REPUBLIC OF RWANDA

MINISTRY OF HEALTH

ROADMAP FOR COMMUNITY-BASED ENVIRONMENTAL HEALTH PROMOTION PROGRAM

Revised March 2020

USAID
FROM THE AMERICAN PEOPLE

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ACRONYMS

CBEHPP : Community-Based Environmental Health Promotion Program
CEHO : Community and Environmental Health Officer
CHC : Community Hygiene Club
CHDS : Community Health Dialogue Session
CHW : Community Health Worker
CHSO : Community Health and Sanitation Office
CRS : Catholic Relief Service
DHS : Demographic and Health Survey
DoHU : Director of Health Unit
DPHPO : Disease Prevention and Health Promotion Officer
DSCs : District Sanitation Centres
EHO : Environmental Health Officer
LODA : Local Administrative Entities Development Agency
MINALOC : Ministry of Local Administration
MINEMA : Ministry In charge of Emergency Management
MININFRA : Ministry of Infrastructure
MoH : Ministry of Health
NECDP : National Early Childhood Development Program
NGO : Non-Governmental Organization
NST I : National Strategy for Transformation I
PWD : Person with Disability
RCA : Rwanda Cooperative Agency
RDB : Rwanda Development Board
SAHO : Sanitation and Hygiene Officer
SCs : Sanitation Centres
SEDO : Social Economic and Development Officer
SFH : Society for Family Health
SHC : School Hygiene Club
SILC : Savings and Internal Lending Communities
SNV : Netherland Development Organization
ToT : Training of Trainers
UNICEF : United Nations International Children's Emergency Fund
USAID : United States Agency for International Development
VSLA : Village Saving and Lending Association
WASH : Water, Sanitation, and Hygiene
WHO : World Health Organization

FOREWORD

Millions of people around the world die every year from preventable diseases caused by unhealthy environments. Rwanda's 2015 Health Sector Policy reports that 90% of consultations at the rural health facilities include diarrhea, malaria, acute respiratory infections, skin diseases, tuberculosis, typhus, cholera, and intestinal parasites, diseases that can be prevented through improved hygiene at the personal, domestic, and community levels.

The Community-Based Environmental Health Promotion Program (CBEHPP) was established in 2009 and remains one of the Ministry of Health's key interventions to decrease the burden of diseases related to the environment. The goal of the program is to improve community health by reducing disease burden related to inadequate sanitation, poor hygiene practices, and drinking unclean water, through comprehensive participatory environmental health dialogues and actions in schools and communities.

Because of the many global and national changes that have occurred in the last decade, the original CBEHPP roadmap has been revised to reflect the current situation. Critical components in the review and revision of this roadmap include the Sustainable Development Goals (SDGs) targets such as target (3, 6, 11, 13, and 15), Rwanda's National Strategy for Transformation 1 (NST1), Rwandan Vision 2050, and the adoption of cultural structures to support community governance.

The Ministry of Health would like to recognize and appreciate the following institutions and the team that worked tirelessly to review and improve the CBEHPP Roadmap, training manuals and dialogue kits, notably RBC/RHCC, USAID, WHO, CRS, SNV, UNICEF, Water Aid, Water for People, NECDP, Ministry of Environment, MINEMA, University of Rwanda, World Vision, and SFH. Special gratitude to USAID, CRS, and SNV for the financial support during this exercise.

Dr. NGAMIJE M. Daniel
Minister of Health

DEFINITIONS OF KEY TERMS

Basic Sanitation: Use of improved facilities which are not shared with other households (JMP).

Basic Hygiene: Availability of a handwashing facility on premises with soap and water (JMP).

Certification: The official confirmation and recognition of the completion of CHC session clusters.

Community Hygiene Club (CHC): Community based clubs comprised of Isibos that are used to conduct community health dialogue sessions (CHDS) as part of CBEHPP.

Community Health Dialogue Sessions (CHDS): A promotion session delivered by an elected facilitator to Isibo from the CHC in a particular village around a defined sanitation and hygiene topic from the CBEHPP curriculum.

District Sanitation Center (DSC): A district level center to showcase sanitation and hygiene products and services for the public to purchase (National Sanitation Policy Implementation Strategy, 2016).

Environmental Health: Aspects of human health that include quality of life, which is determined by physical, biological, social, and psychological factors in the environment. It also refers to the theory and practice of assessing, correcting, controlling, and preventing those factors in the environment that can adversely affect the health of present and future generations (WHO, 1948).

