REPUBLIC OF RWANDA

MINISTRY OF HEALTH

WORKSHOP REPORT
COUNTRY-WIDE SCALE-UP OF THE
COMMUNITY-BASED ENVIRONMENTAL HEALTH PROMOTION PROGRAMME
(CBEHPP)

February, 2015

CONTENTS

APPENDICES

Abbreviations

AA	Africa AHEAD
AVIS	Association of Volunteers in International Service
CBEHPP	Community Based Environmental Health Promotion Programme
CHC	Community Health Club
CHF	Community Health Facilitator
CLTS	Community Lead Total Sanitation
CoK	City of Kigali
CSEDO	Cell Social Economic Development Officer
CT	Challenge Type
DDP	District Development Plan
DP	Development Partner
EP	Eastern Province
GIS	Geographic Information System
GoR	Government of Rwanda
Imihigo	Ministerial and district mayor yearly performance contracts and evaluation
IP	Implementing Partner
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NGO	Non-Governmental Organisation
NP	Northern Province
OD	Open Defecation
PHAST	Participatory Hygiene and Sanitation Transformation
RIWSP	Rwanda Integrated Water Security Program
RWF	Rwandan Franc
SEHO	Sector/Health Centre Environmental Health Officer
SP	Southern Province
SSP	Sector Strategic Plan
SWG	Sector Working Group
Ubudehe	Policy to encourage collective action and mutual support at community level
Umudugudu	"Village", lowest level of Rwandan administration
UN	Untied Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WATSAN	Water and Sanitation
WC EA	Water Consulting East Africa
WP	Western Province
ZOD	Zero Open Defecation

I. Introduction

The Community Based Environmental Health Promotion Programme (CBEHPP) is the premier hygiene behaviour change program in Rwanda that has adopted the Community Health Club (CHC) methodology. Compared to other behaviour change models, such as Community Led Total Sanitation (CLTS) and Participatory Hygiene And Sanitation Transformation (PHAST), CHCs offer a far broader and more holistic focus on preventative health issues and the contributing environmental health factors that negatively affect the well-being of the Rwandan population.

The Ministry of Health (MoH) launched the '**National CBEPHH Roadmap**' on 19th December 2009 to roll out CHCs to all 30 districts. This was clearly an ambitious target given there are nearly 15,000 villages across Rwanda. By 2011, the CBEHPP training manuals and tool kits had been produced to aid information dissemination down to the *umudugudu* (village) level and by 2014 CHCs had been registered in over 98% of all villages. Over the past 5 years, since the initial launch of CBEHPP, many partners have been implementing CHCs to great effect and already 36% of all villages have so far benefitted from thorough CHC training. However there have been challenges as a result of the variety of implementation strategies employed by different IPs and certainly not all have proven to be effective. This has been compounded by inadequate resources to cover distribution costs of the CHC printed training tool kits and manuals to ensure the all-important training of village based Community Health Facilitators (CHFs) together with the six-months of community training in every CHC as required by this model.

In order to bring development partners together to discuss and coordinate national Scale-up of training which is essential for implementation of CBEHPP in Rwanda, on 19th February 2015 a workshop was convened by the MoH in collaboration with UNICEF, USAID and Africa AHEAD.

This report assumes that a CBEHPP based approach is the optimum solution to Rwanda's preventative health problems. This report shall:

1. State the current status of CBEHPP and its achievements to-date;
2. Outline challenges and recommendations;
3. Suggest proposals for the future scale-up of CBEHPP.

II. CBEHPP

The CBEHPP program aims to improve the health of the Rwandan population. It covers a wider range of topics than are usually targeted by typical WASH inventions as it includes: nutrition, maternal health as well as WASH-related diseases (see **Fig 1.** for the list of health topics, as listed on the membership card). CBEHPP utilises cascading training from a MoH national core of trainers to train Sector Environmental Health Officers (SEHOs) based at health centres who then train community health facilitators (CHFs) at the village level. Once trained CHFs set up Community Health Clubs (CHCs) with the target of around 100 households. Each household in the village should be represented by at least one member at the CHC.

No.	Topic	Date	Signature of Facilitator	Weekly Homework	Signature of Facilitator
1.	Introduction			Bring friends and family	
2.	Common Diseases			Know common diseases	
3.	Personal Hygiene			Family Wash Shelter	
4.	Hand washing			Hand Wash Facility / soap	
5.	Skin Diseases			Children no Skin Disease	
6.	Diarrhoea			Knowledge of SSS / ORS	
7.	Infant Care			Correct Child Immunisation	
8.	Worms			Children no worms	
9.	Food Hygiene			Clean drying rack	
10	Nutrition			Good Road to Health	
11.	Food Security			Kitchen Gardens	
12.	Water Sources			Clean Water Source	
13.	Safe Drinking Water			Safe storage and usage	
14.	Adequate Sanitation			ZOD / Clean safe latrine	
15.	Green & clean home			Waste management /greening	
16.	Good Parenting			Clean children	
17.	Respiratory Disease			Good Ventilation	
18.	Malaria			Use of treated bed nets	
19.	Bilharzia			Treatment for Bilharzia	
20.	HIV/ AIDS			VCT	

Fig. 1. Membership card showing all 20 topics and weekly homework

II.1 CBEHPP Objectives

CBEHPP combats the prevailing environmental health threats to the Rwandan population plus the achievement of national and global development targets as listed in the Roadmap.

