbrella Committee, and if so, who should be on the committee and what would be their role?**
5. **What will the Provincial Health Department contribute?**
6. **What will be the role of the National Environmental Health, and how will it receive reports and be involved?**
7. **Is there any need for outside assistance, other NGOs, consultants or donors?**

**TIMING OF THE PROJECT**
**Are you conducting training sessions during the rainy season or agricultural season?**

Discuss when is the best time to start a Community Hygiene Club, bearing in mind that it takes six months of weekly sessions to complete the training. It is important that the timing of the programme is in tune with the demands of the season. In farming areas the rainy season is very demanding on women in particular and they may not have the time for health club activities. If health clubs meet outside, the rain may affect attendance, so for best results it is important to start the sessions at the beginning of the dry season.

If you are obliged to start health clubs at an inconvenient season, make plans as to how this can be achieved, for example, by using a school or the village cultural house for a meeting place.

**After 30 minutes, come together and get feed back from the groups.**

**NB: This is a critical session that must be done properly so allow enough time for full discussion and make sure that the minutes from this meets are summarized and become well understood by all the stakeholders.**

## 6.3. ACTIVITY: Setting up a CHC Executive Committee

Once the member know each other, a committee should be elected from the club members as their representative at the Commune level.

This committee should consist of a Chairperson and Vice Chairperson, a Secretary and Vice Secretary and a Treasurer and Vice Treasurer. All members in the health club should vote annually for a new committee. It is important that the people selected should be the right person for the job.

What type of person is needed to lead a CHC?

Make a list of attributes that would be suitable for the office bearers;

- **Chairperson:**
- **Vice chairperson:**
- **Secretary:**
- **Vice Secretary:**
- **Treasurer**
- **Vice Treasurer:**

Sometimes groups fail because they disagree on who can join, or who should benefit and in what way. A standard way to prevent conflict is to create a set of guidelines that can be used to resolve conflict in an objective way.

A document which outlines the main rules of a Club is important for long term sustainability.

Write a list of possible guidelines so that the club can be disciplined and clear on its objectives:

**OBJECTIVE;**

The objective of the CHC is to: ……..

……..

……..

……..

**TARGET:** The target of the CHC is to:

……..

……..

# 7. PLANNING : TARGETS AND CHALLENGES

## 7.1. TARGETS

**It is important to know when you start the programme exactly what you are trying to achieve in terms of targets.**

**1. How many Health Clubs do you expect to be able to achieve in one year?**

The number of CHCs that you can do in an area depends entirely on the amount of time the Village Health Worker can give to the programme. At a minimum she should be able to run one health club, meeting once a week for two hours. However if she can meet one health club every day and can manage 5 per week, then the program becomes much more cost-effective. As the training takes six months, she may be able to do 10 CHCs in one year. This is the extreme and few manage to coordinate this many CHCs at once.

**2. How many members do you expect per health club?**

In most countries CHC members number between 50 and 100 members. The amount depends on the density of the population, the season when the training takes place, and the charisma and competence of the facilitator. Even if the clubs are small (less than 30 members) it is worth persevering as they often expand later once people have seen what they are about. When a club becomes bigger than 100 it may be worth splitting it into 2 clubs to enable easier communication at the sessions.

**3. What percentage of households in the area should be represented in the health club**?

You should aim for all households to have a representative in the CHC. However, this is seldom possible practically so aim for at least 50% the first year and 80% in the second year.

**4. How many months will the health promotion training continue?**

The training is designed to last for 24 sessions of about two hours each, to be held every week for six months. However it usually takes about a month to mobilize the community to join, as well as to conduct a base line survey (household inventory). In addition sometimes sessions are delayed because of rain, holidays, funerals and other reasonable priorities, so usually it takes 8 months to complete the 24 sessions. Sometimes the community asks for repeats to enable them all to catch up on missed sessions so they can get their certificate. So to be able to be unstressed it is usually wise to plan one intake of members each year rather than try and squeeze in two intakes in a year.

**5. How many of the sessions do you expect each member to complete?**

Of course we would want every member to complete all 24 sessions, but this is setting a very exacting standard which will not be realistic. Past experience has shown that 50-60% of all members are able to complete all the sessions.