Hygiene: Conditions and practices that help to maintain health and prevent the spread of disease. (WHO, 2018b).

Isibo: A Kinyarwanda term defined as a group of 15 to 20 neighboring households in a village (NIC, 2018).

Limited Hygiene: Availability of a handwashing facility on premises without soap and water (JMP).

Limited Sanitation: Use of improved facilities shared between two or more households (JMP).

Peri-Urban: A geographical area between consolidated urban and rural areas (UNICEF, 2012).

Rural: A geographical area that is located outside of towns and cities. A typical rural area has a low population density and small settlements. (Dijkstra and Poelman, 2014).

Sanitation: Sanitation generally refers to the provision of facilities and services for the safe disposal of human urine and feces. Sanitation also refers to the maintenance of hygienic conditions, through services such as garbage collection and wastewater disposal (WHO, 2018).

School Hygiene Club (SHC): Pupil-led clubs providing pupils with a forum to learn about hygiene and sanitation and to tackle community environmental health issues.

Unimproved Sanitation: Use of pit latrines without a slab or platform, hanging latrines, or bucket latrines (JMP).

Urban: A human settlement with a high population density and the infrastructure of a built environment (UNICEF, 2012).

Verification: The process of confirming the successful implementation of homework as agreed upon during the dialogue sessions, using the CHC membership card as a tool for verification.

INTRODUCTION

Globally, avoidable environmental risks account for one quarter of all deaths and morbidity, causing over 13 million deaths each year (WHO, 2019). ARIs, pneumonia, and other preventable diseases are among the top 10 causes of morbidity and mortality, while high levels of malnutrition and parasitic diseases such as amoebic dysentery are frequently reported amongst infants and children (WHO, 2018a)making cities a bedrock for healthy lifestyles-as well as climate-friendly and resilient. WHO's new Urban Health Initiative provides a model for the health sector to contribute to healthy urban planning and policies. A \"health-centric\" approach to planning and development Health is a city's most important asset. Yet most of the 3.5 billion people living in cities-half of humanity-suffer from inadequate housing and transport, poor sanitation and waste management, and air quality failing WHO guidelines. Pollution and congestion, shifts from fresh to processed foods, and a dearth of space for walking, cycling and exercise also combine to make cities epicentres of the NCD epidemic and drivers of climate change. As most future urban growth will take place in developing cities , urban expansion needs to be planned from the \"ground up\" to make cities centres of health and well-being-with durable housing in accessible neighbourhoods, efficient energy and transit networks, robust water, waste and sanitation systems, and ample green spaces-preventing disease and protecting the climate. WHO's new Urban Health Initiative creates a paradigm shift in health systems approaches by focusing on urban environment that is the prerequisite for healthy lifestyles-and disease prevention. The initiative builds a new cadre of health policy leadership positioned to assess and advocate for development that leads to healthier, greener and cleaner cities. This contributes to attainment of a range of SDG goals and the New Urban Agenda of Habitat III. Major impacts on health, development and climate Most of the top ten causes of death (2015. The underlying causes of these diseases are related to poor hygiene and sanitation infrastructure and practices, contaminated food and water, poor control of disease vectors and vermin, and contaminated environments resulting from inadequate solid and liquid waste management (Bruné Drisse and Musngi-Anouar, 2016).

Rwanda's 2015 Health Sector Policy shows that infectious diseases are the primary causes of outpatient morbidity in health centers. Acute Respiratory Infections (ARIs) and malaria account for more than half of the outpatient morbidity (61.9%), largely as a result of environmental health-related conditions (Rwanda Ministry of Health, 2015)as set out in Vision 2020 and the Economic\\r\\nDevelopment and Poverty Reduction Strategy (EDPRS II 2013-2018.