1. Improved household and institutional hygiene practices
2. Safe excreta disposal with zero open defecation (ZOD) and hygienic use of toilets / latrines
3. Hand-washing with soap and water at critical times
4. Safe drinking water handling
5. Safe disposal of solid and liquid wastes
6. Food safety and improved nutrition
7. Minimise indoor air pollution to reduce Acute Respiratory Infections (e.g. promote fuel-efficient stoves with chimneys)
8. Improved vector control

CBEHPP requires the following to be prioritised as shown in the homework for each session in the membership card (Fig.1):

II.2 CBEHPP National Targets

At the CBEHPP Workshop, the Director General of MoH confirmed that by June 2018, MoH wants total (100%) coverage of CHCs across all villages and households in Rwanda. The Health Sector Strategic Plan (HSSP) also has relevant targets as stated in **Table 1.1**.

Expected Outputs/Outcomes	**Baseline 2011**	**Target 2015**	**Target 2018**
Diarrhea prevalence among children <5	2.8	2.1	2.0
% Community Health Clubs with enhanced health promotion and BCC capacity	14%	50%	70%
% Villages with functional Community Hygiene Clubs (CHCs) meeting at least twice a month)	8%	50%	80%

Table 1.1 CBEHPP Related Targets from the Health SSP

MININFRA has a target of 100% of households with improved sanitation by June 2018; improved sanitation is defined as per **Table 1.2**.

CBEHPP is the key GoR implementation program in order to achieve these targets.

Improved Sanitation Facilities	**Unimproved Facilities**
Use of following facilities in home/compound: • Flush/pour-flush to: - piped sewer system - septic tank - pit latrine • Ventilated improved pit (VIP) latrine • Pit latrine with slab • Composting toilet	Use of following facilities anywhere: • Flush/pour-flush to elsewhere • Pit latrine without slab/open pit • Bucket • Hanging toilet or latrine • No facility, bush or field (OD) Use of a public facility or sharing any improved facility

Table 1.2 Improved Sanitation Definition as per the 2010 WATSAN National Policy and Strategy

III. Justification and objectives of the workshop

III.1 Justification for workshop

According to the original CBEHPP Roadmap, implementation was expected to start with two districts, then move to four, then eight and eventually cover the whole country. The speed of roll-out was dependant on the support provided by various IPs and their capacity to cover whole districts or just some sectors. CBEHPP implementation has been coordinated by MoH with initial technical support from World Bank (WSP) and later UNICEF. The support included production of training materials, the training of a core team of national trainers, planning and monitoring implementation of the programme. Currently Africa AHEAD, supported by the Bill & Melinda Gates Foundation is also providing ongoing technical support to MoH.

After clearly establishing 'proof of concept' of the efficacy of the CHC model for achieving holistic hygiene behaviour change, MoH has found it necessary to update and critique CBEHPP and establish whether implementation is in accordance with the original CBEHPP Roadmap, hence this 'Scale-Up Workshop'. Similarly there was a need to take stock of all the achievements to date, while acknowledging associated challenges and then develop a comprehensive plan for the Way Forward.

III.2 Workshop objectives

The workshop was planned and organized to answer the unknowns about the implementation of CBEHPP through the following objectives

1. Assess the CBEHPP implementation in relation to the original Roadmap (2009) and propose a review of the Road map as may be necessary;
2. Map the partners supporting the implementation of CBEHPP and the geographical areas of the districts covered;
3. Take stock of the various modifications made by partners as result of different experiences in implementing WASH promotion strategies;
4. Share the monitoring and data sharing by MoH and implementing partners;
5. Estimate the various expenses based on implementation costs by different partners;
6. Brain storm the various challenges encountered during the implementation of CBEHPP;
7. Make the recommendations necessary for improving the implementation of the programme;
8. Agree on the way forward for increasing the number of districts and village coverage in implementing the programme;
9. Agree on the Way Forward in relation to production of training materials and uniformity and standardisation of training of trainers and facilitators.

IV. CBEHPP Status

The GoR requested District Mayors to establish CHCs in every district. Subsequently, 14,767 CHCs were registered; this means an impressive 98% of all villages responded. Some CBEHPP training was undertaken in 20 out of 30 districts and to-date 36% of all Village Community Facilitators, known as ASOC (Affaire Sociale) have been trained. However there has been an inadequate flow of resources from the GoR or from IPs to ensure satisfactorily training as required for the implementation of CBEHPP across the whole country.

This section of the report summarises the achievements to date as follows:

1. Operational CHCs, in relation to the MoH roadmap
2. CBEHPP areas covered by Development Partners
3. Differing implementation strategies as per information received by development partners
4. CBEHPP cost, as per data supplied by development partners.

IV.1 Operational CHCs

36% of registered CHCs (5,376 out of 14,767) are operational, meaning ASOC have been trained and run ongoing health sessions regularly. Where CHC are not 'functional' ***it does not imply that they have rejected the programme, only that there have been inadequate support to train the trainers and run the sessions***. Particular poorly functioning districts where there are no operational CHCs are Nyagatare (EP), Ngoma (EP), Kirehe (EP), Nyarugenge (CoK), Muhanga (SP), Nyanza (SP), Gisagara(SP), Ngororero (WP), Rutsiro (WP). Operational CHC data is summarised in **Appendix A** and is graphically represented below in **Figure 2.1**.