**6. What do you expect in terms of the average attendance at each meeting?**

Attendance means the number of people at each session compared to the total membership. Adding the attendance of each session and taking an average of all sessions, is a simple way to monitor the relative success of each CHW, and will also enable managers to see which facilitators are the most cost effective, by dividing their costs by the average attendance. Past experience has shown average attendance is between 30 - 50% of the membership. In CHCs where attendance is compulsory, average attendance can be 80-100%.

**7. What do you expect in terms of % members following all recommended practices?**

We can measure how much change is taking place in the Community Hygiene Club, by monitoring the hygiene practices of the members. We see what the situation is at the beginning and then compare to after the training. The difference between the two is the percentage (%) of change. To monitor change is to best to monitor all the members, but if this is not possible due to time constraints then at least 30% of the households should be surveyed. CHC projects in the past have achieved between 20% to 47% change (Waterkeyn & Cairncross, 2005).

## 7.2. ACTIVITY: What are you aiming to achieve?

**DISCUSSION:**
Think of some of the issues that may be a problem and how this could be worked out.

**SETTING TARGETS: Discuss the targets that are appropriate for your area.**

1. **How many CHCs do you expect to be able to achieve in one year?**
2. **How many members do you expect per health club?**
3. **What percentage of households in the area should be represented in the health club?**
4. **How many months will the health promotion training continue?**
5. **How many of the sessions do you expect each member to complete.**
6. **What do you expect in terms of the average attendance at each meeting?**
7. **What do you expect in terms of % members following all recommended practices?**

**POSSIBLE CHALLENGES**
**Remember:**
The training in CHC usually results in a strong demand for sanitation, so management must have a strategy to offer in terms of assistance for sanitation. The CBEHPP does not offer financial assistance / subsidy for the construction of latrines. The group has to make their own plans as to how this can be done at a basic level

**What will you do if /when there is a demand for latrines to be built?**
**What will you do if/when there is a demand for safe water infrastructure to be built?**

- Train a latrine builder in each CHC so there is local skill available for hire by CHC members themselves
- Link the CHC up with the local Women's Union which could assist in starting a revolving fund for latrine construction
- Link the CHC up with the local promoters for the Rwanda Bank of Social Policy water and sanitation loans
- Provide latrine subsidies only to the poorest of the poor

Do not create the expectation that all household latrines will be subsidized. If not expectations can be raised and then unmet, which will make the population cynical and unlikely to join future

# 8. WHERE TO START CHCS

## 8.1. ACTIVITY: Prioritizing Areas

**OBJECTIVES :**

- **To learn to analyze areas and households according to standard of living and facilities**
- **To analyze which are the best areas for a CHC**

**All participants should work together on the following exercise.**
**Draw the following chart on the flipchart.**
**Ask participants to list all the levels of each column in order from worst to best**

| Level | Sanitation level | Water Supply | Health status | Wealth | Schools |
|---|---|---|---|---|---|
| 1: Poor | | | | | |
| 2. Average | | | | | |
| 3. Good | | | | | |

**Divide into groups made up of everyone from each district / sector**

**Ask each group to list the villages in the first column and then award levels to each**

| | Village | Sanitation level | Water Supply | Health status | Wealth | Schools |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |

**WHICH AREA WILL BE THE BEST FOR A COMMUNITY HYGIENE CLUB?**

It is obviously best to target the least developed areas of the Commune, where there is poor sanitation coverage and where hygiene standards are lowest, and levels of diarrhea are particularly bad.

Using your Map of the area, and the above information report back to the Plenary group explaining the reasons for choosing the area for the CHC project.

## 8.2. ACTIVITY: Mapping your Area

For the purposes of this Planning exercise , draw a rough map of the area where you are operating, with the villages, roads, schools, clinics and other interesting information. It does not have to be exact, but clear so you can describe your area.


