Community Based Environmental Health Promotion Program

(CBEHPP)

Report of the third National CBEHPP workshop on "sharing experience and learning in the implementation of CBEHPP"

Hotel Umubano, May 25th and 26th, 2017
Kigali, Rwanda

Foreword

This report contents the summary of the shared experience and discussions held during the third national CBEHPP workshop on 25th and 26th in Kigali. The two day workshop gathered institutions involved in the implementation of the CBEHPP program, Districts and hospitals staff, development partners, academic and research organisations and consultants.

During the workshop the status of the implementation of the CBEHPP, lessons learnt and challenges were shared as well as success stories. Research studies results were also presented to the participants to feed into the discussions. Besides, experienced institutions have shared their.

The workshop ended with an agreement on a number of recommendations to be considered in the coming years.

Background

The Ministry of Health launched the CBEHPP in 2009 and invited all development partners to actively support the programme. Appropriate training materials and financial and human recourses have been mobilised towards achieving effective implementation and achievement of the objectives of the CBEHPP in terms of preventative health and national poverty reduction outcomes. So far, the CBEHPP is being implemented through CHC methodology as planned and 95 % of the country is covered. Yet, the program still needs efforts for effectiveness and total coverage of villages and safe practices towards preventative health and national poverty reduction. Two previous National workshops have been held in Muhanga and Kigali in 2012 and 2015 respectively and helped to share progress and experience to shape and motivate for improved implementation and scale up the program. At the moment of the third national workshop, tangible improvements have been made. The functionality of CHCs passed from 12% of fully functional CHCs in 2012 to 42.3 % of fully Dfunctional CHCs in 2017. The involvement of government/ local leaders and development partners in terms of support, funding and research increased tremendously. Thus, this third National workshop on CBEHPP implementation was held with objectives to:

1. Refresh stakeholders on priorities and plans related to CBEHPP and how best Civil Society Organizations and development partners can support the implementation of CBEHPP at district and national level to ensure that we meet national and global targets related to hygiene and sanitation,
2. Discuss progress according to previous recommendations made in the two national workshops on CBEHPP,
3. Exchange amongst stakeholders on what has and what hasn't worked in the implementation of CBEHPP in their respective districts of operation as a basis of learning amongst all stakeholders,
4. Validation of research studies assessing the implementation of CBEHPP in Rulindo and Bugesera districts,
5. Present a new harmonized reporting tool for CBEHPP,
6. Promote a culture of information sharing for accountability, collaboration and learning amongst WASH stakeholders, and
7. Discuss better coordination of multi sector stakeholders for the realization of the challenge and need for collaboration in the achievement of universal access to sustainable hygiene practice

The expected results from the third national CBEHPP workshop include a common and detailed understanding of status of CBEHPP, consensus on a harmonized reporting tool for monitoring CBEHPP and a joint plan/ way forward in addressing discussed issues among different actors and partners.

Workshop proceedings

1. Participants' expectations

The workshop was introduced with the expectations of participants. Participants were asked to highlights their expectations from the workshop. The main points are listed below:

- To learn from participants on CBEHPP implementation;
- To share experience with participants;
- To discuss how to make CBEHPP sustainable;
- To agree on actions points to incorporate in stakeholders plans;
- This workshop being the third national workshop on CBEHPP, to evaluate where we stand now in rolling out CBEHPP a year before 2018.

The participants' expectations coincided with the objectives of the third national workshop.

2. Opening remarks

The representatives of USAID and MoH addressed opening remarks respectively.

The representative of USAID–Nicole Mukunzi, health promotion and WASH specialist, in his opening remarks, said USAID has included CBEHPP in its projects design as an effective and affordable way to reach and support communities in Rwanda. This because, she said, USAID knows the program will be successful. Nicole Mukunzi continued saying that USAID wishes to see more partners engaging in the implementation of CBEHPP with increased collaboration to avoid duplication. Nicole Mukunzi said USAID is pleased to be part of the momentum and confirmed USAID will continue to support the Government of Rwanda efforts.