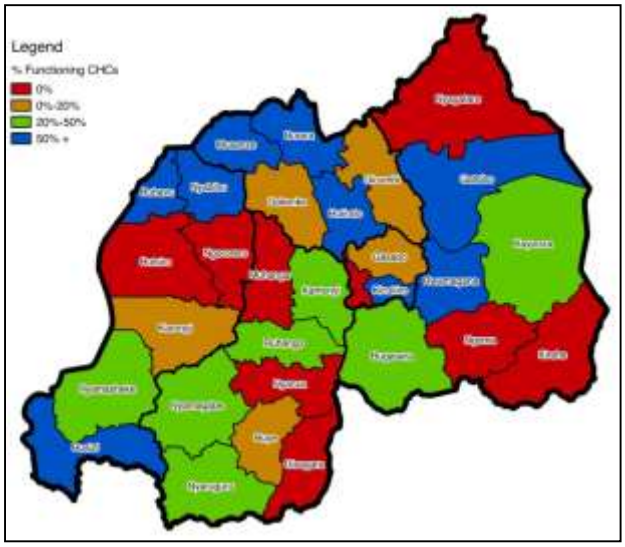

Figure 2.1:

Percentage of Operational CHCs per District as per MOH data

IV.2 Districts, Sectors and Villages covered by CBEHPP

A total of 14 development partners have been working across Rwanda to implement CBEHPP. During the workshop questionnaires were completed by the 68 delegates from these NGOs in order to capture where they are funding or implementing CBEHPP. There was a good response, the data received is summarised in a table in **Appendix C** and represented in **Figure 4.2**.

So far, IPs have already covered or are planning to cover 46% of the sectors in Rwanda leaving a balance of 54% without CBEHPP by April 2015.

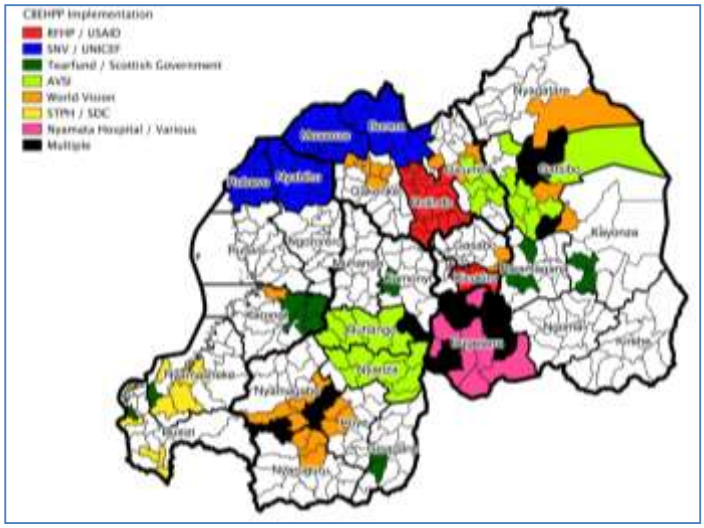

Figure 3.2:

Coverage of Completed, Ongoing or Planned CBEHPP Programs

IV.3 CBEHPP Costs Rates and Implementation Variation

CBEHPP implementation strategy and cost information was received from six development partners.

IV.3.1 Implementation Strategies

The implementation strategy has been outlined in the CBEHPP Manual and is meant to be followed by all partners, but they vary in some respects. The variation usually driven by available resources and donor requirements, and is demonstrable by quantity of trainings, magnitude of allowances and level of M&E undertaken. However it is also clear that some IPs do not grasp the basic assumptions of the Model which relies strongly on sufficient meetings to reinforce key messages and the development of a critical mass of members to ensure group by in to the recommended practices. Some organisation try a medley or mix of approaches which include elements of CLTS and PHAST. There is a tendency for international organisations to strive for innovation and adjust the basic CHC model in tune with their own perceptions. To counter this MoH has been trying to coordinate the IPs and ensure a uniformity of approach across Rwanda.

Accordingly IPA (Innovations for Poverty Action) in a randomised control trial being undertaken in Rusizi District, have been supported by Gates Foundation to measure the cost effectiveness of the CBEHPP programme and two levels of implementation are being assessed:

- The Classic CHC Model as per the text book with all key aspects carefully included
- The 'Lite' version of the CHC Model which neglects one or more of the key aspects.

Training variations for Lite CBEHPP include:

- Training only CHFs without training SEHOs
- Smaller number of members
- Lack of use of membership card
- Reduced number of session to focus only on WASH subjects
- Reduced duration of training.
- Use of photocopied or b/w visual aids
- Reduced support for field workers
- Lack of monitoring with the household inventory
- Lack of certificates at the end of training
- Lack of transport for EHO and ASOC

IV.3.2 Monitoring and Evaluation

The CHC approach enables managers to quantify behaviour change using community monitoring tools as an integral part of the process of change. After the election of a CHC Executive Committee, together with the CHC Facilitator are responsible to ensure attendance by members to the dialogue sessions and that the levels of hygiene improvements/change through implementation of the homework are monitored. In order that SEHOs and CHFs can perform their monitoring and reporting role more easily and periodically some development partners have provided motorbikes and bicycles respectively.