**When you are in the CHC village the MAPPING should be as follows:**

1. **Draw a map showing everything in the catchment area of the CHC: roads, school, clinic, graves, plantations, shops, factories, government buildings etc.**
2. **Make sure all the homes are on the map, and mark which are CHC members homes. (A circle for non members, and a star for CHC member)**
3. **Mark if the CHC members have a latrine or not: Use a symbol with a colour,**

   **(red for no latrine, yellow for temporary latrine, and green for improved latrine)**
4. **When everyone agrees that the map is correct transfer it onto the cloth.**
5. **Sew or draw the map carefully, making it as beautiful as possible.**
6. **Remember there will be prizes for the best banner at the end of the programme.**
7. **Attach the banner to two sticks on either side of the banner, so two people can hold it up when parading.**
8. **Write the name of the CHC in large letters at the top of the banner.**
9. **Write the slogan at the bottom of the banner.**

# 9. TRAINING METHODS AND TRAINING MATERIAL

## 9.1. THE PARTICIPATORY APPROACH

### GOOD FACILITATION

Teaching adults is different from teaching children and a way to respect experience of adults is to allow them to contribute instead of dominating them. At school, the teacher usually instructs the pupils who often have to listen and learn without making any comments or decisions themselves.

In the participatory approach, the *trainer* become a *facilitator*, and should not spend all the time instructing, although some knowledge has to be transferred. The word 'Facilitator' means 'one who makes things easier' and this is their main role.

**A GOOD FACILITATOR** should

- provide a good forum which encourages people to think for themselves.
- talk as little as possible and encourage others to interact and come up with their own ideas.
- should not hold onto the pictures, and do all the talking but whenever possible they should hand out the pictures and give others a chance to express themselves.
- should not hold the pen and do all the writing like a teacher at a blackboard, and that is why we seldom use paper and pen in the CHCs.
- call on those who normally remain quiet and calm those who often take over the meetings, particularly strong minded people, (often males) who usually dominate.
- guide the group towards a positive conclusion where solid action will be taken.

### THE MANDELA WAY: Leading from Behind

Leadership is usually about moving people in a certain direction, usually through changing the direction of their thinking and their actions. The way to do it, according to one of the greatest leaders in Africa, Nelson Mandela, is to 'lead from behind'. As a child he grew up in the rural areas of South Africa, herding cows, and he learnt how to manipulate them so that they went in the right direction. He is quoted as saying in the new book called Mandela's Way (Stengel, 2010),

> ***"You know, when you want to get cattle to move in a certain direction, you stand at the back and then you get a few of the clever cattle to go to the front and move in the direction that you want them to go. The rest of the cattle follow the few more energetic cattle at the front, but you are really guiding them from the back. That is how a leader should do his job"***

## 9.2. PARTICIPATORY ACTIVITIES

The activities listed below are tried and tested 'games', which can be used for most sessions. By asking people to hold the cards up in front of the audience they can be with large crowds. Alternatively, the CHC can be split into smaller groups to enable more interaction.

### 1. MAKING STORIES

There are three main ways to use a story to get participants to identify problems and solutions:

**Open ended story:** Each person takes a card and explains what they see and what will happen next.

**SWAG** (Story with a Gap): Take two cards to show 'Before' and 'After' and explain what happened in between the two cards, so analysing how to get from one situation to another.

Make a full story: Select series of cards to show a problem and how it was solved.

### 2. THREE PILE GROUPING

A variety of picture cards are given out, depicting a range of different hygiene practices or situations typical of the local area. Each participant must hold up a picture and decide if it is 'Good' (Safe) practices, 'Bad' (Unsafe), or 'Medium' in terms of health risk. Either put the cards into 3 piles or people with their cards form three groups, and discuss reasons for the grouping.

### 3. RANKING

Once the three pile grouping has been done, an extension to this activity is to rank the cards from best to worst. Everyone holds up the cards for all to see and one person is asked to arrange them in an order. Often this provokes debate and another person is asked to make their changes to the order. This continues until most of the people are satisfied with the ranking.

### 4. SANITATION LADDER or WATER LADDER

Often this shows a range of technical options such as water sources, or types of sanitation. The pictures will depict the least safe, or feasible technical option to the most favored solution. This enables a discussion to take place focused on a consensus achieved through brainstorming as to the advantages and disadvantages of each option.