On behalf of the Minister of Health, Director General of Clinical and Public Services addressed his opening remarks, expressing his pleasure to be present in the workshop organised to and discuss with field stakeholders on how far are we, what should be accelerated, and what should we do to achieve health outcomes. Indeed, he mentioned, health promotion is important to achieve development gaols of Rwanda and to achieve wellbeing of citizens that why CBEHPP was started in 2009 and is being implemented country wide. Therefore, he continued thanking the participants for coming, and thanked partners who supported technically and financially the event as well as CBEHPP implementation. On these remarks, he declared the workshop opened and wished a successful workshop and practical recommendations out of the discussions.

3. Progress according to previous recommendations made in the two national workshops on CBEHPP

On the progress of CBEHPP implementation, World vision, one of pioneers in the implementation of the program presented their achievements/challenges and recommendations. Indeed, World vision has made since 2012 good progress with CHCs in 12 districts and a midterm evaluation is expected in 2017. So far, World vision program created 752 CHCs in 12 districts among them 166 CHCs are still ongoing while 596 CHCs have graduated. 70% of them have been linked with economic activities. In the World vision working zone, the CBEHPP contribution the last 5 years in sanitation claims 60,000 improved latrines constructed. The lessons learnt are that (1) economic activities increasing households income contribute to hygiene and behavior change ;(2) graduation ceremony motivates CHC adherence; and (3) poorest club members must be supported to do some of their homework/recommended practices. For challenges, CBEHPP tools (images/ pictures and training manuals) are expensive to print; and the case of poor households is a serious challenge for improved sanitation practices. As recommendations, World vision stated that village leaders must be among CHC facilitators to yield more results; good monitoring of CHC activities has to ensure 30 CHCs maximum per EHO at health centre per year; and implementers should think of empowering CHC economically. Following the world vision presentation, two questions were raised on how WASH achievements are reducing diarrhea and the contribution of WASH on malnutrition. World vision responded to have details in the main report and promised to share it with participants. The Director General /RBC urged partners to make sure they are able to show progress on WASH process indicators so that we can move a step further on questioning the contribution to nutrition.

4. Exchange amongst stakeholders on what has and what hasn't worked in the implementation of CBEHPP in their respective districts of operation as a basis of learning amongst all stakeholders

A testimony of a CHC member from Bugesera district revealed:

"After being trained as CHC facilitator on 20 topics by Water Aid, I went on to train villages' members. They completed all the topics in her village. They set up a saving group and agreed to buy a cow for each member. And they reached this target. Anyone doubting on the impact of CBEHPP is invited to visit Bugesera to see their achievements."

The main strengths, challenges and recommendations from the experienced participants include:

Strengths

- Monthly monitoring of CBEHPP;
- Involvement of local leaders.

Challenges

- Budget constraint;
- Coordination of the program.

Recommendations

- Establishment of long term investments of CBEHPP;
- Involvement of leaders at all level.

5. Validation of research studies assessing WASH indicators and the implementation of CBEHPP in Gikururiro, Bugesera and Rusizi districts

Four research studies were presented among them one baseline in the Gikuriro working zone (8 districts), 3 research studies on evaluation of CBEHPP in Bugesera and Rusizi, and one RCT study on water filters and stoves. These research studies are focused on assessing WASH indicators and the implementation of CBEHPP.

a. Gikuriro baseline- WASH section by By Collins Lotuk – MEAL Advisor, Gikuriro Program, CRS

Gikuriro is a USAID funded program on integrated Nutrition and WASH and being implemented by CRS in a consortium with SNV for the period 2016-2020. The WASH component of the program focuses on the implementation of CBEHPP in eight districts (Kayonza, Kicukiro, Ngoma, Nyabihu, Nyanza, Nyarugenge, Ruhango and Rwamagana).

A baseline study for Gikuriro program was conducted in October 2016 and the presentation intended to share with the participants the status on WASH indicators for Gikuriro districts. For the baseline data was collected in 6 districts because two other organisations (FXB and caritas) also funded by USAID are conducting the same study in the remaining two districts.

Data was collected in 2,592 households with79% response rate. The results show that 50%of respondents don’t know about Community Health Clubs (CHCs) in their village. Only 14% of respondents knowing about CHC in their village actually participate in CHC

activities. People mentioned that CHC may be initiated by not functioning due to lack of supervision.