House to house visits by the CHC Executive Committee reinforce the implementation of the homework and this is recorded on the membership cards where there are two sections, one for the attendance in the dialogue session and the other for the homework (See Fig 1. Above).

The above procedure was designated in the Road Map and has been implemented by some partners. This data is collected from each village (CHC) and transmitted to the EHO located at the Health Centre. It is then compiled and transmitted to the EHO at the DH who in turn compiles and send the information to the MOH.

These observations are known as the 'Household Inventory' and should be conducted on a regular basis and recorded in registers (exercise books) thus enabling each CHC to identify exactly when the agreed behaviour and lifestyle changes have been made.

The MoH developed the ten key indicators, each with five sub indicators and the booklet was printed. A base line survey was meant to have bene done throughout the country, but was in fact on done in Rusizi in approximately 10,000 households. The challenge of collecting and entering a survey for every household was a challenge so the same survey is now available as a digital survey.

Africa AHEAD is currently supporting the MOH to shape and use an efficient M&E system that begins with collection of data using a mobile phone platform and also the use of a website where all CHCs can be registered and all their reports submitted, stored and accessible while online. ***See. www.chcahead.org***

The website can be used to access information regarding any CHC across the country and its progress, and Training of Trainers is available from Africa AHEAD for all implementing partners.

Training for CBEHPP includes

- one day introduction,
- 2 day Planning Module for managers,
- 4 day training of trainers on the use of visual aids and CBEHPP manual,
- 2 day practical in the field, a one day training for enumerators on the use of the monitoring tool, and
- one day training for users of the monitoring website. See Appendix XX.

IV.3.3 Variation in cost for implementing CBEHPP

In part due to the differing implementation strategies, development partners report different costs for CBEHPP implementation; see **Table 4.1**.

If the costs received are reliable, the cost per head of population varies from RWF 130 (US$0.19) to RWF 2969 (US$4.36) with an average across the six development partners of RWF 973 (US$1.43). At under US$5 per beneficiary the CBEHPP Model is proving cost effective. N.B. Rate of exchange in April 2015: US$1 = Rwandan Franc 690

Another measure of cost efficiency is per CHC as the variation in size of CHC can effect this efficiency of implementation. The cost per CHC has an average of RWF 324,721 (US$477) and ranges from RWF 52,000 (US$76) to RWF 844,444 (US$1,241); a factor of 16 times. Taking an achievable average of 80 members per CHC it can be estimated that the cost per beneficiary is from US$0.95 to US$15 per CHC Member. If each household is estimated at an

average of 5 people, the cost per beneficiary drops to between 19c and US$3. This is considered cheap by any comparable standards.

SEHO and CHF training costs – Training costs per SEHO varies from RWF 79,683 (US$1,146) to RWF 221,664 (US$ 325); a factor of 3 difference.

Training costs per CHF varies from RWF 6,900 (US$10) to RWF 55,757 (US$81) - a factor eight difference.

Material costs – These vary from RWF 23,733 to RWF 136,710 per CHC with an average across five development partners of RWF 66,958. The material cost of the fourth development partner (RWF 136,710) includes many promotion items as well as printed materials. From the data is seems reasonable to assume a typical material cost of RWF 50,000 (US$ 73) per CHC.

M & E costs – Monitoring costs vary from 6% to 42% of program costs as declared by the six development partners and vary from RWF 3,622 (US$5.32) to RWF 355,556 (US$ 960) per CHC - a factor of 98 times. This reflects differing donor requirements, available funds and reliance on GoR to collect and collate the data.

Allowances – IPs have a variation of allowances which are often used as an incentive for attendance. Some development partners do not give transport allowances for CHF training although a good meal and drink is usually provided.

Cost Type	DP 1	DP 2**	DP 3	DP 4**	DP 5**	DP 6	Av.	Min	Max
Coverage Figures									
Population Covered (Capita)	500,000	4,000	48,501	40,000	757,714	89,602	-	-	-
Number of CHCs	2001	10	129	100	1894	315	-	-	-
Population covered per CHC	250	400	376	400	400	284	**352**	**250**	**400**
Key Costs									
Total Cost (RWF)	114 million	520,000	19.5 million	58 million	507 million	266 million	-	-	-
Cost Per CHC (RWF)	57,072	52,000	151,450	581,670	267,687	844,444	**324,721**	**52,000**	**844,444**
Cost per head of population (RWF)	228	130	403	1,454	669	2,969	**973**	**130**	**2,969**
Other Indicative Cost Components									
Training per SEHO (RWF)	90,526	Does not train	Unknown	133,611	79,683	221,664	**131,371**	**79,683**	**221,664**
Training cost per CHF*** (RWF)	7,008	15,333.33	24,587	6,900	34,417	55,757	**24,000**	**6,900**	**55,757**
Material Cost per CHC (RWF)	23,733	Unknown	Unknown	136,710*	52,500	54,890	**66,958**	**23,733**	**136,710**
M&E Project Cost per CHC (RWF)	3,622	10,000	30,598	64,800	Unknown	355,556	**98,915**	**3,622**	**355,556**
Donor / Supervision Costs (RWF)	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	-	-	-
MOH Costs									
MOH / DEHO coordination	Unknown						-	-	-
MOH Data Collation Summarisation	Unknown						-	-	-

Table 4.1 Summary of Costs of CBEHPP by Different Development Partners

** Includes many promotional items as well as printed materials –*
*** Assumed 80 households as average CHC size and/or 5 people per household. –*
**** Cost per CHF trained. Some DPs train more than 1 CHF per CHC.*

Note – No appraisal of varying CBEHPP program quality has been undertaken, development partner supervision costs are unknown and there are variations in implementation strategies. It is expected that when the forthcoming results of the RCT in Rusizi District are published some objective evaluation will link the RCT findings of Classic and Lite impact to similar levels of implementation to enable a clear picture of the ideal cost effective model to be identified.