### 5. BLOCKING THE ROUTE

This is the most useful activity for enabling a group to see how to prevent a certain disease. The transmission 'ROUTE' of the disease is represented in stages on different cards which are given out. Each person holds up one card and the group arranges the correct sequence of 'transmission'. The other cards that show how to prevent the disease are given out. Each person comes forward and shows which stage of the transmission can be blocked by the practice shown on their card. They stand behind the transmission card that they could block. When all cards have been shown, a discussion takes place as to the most effective interventions that

## 9.3. ACTIVITY: SELECTION OF APPROPRIATE VISUAL AIDS

### APPROPRIATE VISUAL AIDS

As pictures help people to imagine issues more clearly, most the activities in CHC rely on the use of visual aids. For less educated people it is much easier to select ready-made pictures to express ideas than to write down these ideas in words.

### TOOLS: NATIONAL CHC TOOLKIT (MoH) CBEHPP PROGRAMME

Divide into groups of four participants.

Give out one topic of the visual aids to each group

Discuss the following issues:

- **What ethnic groups live in the project area?**
- **Do they resemble the people in these pictures?**
- **Do their homes and environment resemble those in the pictures?**
- **Do the situations depicted represent the problems in your area?**

**Three pile sorting**

Look at each card and sort them into three piles:

1. Appropriate, 2. Not appropriate, 3. Possible to alter.

Once you have selected the cards that could be used in your area, make a list of the pictures that are missing.

In the workshop, feed this back to the main group to enable changes to be made by the artist.

- **Do you need to design new visual aids for the Toolkit because the picture do not reflect your area?**
- **What are you going to use if visual aids are not available or are not appropriate?**

Use these pictures and explain to members that you are in the process of adapting them

Get a local artist to redraw the pictures to represent the local community

## 9.4. PRETESTING THE TOOLKIT

The CHCs usually take some time to start up, so the programme should begin with a month of mobilising the community. This will involve spreading the information to all relevant leaders and officials in each district to ensure that they are fully aware and endorse the programme. Once this has been cleared the Community Health Workers (CHW) will be required to move around the selected area and mobilise interest to join the health club. This can be done in conjunction with pretesting of visual aids and a household inventory. Both these activities will raise interest in the CHC and members can be signed up immediately.

**1. Random Sampling for pretesting pictures:**

The CHW should make a list of each household within each catchment area (Annex 3), and then select every 3rd house to survey. N.B. To sure that there is no bias in selection, it is important that she does not go the nearby, easily accessible or neighbouring houses, or those households that she knows. Every third household on the list should be visited. These should be marked and numbered on the map.

The following should take place:

**Introduction:**

The CHW should explain the purpose of the visit and what a CHC is and what will take place. Ask for the household head and preferably the wife, to be present if possible. She can then explain that there are pictures that need to be pretested. Ask if the respondent has time (30-60 minutes) to conduct this survey. The CHW must stress that they do not need to worry as this is not to test the household's knowledge but to help provide insight so that the training materials can be very appropriate and that it will be very much appreciated if she/ he can assist.

**Pretesting Pictures**

Each household reviews one topic (20 pictures ). Try not to get those with the highest education, as they will find the pictures too easy. The objective is to test three main things:

1. **COMPREHENSION:** Can they interpret what is drawn in the picture correctly?
2. **APPROPRIATENESS:** Does the picture show what is seen in the area, geographically and culturally, and the appropriate technology?
3. **INTERPRETATION:** Does the picture convey the right message; if it is trying to show a positive situation is this understood by the audience.