Respondents preferred time for listening to radio is evening, while their main source of WASH messages are: Umuganda, local leaders and radio.

Only 25% of households have a handwashing facility located 5m from the toilet. When asked why respondents are not washing their hands, the reasons mentioned are: cannot afford soap, lack of water and no handwashing facility.40% of households take 5mn to 30mn for water fetching in a round trip. The common water treatment method mentioned is for 90% boiling.

Access to improved unshared sanitation facilities is recorded at 52%. The toilets are found in households but they are not improved as expected. In the 2 weeks preceding the survey, 22% of children aged under 5 years had diarrhoea. This was higher than the national diarrhoea prevalence rate of 12%.

Recommendations:
The study recommended the use of radio for education on WASH and hygiene practices, promotion of Behaviour Change Communication (BCC) among health services providers, motivation of CHC members to be active and refine CHC monitoring system.

Additional comments from discussions:
The study didn't consider the sanitation ladder in the assessment. Only presence of toilet was checked, and then classified as improved or unimproved.

There is a package on economic development activities like agriculture and Savings and internal lending Community (SILC) to enable households to access finance and acquire needed WASH facilities. Also, basic materials linked to nutrition will be distributed to vulnerable people under the nutrition component of the program.

The link WASH Nutrition is available in the full report.

b. Assessment of Community Based Environmental Health Promotion Program (CBEHPP) achievements and sustainability in Bugesera District by Theonest Ntakirutimana, Lecturer at University of Rwanda

The objective of this study was to assess achievements of CBEHPP implemented by WaterAid, capture challenges and plan actions for

sustainability. The assessment considered the period from 2010 to 2013.

The study population comprised of 8,223 CHC members, 195 CHWs and 195 heads of villages.

The results of the study showed that90% of head of villages participated in CHCs. Regarding changes brought by CHCs, progress was observed on: drying racks, toilets, handwashing facilities, boiling of drinking water, shelter for shower. In many villages, apart from the changes mentioned above, evening meetings on hygiene are now being organised. The study also reported the creation of tontines where members support each other on buying materials. It also reinforced community cohesion.

120 CHCs out of 195 fully implemented the CBEHPP recommended practices. For those who didn't apply the practices; lack of time, neglecting of the CHCs, and lack of follow up where mentioned as reasons. CHCs facilitators' difficulties in interpreting pictures cards were assessed as part of the study. 40% of facilitators said it was difficult to interpret the pictures.

To improve the CHCs activities the members suggested some actions: organisation of study tours, motivations like rewarding local leaders, engagement of local leaders in CHC.

Challenges reported by the respondents are: lack of transport and communication for CHC committee, villages where access to drinking water is still a challenge, lack of knowledge of committee members.

For sustainability of CHCs respondents also recommended to incorporate mandatory Village Savings and Lending Associations (VSLA) after 6 months activities, and to lobby for more engagement from districts.

Recommendations:
The researcher recommended that there is a need to invest more resources in communities, and further to conduct a research on the impact of CBEHPP on health.

Addition comments from discussions

During the research the team eliminated all confounders. Statistical methods were used to remove other aspects that may influence the results of CHC.

The negligence as indicated in the paper referred to the people knowing the importance of the safe practices but don't practice.

The facilitators mentioned materials they need including boots, umbrella, t-shirt in their work.
The saving groups are the best way to keep incentives in the group and this mechanism has shown good results in Bugesera.

The DG Clinical Services and Public Health encouraged partners to focus on the CBEHPP 7 golden indicators advised when evaluating the CBEHPP results, the aspects on saving groups being secondary and should come after the core targets are met.

c. Impact of community health clubs on child diarrhoea, nutritional status, and water quality in western Rwanda by Innovations for Poverty Action (IPA) research team

This presentation showed the results of a survey aiming at evaluating the impact of CHC on health. Data was collected in 2013 as baseline and in 2015 for the end line.

Baseline (2013): 8,734 households with 13,252 under five children in 150 villages.

End line (2015): 7,934 households with10,000 under five children in the same 150 villages. The percentage of households surveyed at the baseline that was re-enrolled at the end line was 91%.