V. CBEHPP Challenges and Recommendations

During the workshop and follow up interviews challenges were raised and discussed. In this section and especially in **Table 5.1** and **Table 5.2** those challenges are stated with recommendations, considerations or discussion. Challenges have been summarised into the following categories: GoR leadership and support, development partners, funding and costs, M&E

V.1 Challenges and Recommendations within the Existing CBEHPP Framework

In this section, the focus is to highlight and mitigate the challenges around implementation of CBEHPP in its current form.

CT	Issue	Recommendations
GoR Leadership and Support	MOH providing insufficient CBEHPP monitoring and support.	1. MOH to be more proactive in information gathering, meeting development partners and district officials. 2. MOH to reach and engage at district level by phoning and visiting districts in order to provide a unified Rwandan CBEHPP structure. 3. Add in CBEHPP targets in the Minister of Health's *imihigo*. 4. MOH to coordinate quarterly CBEHPP meetings at national level. 5. Create a Head of CBEHPP role at MOH under the EHD. 6. Create two addition M&E/organisational roles under the head of CBEHPP.
	District leadership support and district leadership often placing greater attention on other activities e.g. water supply.	1. Emphasis the importance of CBEHPP to district governments in disease reduction and achievable health cost burden reduction on the district population. 2. District leadership and district environmental health officer to reach up to MOH. 3. District to convene a meeting of all the Health Centre EHOs quarterly. 4. Consider not implementing CBEHPP in district if mayor is not supportive.
	Village leadership support	1. Attain the village leader's permission before CBEHPP implementation. 2. Consider not implementing CBEHPP if village leader is not supportive.
	CBEHPP monitoring not written environmental health officer's job description.	1. Write CBEHPP monitoring activities in to district and sector environmental health officers' job description.
	MOH gives curative services much more attention than preventive ones	1. Encourage MOH to support preventive actions; emphasising the monetary savings.
	CBEHPP not coordinated with other village programmes.	1. Consider merging activities once the 6 month initial programme is complete.: akagoraba kababyeyi/Umuganda/Savings clubs/Ubudehe/Itorero
Development Partners	Implementing partners not communicating with MOH	1. Attend quarterly SWG meeting chaired by MOH. . At an early stage of program development, development partners should communicate with MOH and receive geographic directed information as per the need of CBEHPP implementation.
	Development partners implementing CBEHPP in order to achieve specific result(s) within CBEHPP and therefore not fully implementing the other CBEHPP elements	1. If development partners are implementing CBEHPP, or part thereof, ***every*** aspect of CBEHPP program should be implemented as a service to the Rwandan people.

CT	Issue	Recommendations
	Different approaches by different partners contrary to the written manual.	1. In communication with MoH a standard approach must be understood by the development partner and implemented.
	Lack of uniformity of training of CHC Facilitators	1. Ensure critical understanding of the manual. Harmonisation of the training 2. Consider organising exchange visits among CHCs and documentation. 3. Use the national core of trainers.
Funding / Costs	Costs of Materials	1. Knowledge sharing between development partners on costs of material. 2. Procure materials centrally and/or have a preferred supplier with economical rates.
	Not enough funding to complete 100% rollout.	1. Consider funding each district hospital to implement CBEHPP in it's own district. 2. Emphasise to donors the value of CBEHPP
	Lack of consistency of funding leads to inconsistent and inefficient CBEHPP rollout.	1. At quarterly CBEHPP meetings, donors to coordinate smooth fiscal support.
M&E	M&E infrastructure.	1. MOH and District Governments/MINALOC to strengthen the monitoring and Evaluation mechanism with an efficient and effective system.
	M&E	1. Request donors to reinforce the M&E structure through supportive staff at ministerial level.
	M&E system and reporting standards	1. Follow CBEHPP Roadmap designated M&E system. 2. Adhere to the use of Household inventory for baseline and endline data collection 2. MOH to consider mandating a small number of indicators that partners monitor and report.
Sustainability	72% of CHCs are not operational There is a lack of specified activities after the 6 month program.	1. During training emphasise the ongoing role of the CHC after the 6 month period during training, as a health forum feeding back health issues to health centres and district . 2. Some groups have continued to operate as cooperatives often with an money earning dimension. Development entry point. 3. Link CBEHPP with Hygiene campaigns, Umuganda and other GoR platforms. 4. Hygiene clubs being viewed as community development entry points.
	Migratory labour miss the CBEHPP program	1. Ensure all households are covered by CBEHPP.
	Development partners providing monetary incentives provides a negative incentive once funding stops.	1. Development partners to implement CBEHPP uniformly without an emphasis on monetary rewards. 2. Follow Rwandan government standard allowance guidelines.
	Threat to local leaders authority.	1. Ensure permission is granted from the village leaders
	CHFs move from time to time	1. Train 3 CHFs per CHC

Table V.1 Challenges, Recommendations and Considerations to the Existing CBEHPP Program

V.2 Challenges in CBEHPP

Several challenges that were highlighted at the CBEHPP workshop that would gently modify the existing CBEHPP program. **Table 4.2** documents these challenges and provides discussion.