**PLEASE CONSULT THE MOH PRETESTING INSTRUCTIONS FOR MORE DETAILS**

# 10. EXIT STRATEGY AND SUSTAINABILITY

## 10.1. TYPES OF SUSTAINABILITY

After six months, the first 24 sessions should be completed. So what happens to the Hygiene Club when the sessions have finished? The effects of the project on the beneficiaries can be sustained in two ways:

**1. SUSTAINABLE BEHAVIOUR CHANGE:**

The lessons that are learnt have been completely taken into the daily lives of the health club members so that they have changed their hygiene behaviour and continue to practice good hygiene. This is the most important objective of the whole programme. If this is achieved the programme will have met its objective to improve family health and prevent diseases like diarrhoea, cholera, malaria, skin diseases and worms. Transfer of knowledge can be done within six months and experience shows that some behaviour change does take place immediately. However but to ensure this is **sustained**, it must be **continually reinforced.** It takes at least 2 years to ensure a new behaviour becomes a habit. Once a Culture of Health has been developed people have fully taken on many beneficial hygiene practices that will improve family health in the long term. Although the CHC may cease to meet the benefit of the information will remain as long as good habits have been adopted permanently.

**2. SUSTAINABLE STRUCTURE:**

It is a bonus if the health club continues to meet and actively work together into the future, without any external support. Many CHCs do survive without external support for many years but they need good support from the leadership

**A HOLISTIC APPROACH**

To use a Community Hygiene Club to its fullest potential, the health promotion is only the first stage, an entry point into a water and sanitation project, as a strong demand for improved facilities is the natural outcome of this methodology. After this, CHCs will want to continue to improve their standard of living. The following year they may want to become a FAN Club (Food and Nutrition Club) with an agricultural project and nutrition gardens, bee-keeping, reforestation, or income generating projects such as bee keeping, paper making, and soap making. Once the CHC is operational so many other skills can be developed.

A Community Hygiene Club that is properly set up should be able to address social issues within their community. CHCs can be active without the assistance of outside support, and find activities that are initiated by their own efforts. This may include social support for vulnerable families, widows, orphans, those suffering from HIV/AIDs or other disabilities. Some CHCs have started play schools and soup kitchens and there is no limit to the usefulness of such an empowered group of people. At this stage other Ministries and organizations will readily support these initiatives as it is clear that they are organized and they will be able to raise loans, and micro credit . Health Promotion is the first step on the ladder of holistic development.

**EMERGENCY PROJECTS**

CHCs can be also used in emergency situations, and be formed for the express purpose of dissemination of information to avert outbreaks of cholera. However, unless CHCs are supported for some time after the emergency are unlikely to remain operational for long.

# 10. EXIT STRATEGY AND SUSTAINABILITY

## 10.2. AN EXIT STRATEGY

An exit strategy means that CHCs have to be weaned from the organization that helped to start them, the Ministry of Health or an NGO, so that they become independent, like a child that has grown up, stands on its own without external support. There are three critical components in an exit strategy.

**1. Time:**

For a CHC to survive it must have been going for 2-4 years. Experience over the years has shown that the AHEAD approach in which the Community Hygiene Club goes through a series of phases (Health Promotion, Water & Sanitation, Skill Development and Social Support) will usually ensure the sustainability of the CHC.

**2. Activities:**

In order to keep meeting, groups must have ongoing activities. If the activities fail, the group is likely to stop meeting. Therefore plans have to be made by the CPM to ensure there are activities that are sustainable: annual competitions, netball health revision sessions, literacy groups and play schools are all simple things that have been done to provide an ongoing attraction to keep the club 'alive' with minimal funds.

**3. Transfer of Allegiance**

The Community Hygiene Club may have been started up under the MoH, but in the long term it is more practical that the CHC is affiliated with local NGOs who already have mechanism for sourcing funding and training opportunities. The CHC may turn into FAN Clubs (Food and Nutrition) and be taken over by the Ministry of Agriculture. No one Ministry owns the CHCs, although they may have been started under the MoH, and they are free to affiliate with whatever organisation can use their structure effectively. However it is usually best if this is done in stages, so that the CHC is married to one Ministry and then another, rather than being married to all the Ministries at once in a polygamous relationship!

## 10.3. A VISION FOR THE FUTURE: CHCs - A NATIONAL MOVEMENT

The CHCs are to be started in all 15,000 villages throughout Rwanda within the next five years. This means that a national movement is being set up rather like the Boy Scout Movement or the Girl Guides. The CHC all share the same Culture of Health, the same ethos, and are united in a common purpose to improve living conditions of the poorest of the poor in Rwanda.