For both surveys, the team used structural survey tools, observation of households' latrines and handwashing stations, anthropometric measures, and water sampling in 10% of households.

The results consist of comparison of the baseline and end line data among communities part of CHC activities and those who are not. The results shows this:

Do CHC improve respondent knowledge: When scored on WASH questions, people members of CHC groups don't do better than people in villages without a CHC.

There was no difference in diarrheal diseases, in stunting and wasting between groups members of CHC or not. There is also no difference on faecal contamination of drinking water at household level in the study population whether the household participated in CHC or not. In terms of WASH classic indicators there was no significant improvement difference between the two different groups of households.

Improvement on 2 indicators: treating water at home and using improved sanitation facilities that can be attributed to the interventions.

Is it possible that people participating more in the CHC meetings benefit more than others: The average attendance sessions was 9.5 sessions for the study population. There was no difference between people attending all sessions and those attending only average number of sessions.

Limitations of the study

The study carries potential bias in self-reported data for key variables.

Conclusion

- No impact on any main or secondary health outcomes was observed in this study;
- Other studies show that improvement in WASH behaviour doesn't have impact on health/ diarrhoea. The results of this study are therefore quite consistent with similar studies in India, Bangladesh and Kenya.

Impact of CHC on Social capital

The results also showed that there was no significant difference in term of social group efforts in improving WASH; in water access for instance. In the use of the group to improve roads, the difference was also not significant.

Recommendations and way forwards

- Identify and overcome the barriers that adversely impact implementation of CHCs;
- Consider possible additions to CHC curriculum based on findings from studies and literature review:
    - Alternative behaviour change approaches, particularly for handwashing that do not rely on information provision (example of SuperAmma campaign in India);
    - Consider access to water filters;
    - Address management of animal faeces.
- Continue to work with all stakeholders to develop an agreed set of objectives and verifiable indicators that can be used to assess impact of the program on environmental exposure. (eg: water quality testing, hygiene and sanitation monitoring as per WHO SDGs standard);
- Standardisation of CBEHPP monitoring.

Additional comments from discussions

Because the study was looking at exposure at point of consumption, it was not necessary to test water at the source.

It is possible that CBEHPP had an impact but the study concluded with 95% confidence that this difference cannot be measured.

The study was conducted in Rusizi because Rusizi district was the place where the WASH situation was worse.

The process of domestication of SDGs is done under MINICOFIN leadership. This concern is already captured. The rest is to find means to get to those goals.

Evaluation of the impact of the program
In the roadmap of CBEHPP it was more about scaling up the program. No timeline for impact assessment was set. Nevertheless, all small studies conducted by implementers will inform enough MoH to decide on to go for impact assessment or not.

d. Effectiveness of the Community Hygiene Club approach in Rwanda - Rusizi district by Africa AHEAD

Can community health clubs change hygiene behaviour in developing countries? Reflections on the findings of a randomized control in Rusizi district, Rwanda.

Africa Ahead presented the results of a research on continuous monitoring of outcomes of CHCs in Rusizi district. The monitoring used the households CHC membership cards and the household inventory to assess the changes at household level. Some key results from the results are mentioned below:

Regarding community mobilization, the measured average number of members per CHC is 80, for a duration of training of about 16 weeks on average. The study found that the CHC coverage in a village is 65% (of households) on average.

On the outcome indicators, the study reported that access to improved water source increased from 55% to 81% in 2015. The treatment of drinking water in CHC households increased from 37% to 87% in one year, then to 91% in three years. Access to improved sanitation moved from 6% to 13% in three years period. Zero Open defection in CHC households (covering squat hole) increased from 37% to 68% in three years period. Sanitary disposal of children stools moved from 97% to 99%. The use of handwashing facility (step and wash) was increased from 3% to 77%.

Additional comments from discussions

Director General from MoH mentioned that the discussions following the two presentations should focus on constructive perspectives. And not build on contradictory statements from the two studies presented.

Lessons learnt from other countries and the biggest challenge in the implementation of CBEHPP in Rusizi?