Challenges	**Discussion**
Too many topics within CBEHPP	CBEHPP provides a holistic environmental change program. However a some partners want to cut corners because of expense and time. A variation on the classic 20 session of CBEHPP light training suit some NGOs. However this should not be considered until the merits of the classic and the light training in Rusizi have been produced by IPA/Gates which are scientifically evaluating in RCT to measure the impact of CBEHPP on hygiene behaviour.
Produce materials at a low cost and possibly low quality.	If the CHC training materials are to be used for the foreseeable future, their quality cannot be compromised. Costs can be reduced by printing a large quantity or in b/w. However for durability it is important to print on strong card and not economise by using paper.
CHCs in urban areas difficult to implement	Some felt, that if the attention of urban residents is more difficult to hold, a short course could be developed for an urban setting. However experience in Zimbabwe shows that unless there is an emergency such as a cholera outbreak urban CHCs enjoythe sessions as much as th rural counterparts and there is no need to shorten the training.
Turn over of CHWs leads to loss of knowledge and destabilisation of the group	To mitigate this risk 2 subordinates CHFs could also be trained at the same time as a head CHFs or the head CHF could train two subordinates to take over the group during operation.
No specific actions are specified to continue the CHCs after CBEHPP	Incorporate formally into the program a mandatory health objective for the CHC after the 6 month phase of CBEHPP and options for other activities to keep the CHC together.

Table 5.2 Challenges and Discussion that Require Changing the CBEHPP Programme

The following is still outstanding:

Agree on the way forward for increasing support and improve coverage in the number of district and sectors implementing the programme

Agree on the way forward in relation to production of training materials and uniformity in training of trainers and facilitators and monitoring the implementation of the programme

V.3. Way Forward for CBEHPP

CBEHPP implementation is now covering 46% of sectors across Rwanda leaving 54% still to be addressed. Other future activities can be categorised as sector coordination between development partners, sector leadership and funding. There remain methodological gaps between many of the CBEHPP sector actors which need to be harmonised in order that an efficient and sustainable roll out of training is achieved.

V.3 Areas without CBEHPP Implementation

See **Figure 6.1** and **Appendix D** for diagrammatical and table ray data on areas where CBEHPP has not been reported as implemented by development partners at the workshop.

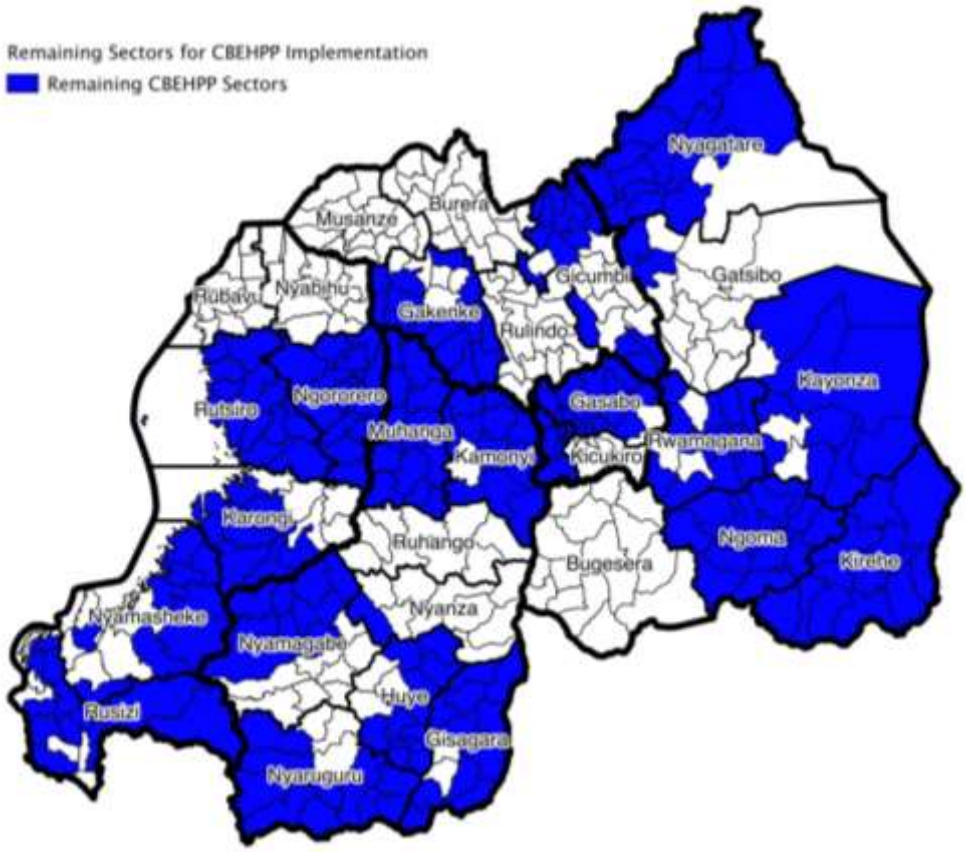

Figure 6.1: Remaining Sectors for CBEHPP Implementation

Table 0.1 Recommended Tranches of Districts for CBEHPP Implementation

V.4 Sector Leadership and Coordination Future Activities

In order to ensure a robust way forward, CBEHPP leadership and coordination needs to be improved. In general there are four categories of stakeholder: MOH, DG and district based government employees, donors/funders and CBEHPP implementers. MOH is the key stakeholder that coordinates other stakeholders and CBEHPP in Rwanda.