As the number of CHCs grow in each district, they should develop a District Umbrella Committee, and growing from the bottom up, a Provincial Umbrella committee, and finally with a Leader at the top who, who has come up from the bottom, who will represent all CHCs National Level. There should be radio and TV programme dedicated to showcasing the different CHCs and their achievements.

There could be Annual Rallies, where representatives gather in their CHC uniforms, from all over the countries in solidarity with other CHCs. The CHC Movement must have a vision that steers clear of political and religious affiliation so that it rises above divisive issues, building a strong Rwanda based on a Culture of Health and Welfare for all Rwandans to move forward into a more prosperous future.

## FURTHER READING ON THE CHC APPROACH

.

Falkenmark. M. (2008) Overreaching summary of workshop contributions and personal reflections. World Water Week conference, Stockholm.

Poverty-Environment Partnership (2009) Poverty Health and Environment : Placing Environmental Health on the Development Agenda. Joint Agency paper.

Waterkeyn, J. and Cairncross, S. (2005) *Creating demand for sanitation and hygiene through Community Hygiene Clubs: a cost-effective intervention in two districts of Zimbabwe*. Social Science & Medicine. Vol 61, pp.1958-1970.

Waterkeyn, J. (2010) *Hygiene Behaviour Change through the Community Hygiene Club Approach: a cost effective strategy to achieve the Millennium Developments Goals for improved sanitation in Africa.* Lambert Academic Publishing. Germany.www.amazon.com

For all information on Community Hygiene Clubs see: www.africaahead.com

### Resource Kit for Community Health Workers

This is a Information and Training Material Pack: a collection of resource material available in Rwanda which provides additional information and visual aids for training.

**Pretesting Guidelines :** J. Waterkeyn for MoH

**Inyigisho Ku Buzima Bw'umwana:** A flip chart and posters for CHWs summarizing all correct messages for Key Family Practices as promoted by the Ministry of Health, Community Health Department

**Posters for Children's Forum**: developed by Child Protection Department (Unicef)

**Training Guide for Hygiene and Sanitation Facilitators: Water Hygiene and Sanitation**, developed by PURA-SAN (JICA) for MININFRA

**Nutrition Cards:** developed by Unicef Nutrition Department for MoH

**HIV AIDS:** Picture codes developed by CHF International

# ANNEX

**ANNEX 1: CHC Toolkit Pretesting Form**

**Enumerators Name…….. Date…… District …….. Village……**

| Set # | PICTURES | CARD SET TITLE: | | | | | | |
|---|---|---|---|---|---|---|---|---|
| CARD | QUESTION | REQUIRED RESPONSE | 1 | 2 | 3 | 4 | SUB TOTAL | TOTAL |
| | WHAT DO YOU SEE HERE? | | | | | | | |
| | WHAT GENDER ARE THEY? | | | | | | | |
| | WHAT ARE THEY DOING? | | | | | | | |
| | WHERE IS THIS? | | | | | | | |
| | IS THIS POSITIVE / GOOD? | | | | | | | |
| | **DOES THIS HAPPEN HERE?** | | | | | | | |
| | WHAT DO YOU SEE HERE? | | | | | | | |
| | WHAT GENDER ARE THEY? | | | | | | | |
| | WHAT ARE THEY DOING? | | | | | | | |
| | WHERE IS THIS ? | | | | | | | |
| | IS THIS POSITIVE / GOOD? | | | | | | | |
| | **DOES THIS HAPPEN HERE?** | | | | | | | |
| | WHAT DO YOU SEE HERE? | | | | | | | |
| | WHAT GENDER ARE THEY? | | | | | | | |
| | WHAT ARE THEY DOING? | | | | | | | |
| | WHERE IS THIS? | | | | | | | |
| | IS THIS POSITIVE / GOOD? | | | | | | | |
| | **DOES THIS HAPPEN HERE?** | | | | | | | |
| | WHAT DO YOU SEE HERE? | | | | | | | |
| | WHAT GENDER ARE THEY? | | | | | | | |
| | WHAT ARE THEY DOING? | | | | | | | |
| | WHERE IS THIS? | | | | | | | |
| | IS THIS POSITIVE / GOOD? | | | | | | | |
| | **DOES THIS HAPPEN HERE?** | | | | | | | |