In other countries Community based programs are mainly implemented by NGOs without coordination from Ministries. But the best way so far seems to be the Rwandan approach where the Ministry of Health owns the program and coordinates with NGOs.

e. RCT study on water filters and stoves By Tom from IPA

LifeStraw is 18,000litres filter (3year use for a family of 5) that was distributed in western province for the sake of the study. Filters and stoves were distributed free of charge by MoH/DelAlgua. The use of filters by households resulted in improvements on diarrhoea in the area of the project. The filters coverage and use was evaluated at 77%and 40% reduction in caregivers reported diarrhoea was measured as outcome. What it tells is that water is making people sick and we need to do something about that.

A sub-study of longer term performance (month 19-24 after intervention) showed that 19-24 months after the distribution of filters:

- 84.5% were working;
- 86% of working filters contained water;
- And sensors confirmed that half of households with working filter filled them at least once every other day.

Additional comments from discussions

What was the cost of the filter? And how much all the implementation would cost?

A LifeStraw filter costs between 20 and 25 US dollars. The presenter does know what it takes to get them to community level. But adding filters as options to existing program would just cost the unit cost of the filter.

The cost of 25 dollars for filter may be expensive for rural poor household. Otherwise the technology is very interesting and can solve water problems.

Distributing filters to households should go with supportive measures. Like hygiene of cups and other hygiene measures to make it more effective.

6. Priorities and plans related to CBEHPP and how best Civil Society Organizations and development partners can support the implementation of CBEHPP at district and national level to ensure that we meet national and global targets related to hygiene and sanitation

The priorities and plans were presented and given for discussion among stakeholders and partners and include:

a. Review the CBEHPP reporting tool to make it simple for use at each level,
b. How do we improve the coordination and collaboration at various level (village, sector, district, and MoH),
c. How to harmonize improvement of CBEHPP implementation (materials, time, same standard for training),
d. Sustainability and ownership (role of local government for CBEHPP management at all levels: how do we do it, turnover of ASOCs at village level),
e. Menstrual hygiene & wash for disabled (how it can be implemented and how to include in CBEHPP modules).

These points were discussed in the world coffee group discussions and participants presented their contributions at the end of the workshop in plenary session (Annex...)

7. New harmonized Monitoring and reporting tools for CBEHPP, culture of information sharing for accountability, collaboration and learning amongst WASH stakeholders

As part of the priorities of the program, the CBEHPP monitoring and reporting templates to be used by all districts were presented and worked on. Indeed, the program is being implemented by many institutions across the country and it came up that comparing results from different implementers is challenging because the monitoring tools used are different. Therefore the environmental health desk of

MoH had tasked a core team to work on the harmonisation of the reporting tools. From the core team, three formats were shared with participants among them the CHC monthly report, the sector level CHC activities monthly report, and the household inventory. The CBEHPP monitoring and reporting templates to be used by all districts were worked on during the world coffee group discussions and details are part of the annex 2. On this, the DG clinical services and public health mentioned the tools should be tested while discussions for final harmonised version of the reporting tools are ongoing. The DG clinical services and public health and DG RBC agreed to consult and come up with conclusions on the monitoring and reporting tools.

8. Coordination of multi sector stakeholders for the achievement of universal access to sustainable hygiene practice

This point was also discussed on during the world coffee group discussion (Annex 1) and main 4 points were agreed on.

a. Proposal of coordinator at each level

- Village level: Village leader, ASOC, Health Worker (to lead specific sessions on diseases);
- Cell level: In Charge of Social Economic Development Officer;
- Sector level: Executive Secretary, In Charge of Sanitation and Health Officer (SAHO)/In Charge of Social Affairs/Environmental Health Officer;
- District level: District V/S ASOC, District Hygiene and Sanitation Officer/DH Environmental Health Officer;
- Central level: MoH/MINALOC/MININFRA/MINEDUC/MIGEPROF/MIDIMAR (social cluster)/WASH Steering Committee and Technical Working group.

b. Collaboration and reporting

- Village: CHC: Weekly meeting
- Cell: Monthly meeting
- Sector: Monthly report
- District: Quarterly report
- National level: Quarterly report

c. Joint supervision

- Cell: Weekly basis
- Sector: monthly basis
- District: Quarterly basis
- National level: Quarterly basis

d. Flow of reporting

- Village leaders → Cells level SEDO → Sanitation and Hygiene Officer → District Hygiene and Sanitation Officer → MINALOC with Copy to MoH.