V.4.1 MoH

In order for MoH to be proactive in coordination of development partners, district governments and M&E tracking, MoH requires increased capacity above and beyond its current resources. Within the MoH, the Environmental Health Desk (EHD) now led by Alphonsine Mukamunana, is responsible for the implementation of CBEHPP. Due to insufficient staff in this part of MoH, a National Monitoring Officer, seconded to MoH, supported by Africa AHEAD / Gates who is assisting in the MoH specifically with the registration of CHCs and the monitoring of behaviour change within CBEHPP. With the recent reshuffle in MoH, some capacity for CBEHPP has been lost with two officers redeployed, leaving a vacuum and making it difficult for implementing partners to know who to report to for CBEHPP.

Therefore a full time MoH Officer is needed to be specifically in charge of CBEHPP within the EHD to ensure timely monitoring and guidance towards its implementation reaching out to development partners and administrative districts. Currently a full time Monitoring Officer seconded by Africa AHEAD to MoH at Head Office is fulfilling this role but this position will need to be funded by government and become an institutionalised role within MoH.

New Roles within EHD	**Role Responsibilities**
Head of CBEHPP	To lead CBEHPP by coordinating donors, implementers and districts . Ensure that CBEHPP is working optimally to maximise M&E collection and collation. The head is required to coordinate periodic sector meeting and workshops that continue until June 2018.
CBEHPP Officer 1	Kigali based officer to collate M&E data at national level and aid the coordination of sector meetings. Also 25% in the field.
CBEHPP Officer 2	75% field based officer responding to inadequate M&E collection. Meet and provide a link to DEHOs i.e. from national level to district level

Table 8.2 Recommended for New Roles within EHD for CBEHPP

MoH is required to ensure CBEHPP targets are included in the Ministry of Health and all District government *imihigo* before they are published for the period July 2015 to June 2016. The MOH shall organise a one day advocacy event for district mayors and DEHOs and quarterly development partner events for information sharing, progress reporting and challenge airing. Therefore the website which has been undergoing a pilot in Rusizi district should be opened u to all IPs and government so that CBEHPP data can be included in a centralised website under the control of MoH at Head Office. Africa AHEAD will be inducting all partners into the use of the website in the next month.

V.4.2 Development Partners

The development partners have different incentives and constraints when implementing CBEHPP. It is the responsibility of the developments partners to actively communicate with MoH and attend and prepare for MoH's periodic sector meetings.

Development partners are required to work to ensure they implement CBEHPP in it's entirely if they would like to implement any behaviour change program in Rwanda.

V.4.3 M&E

As SEHOs and DEHOs are based in health facilities, MoH shall oversee data collection and national level collation. Development partners as a minimum must work and report to the existing data collection structures.

The job descriptions of the SEHOs and DEHOs and Cell Social Economic Development Officers (CSEDOs) should be revised to include CBEHPP/CHC data collection and collation responsibilities.

V.4.4 CBEHPP Sustainably

Sustainability is the single largest issue when trying to achieve the Health SSP target of 80% operational CHCs by June 2018. Currently beyond the six months of CBEHPP there is not a firm plan of purpose for CHCs. At a national level it is not possible to state in what form a CHC should continue due to individual differing circumstances of each CHC. What can be said however is that the CHC should begin internally discussing the sustainability issue well before the end of the six month CBEHPP implementation period so as to come up with their own plans for sustainability

It is recommended that at a minimum the CHC would continue to be meet to reinforce health behaviours, communally combat health threats for the greater good, and periodically audit CHC member households using the CBEHPP assessment methodology. If additional saving groups or cooperatives can be formed as is already happening in some areas these should be encouraged by implementers without removing the central health activities. Therefore IPs are encouraged to adopt a more holistic and long term support for CHCs and not merely focus on the first phase of health promotion.

According to the AHEAD methodology, upon which CBEHPP is based, training in hygiene promotion is merely the 1st stage in the life of the CHC (see www.africaahead.com) . There is more to be done in successive stages which include Food Agriculture and Nutrition (FAN) as extensively done in Zimbabwe. It is therefore timely to plan the next stage to envisage the way forward after 2018, when all CHCs in every village throughout Rwanda should be fully operational.

V.5 Suggested Schedule

CBEHPP way forward schedule is bounded by the 100% CBEHPP implementation by June 2018. A suggested schedule can be found in **Appendix E**. This schedule can be broken down into three parts: national organisational period, a CBEHPP training rollout period and an M&E period.

V.5.1 National Organisation Period

This period is expected to last ten to eleven months in total. In the first three months and as stated above, MoH is required to increase its capacity by formalising and organising the suggest roles within the EHD. Due to time constraints CBEHPP must be done in tandem.

Following the initial three months and during the next eight months MoH and partners must liaise with districts and development partners aligning them with the needs of CBEHPP 100% national implementation targets.

These eight months do not preclude any CBEHPP implementation being undertaken but it is intended to give some time for large development partners procurement processes. In the same vain, MoH must time the district advocacy day to be the most impactful in terms of program commencement timing.