**ANNEX 2: RWANDA CBHEPP HOUSEHOLD INVENTORY DATA FORM (PAGE1 OF 1)**

**Date of survey…… District…… Sector…… Village……Ennumerator ……**

| | OBSERVATION (page 1) | 1 | 2 | 3 | 4 | 5 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Is there paving around the house? | | | | | | | | | | |
| 2 | Is there grass /lawn around the house | | | | | | | | | | |
| 3 | Is there any rainwater harvesting system? | | | | | | | | | | |
| 4 | Are there vegetables growing for the household? | | | | | | | | | | |
| 5 | Is there a grey water drainage system? | | | | | | | | | | |
| 6 | Is there a rain water drainage system? | | | | | | | | | | |
| 7 | Is there a washroom outside? | | | | | | | | | | |
| 8 | Where are livestock housed at night? | | | | | | | | | | |
| 9 | How is rubbish disposed? | | | | | | | | | | |
| 10 | How are human faeces disposed? | | | | | | | | | | |
| 11 | If there is a latrine, is it improved? | | | | | | | | | | |
| 12 | Is the latrine clean? | | | | | | | | | | |
| 13 | Is the latrine used/maintained? | | | | | | | | | | |
| 14 | If there is a latrine, Is there any anal cleaning material ? | | | | | | | | | | |
| 15 | Do you see many flies around the compound? | | | | | | | | | | |
| 16 | Is there a handwashing facility outside? | | | | | | | | | | |
| 17 | Do you see soap nearby HWF? | | | | | | | | | | |
| 18 | Where is the cooking done? | | | | | | | | | | |
| 19 | How is the smoke controlled? | | | | | | | | | | |
| 20 | How are the cooking utensils stored? | | | | | | | | | | |
| 21 | How are pots and plates stored after washing? | | | | | | | | | | |
| 22 | How is food stored? | | | | | | | | | | |
| 23 | How is drinking water stored? | | | | | | | | | | |
| 24 | How is drinking water accessed? | | | | | | | | | | |
| 25 | Is drinking water treated? | | | | | | | | | | |
| 26 | Is the kitchen clean? | | | | | | | | | | |
| 27 | Do the children looked well cared for? | | | | | | | | | | |
| 28 | Do any children have any eye/skin diseases? | | | | | | | | | | |
| 29 | If a baby is their growth monitoring chart in safe area? | | | | | | | | | | |
| 30 | Any current health problem in family? | | | | | | | | | | |

| | Observation | Choose one or more of the numbers 1-5 for each observation | | | | |
|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 3 | 4 |
| 1 | **Is there paving around the house?** | none | On path only | Around house only | Path and around house | other |
| 2 | **Is there grass /lawn around the house** | none | Some | completely | | |
| 3 | **Is there any rainwater harvesting system?** | none | Yes, uncovered | Yes, covered | | |
| 4 | **Are there vegetables growing for the house-hold?** | none | Yes, now not functional | Yes, a mound | Yes, nutrition garden | Yes, communal nutrition garden |
| 5 | **Is there a grey water drainage system?** | none | pit | Covered pit | | |
| 6 | **Is there a rain water drainage system?** | none | A channel | A proper drain | | |
| 7 | **Is there a washroom outside?** | none | Temporary, but no drainage | Temporary, with some drainage | Permenant, no drain-age | Permenant , with good drainage |
| 8 | **Where are livestock housed at night?** | None/ no live-stock | In kitchen | In house | In pen near house | In pen far from house |
| 9 | **How is rubbish dis-posed?** | No disposal method | Dumped in one place in yard | Disposed outside own compound | In rubbish pit in the yard | Separation of rubbish into non/degradable |
| 10 | **How are human faeces disposed?** | No disposal method | Childrens faeces in yard | Adult faeces nearby | Temporary latrine | Permenant latrine |
| 11 | **If there is a latrine, is it improved?** | No latrine | Yes, Lined pit | Yes, Concrete slab/ sanplat | Yes, Covered squat hole | Yes, Ventpipe |
| 12 | **Is the latrine clean** | no latrine | Clean floor | Clean walls | Clean around squat hole | All of above |
| 13 | **Is the latrine used?** | Not used | Not used because it is dirty | Not used because it is full | Not used because it is broken | The latrine is in use |
| 14 | **If there is a latrine, Is there any anal cleaning material ?** | No latrine/ latrine not used | No anal cleaning material | Yes, leaves | Yes, newspaper | Yes, toilet paper |
| 15 | **Do you see many flies around the com-pound?** | No flies at all | Flies on people | Flies in compound | Flies in toilet | Flies in kitchen |