9. The National sanitation policy and its implementation strategy

A representative from MININFRA presented the new sanitation policy to the audience. The sanitation challenges identified in Rwanda are among others: the lack of improved sanitation facilities, the limitations in excreta disposal, constraints in management of flooding, and sanitation technologies are not affordable for all.

The policy vision is to ensure equitable and affordable access to safe sanitation and waste management services for all Rwandan.

The policy is developed around objectives and there are key policy statements under each objective. Each policy statement has indicators and targets. The main areas of focus found in the policy are: collective sanitation, storm water management, solid waste management, e-waste, industrial waste, nuclear waste, and health-care waste.

Responsibilities in the policy design shows that MoH with MININFRA and MINALOC are responsible for the implementation of individual and collective sanitation.

The policy is currently at the phase of dissemination at provincial and district level. A policy implementation plan will be drafted and finalised with stakeholders inputs. MININFRA invites all partners to join efforts in the implementation of the policy.

Additional Comments from discussions

It is of an added value if banks can be part of the momentum, this will be discussed at ministry level. The sanitation centres are also a good idea that can be considered.

Workshop recommendations

The Head of EHD presented the background and recommendations from fist and second CBEHPP workshop. She also presented the progress on implementation of the previous CBEHPP workshops 2012/2015. She finally shared with the participants the main recommendations that came out of the two days' workshop. The workshop recommendations are:

- Review of CBEHPP roadmap and incorporate menstrual hygiene and WASH for disabled people in the training manual;

- Finalise CHC monthly report tools;
- Work on better coordination and collaboration between implementing partners;
- Involve more the local leaders in the implementation;
- Organise regular annual CBEHPP workshops to assess progress and conduct quarterly coordination meetings;
- MoH to draft action plan to implement the recommendations of the workshop.

Closing remarks

The Bill and Melinda Gates Foundation - WASH program manager was the first to express his good impression from the two day workshop. He appreciated the information with a lot of evidences of success of the approach shared. "It is encouraging", he said, to see that the ministry is still seeing the program as the way to go and looking forward to see recommendations from the workshop to be incorporated into the future of the program.

The USAID - Health promotion and WASH specialist, recognised the meeting was energizing. She expressed her hope the recommendations will guide MoH and local leaders to be involved. The USAID representative concluded she wishes to see more coordination in the future.

The Permanent secretary Jean Pierre Nyemazi in his closing remarks reminded the participants that hygiene and sanitation is a top priority for MoH and the country development vision. He continued saying MoH is currently developing the Health Sector strategic plan 4, looking at what will make a difference with other strategic plans. Emphasis, said the PS, will eventually be on health promotion as priority before clinical care. The WASH sector, he declared, will consequently have a critical role and need to position itself to contribute.

The PS appreciated the work done so far and the work being done on field currently. He hopes failures were shared next to the best practices. He further thanked USAID, Gates Foundation, UNICEF, Africa AHEAD, ADRA and all partners involved in the CBEHPP program as well as the local governments' efforts.

This being the 3rd CBEHPP workshop, the PS said he was keen to see how far the implementing agencies have gone in implementing the recommendations of last workshops. He urged the stakeholders to be organised and coordinated much better, paying attention to the hygiene and sanitation policy to see where we should put more

efforts. He continued saying that partners should look at the design of the intervention to see how it is providing value for money. The PS appreciated all partners working with population and villages, because that's where we have to build sustainability, both at design and implementation stages. It is important to go back and make results simple for people to see, appreciate and give feedbacks, he recommended.

The PS promised the MoH to continue supporting partners to have an enabling and conducive working environment and requested timely evaluation to make sure we are having results. He finally thanked participants for their time, ideas and recommendations and called for agreement to translate recommendation into actions. No too much effort into evaluation issues and theoretical debates are needed, he reminded participants, the impact will be seen through reduction of infectious diseases.

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