V.5.2 CBEHPP Rollout Period

The remaining districts and sectors for CBEHPP have been grouped together for large development partners or smaller development partners to group together to choose to

implement. The way forward schedule assumes a period of 28 months for CBEHPP implement which is split into seven month blocks for each of the four districts.

V.5.3 M&E Period

MoH, with its new planned employees, is to provide leadership and impart discipline to the M&E data collection and collation process through the existing structures and through development partner compliance. This period lasts for the entire schedule.

V.6 Budget

As stated above the MoH needs to be ***leading*** the CBEHPP implementation and M&E. The three suggested roles incur additional expense for GoR who already pay for government employees and facilities at national and district level. Therefore is it recommended that a development partner fund these roles for MoH. The detailed budget has been removed since this document shall refer only to workshop proceedings.

Resources

[1] *Improving Hygiene Behaviour of Communities throughout Rwanda*, MOH Environmental Health Desk, November 2009

[2] *Roadmap of CBEHPP*, MOH Environmental Health Desk, January 2010

[3] *Manual for Training of Environmental Health Officers*, MOH Environmental Health Desk, 2011

[4] *Manual for CHC Facilitators and Community Health Workers*, MOH Environmental Health Desk, 2011

[5] *Rwanda Health Statistics Booklet-2013*, Ministry of Health, 2013

[6] *Interviews with key stakeholders*, February 2015

[7] *Third Health Sector Strategic Plan*, Ministry of Health, 2012

[8] *National Policy and Strategy for Water Supply and Sanitation Services*, Ministry of Infrastructure, 2010

Province	District	Number Villages	CHCs Established	CHCs Fully trained	% of CHCs trained	Comment
City of Kigali	GASABO	494	365	6	2%	Under 20%
City of Kigali	KICUKIRO	327	326	326	100%	
City of Kigali	NYARUGENGE	355	342	0	0%	0%
City of Kigali	**Total / Average**	**1176**	**1033**	**332**	**32%**	
East	BUGESERA	581	683	315	46%	Under 50%
East	GATSIBO	606	603	500	83%	
East	KAYONZA	421	424	164	39%	Under 50%
East	KIREHE	612	612	0	0%	0%
East	NGOMA	473	473	0	0%	0%
East	NYAGATARE	629	630	0	0%	0%
East	RWAMAGANA	474	522	474	91%	
East	**Total / Average**	**3796**	**3947**	**1453**	**37%**	
North	BURERA	571	571	571	100%	
North	GAKENKE	617	621	80	13%	Under 20%
North	GICUMBI	630	353	62	18%	Under 20%
North	MUSANZE	432	432	342	79%	
North	RULINDO	494	771	494	64%	
North	**Total / Average**	**2744**	**2748**	**1549**	**56%**	
South	GISAGARA	524	345	0	0%	0%
South	HUYE	508	508	48	9%	Under 20%
South	KAMONYI	317	317	62	20%	Under 50%
South	MUHANGA	331	497	0	0%	0%
South	NYAMAGABE	536	356	152	43%	Under 50%
South	NYANZA	420	420	0	0%	0%
South	NYARUGURU	332	332	124	37%	Under 50%
South	RUHANGO	533	533	118	22%	Under 50%
South	**Total / Average**	**3501**	**3308**	**504**	**15%**	
West	KARONGI	538	619	55	9%	Under 20%
West	NGORORERO	419	243	0	0%	0%
West	NYABIHU	473	513	472	92%	
West	NYAMASHEKE	588	862	292	34%	Under 50%
West	RUBAVU	525	750	525	70%	
West	RUSIZI	596	184	194	105%	
West	RUTSIRO	485	560	0	0%	0%
West	**Total / Average**	**3139**	**3171**	**1538**	**49%**	
Total / Average		**14841**	**14767**	**5376**	**36%**	

Province	District	# Referral Hospitals	Number of District Hospitals	Number of Health Centres
City of Kigali	Gasabo	2	1	16
City of Kigali	Kicukiro	1	1	9
City of Kigali	Nyarugenge	1	1	10
City of Kigali	**Total**	**4**	**3**	**35**
East	Bugesera	0	1	15
East	Gatsibo	0	2	19
East	Kayonza	0	2	14
East	Kirehe	0	1	15
East	Ngoma	0	1	12
East	Nyagatare	0	1	20
East	Rwamagana	0	1	14
East	**Total**	**0**	**9**	**109**
North	Burera	0	1	17
North	Gakenke	0	2	20
North	Gicumbi	0	1	23
North	Musanze	0	1	13
North	Rulindo	0	2	19
North	**Total**	**0**	**7**	**92**
South	Gisagara	0	2	13
South	Huye	1	1	15
South	Kamonyi	0	1	12
South	Muhanga	0	1	15
South	Nyamagabe	0	2	18
South	Nyanza	0	1	15
South	Nyaruguru	0	1	16
South	Ruhango	0	2	14
South	**Total**	**1**	**11**	**118**
West	Karongi	0	3	22
West	Ngororero	0	2	12
West	Nyabihu	0	1	15
West	Nyamasheke	0	2	19
West	Rubavu	0	1	10
West	Rusizi	0	2	16
West	Rutsiro	0	1	17
West	**Total**	**0**	**12**	**111**
Rwanda	**Total**	**5**	**42**	**465**