| | | | | | | |
|---|---|---|---|---|---|---|
| **16** | **Is there a handwashing facility outside?** | None | A water container | A home made tippy tap | A metal tippy tap | A tap connection |
| **17** | **Do you see soap nearby HWF?** | Not applicable/ no HWF | No soap in home | Soap available but not left by HWF | Soap by HWF | Soap by HWF and wash room |
| **18** | **Where is the cooking done?** | n/a | Outside on open fire only | In a shack kitchen | In a closed kitchen | In more than one place |
| **19** | **How is the smoke controlled?** | No control | Ventilated area | Fuel efficent stove | Fuel efficient stove with chimney | Parafin stove/electric stove |
| **20** | **How are the cooking utensils stored?** | No safe storage system | Nearby in container on floor | In kitchen in container on floor | In kitchen on open shelves | In kitchen in closed cubpoard |
| **21** | **How are pots and plates stored after washing?** | No safe storage system | Nearby in container on floor | In kitchen in container on floor | On a drying rack outside | On a pot drying inside |
| **22** | **How is food stored?** | No safe storage system | Nearby in container on floor | In kitchen in container on floor | In hanging baskets | Use of rat cones |
| **23** | **How is drinking water stored?** | No storage/ n/a | Open containers, no cover | Jerry can, no cover | Sealed containers, but not clean | Sealed containers and clean |
| **24** | **How is drinking water accessed?** | No system | One cup | A two cup system | A ladle | A jug |
| **25** | **Is drinking water treated?** | No treatment | Treatment not necessary | Boiling of water | Sur Eau added | Chlorine / other |
| **26** | **Is the kitchen clean?** | Not applicable/ no kitchen | Dirty floor with left over food | Dirty pots and plates | Quite dirty work sticky surfaces | Very dirty with many flies |
| **27** | **Do the children looked well cared for?** | Not applicable/ no children | Dirty faces and flies | Dirty clothes | No shoes | Not responsive/ tired |
| **28** | **Do any children have any eye/skin diseases** | Not applicable/ no children | scabies | ringworm | sores | Eye infections |
| **29** | **If a baby is their growth monitoring chart in safe area?** | Not applicable/ no baby | Below safe area | In safe area | In safe area and improving | Very good growth, above safe area |
| **30** | **Any current health problem in family?** | None | Diarrhoea | Malaria | Pneumonia | other |

# ANNEX 1:

# EVALUATION FORM FOR THE WORKSHOP MODULE 2

| | TOPIC | Not applicable: I would not use it in my training. | Not very interesting | Quite Interesting | Good / average | Interesting / applicable | Very inter-esting | I will definitely use it in my training |
|---|---|---|---|---|---|---|---|---|
| | Introductions | | | | | | | |
| 1. | Health Promotion Theory | | | | | | | |
| 2. | The CHC Approach | | | | | | | |
| 3. | Membership Card | | | | | | | |
| 4 | Household Inventory | | | | | | | |
| 5 | CHC Executive Committee | | | | | | | |
| 6 | Targets & Challenges | | | | | | | |
| 7 | Where to start CHCs | | | | | | | |
| 8 | Mapping your area | | | | | | | |
| 9 | Development of Pretesting forms | | | | | | | |
| 10 | Pretesting | | | | | | | |