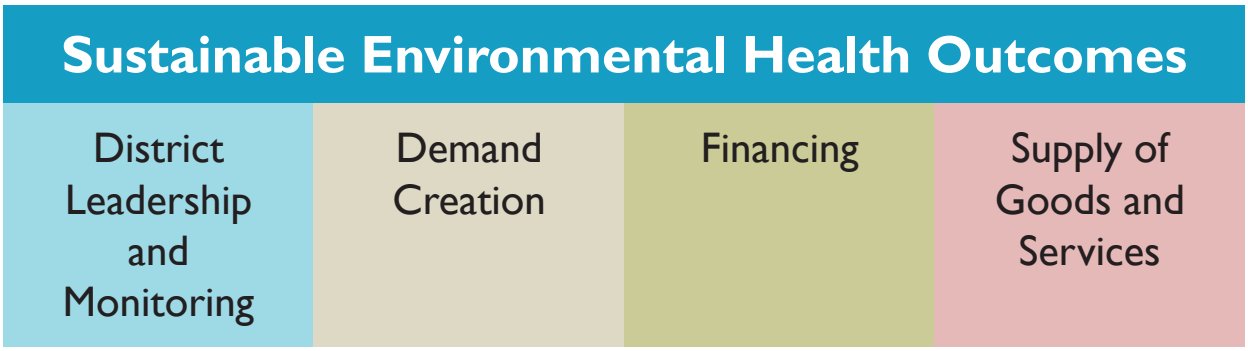
The 2016-17 Integrated Household Living Conditions Survey report indicates that while 87% of households have access to an improved source of drinking water within 500m of the house; only 44% of households use an appropriate treatment method prior to drinking[1]. While 86% of households have access to an improved latrine, only 66% of households have basic sanitation –

[1] Rwanda Demographic Health Survey, 2016-17.

their own improved latrine[2]. According to the 2014-15 Rwanda Demographic Health Survey, 12% of households in Rwanda have a place for handwashing; of these only 37% of places are equipped with both water and soap, equating to only 4.3% of households in Rwanda being equipped to enable the practice of handwashing with soap. Profound improvements in environmental health conditions and behaviours are essential to improve the health and well-being of all people in Rwanda.

While many development outcomes and goals require specialized strategies in only one sector and with one methodology, environmental health requires an integrated series of strategies that span different ministerial partners to achieve sustainable outcomes. There is need to ensure that improvements consider the range of strategies to bring about change in behaviour, infrastructure, and operation and maintenance, while reaching all levels of society, especially the most vulnerable. In 2019 the Environmental Health and Health Promotion Technical Working Group collaborated to define the critical components to achieve and sustain the Ministry of Health's targeted environmental health outcomes.

The resulting framework identifies four key pillars deemed critical to achieve and sustain the targeted environmental health outcomes:



1. **District Leadership and Monitoring.** Leading, coordinating, and monitoring the implementation interventions and systems by district authorities to improve environmental health outcomes.
2. **Community-Based Promotion.** Improving knowledge and attitudes and creating demand for environmental health behaviours.
3. **Supply of Goods and Services.** Strengthening chains of supply so that households can access the affordable products that they desire.
4. **Finance.** Ensuring financing is available to implement interventions and systems needed for environmental health as well as financing the supply of goods and services to households, especially vulnerable households.

[2] The Fifth Integrated Household Living Conditions Survey (EICV5), 2016-17.

Background of the CBEHPP

In 2009 the Community-Based Environmental Health Promotion Program (CBEHPP) was developed as an" approach to reach out to all communities and empower them to identify their personal and domestic hygiene and environmental health related problems (including safe drinking water and improved sanitation), to actively participate in the solving the problem." The program was introduced to Rwanda in 2010 to mobilize communities to adopt hygiene behaviours with the aim of reducing the national disease burden, thus contributing to the improved health of the population.

CBEHPP strengthens the capacity of village facilitators to use the Community Hygiene Club (CHC) participatory methodology to guide and mobilize households towards hygiene and sanitation transformation for sustainable targeted environmental health outcomes. The Community Hygiene Club methodology triggers and supports households to adopt key behaviours to improve the environmental health of both the home and the community. At the village level, this approach will be facilitated and managed by Community Health Workers (CHWs), who the Ministry of Health has trained in environmental health. In turn, the CHWs will be supported and mentored by the Community and Environmental Health Officers (CEHOs), who are critically important and active at all levels of decentralization.

Rationale for the CBEHPP Revision

The Ministry of Health has laid out environmental health strategies and devised innovations to contribute to the wellbeing of the general population. According to the Health Sector Strategic Plan IV, the prevalence of diarrheal diseases will be reduced to 9% by 2024 (Health, 2018). Rwanda's 2015 Health Sector Policy asserts that the CBEHPP will be scaled up and implemented nationwide to augment efforts in the promotion of good hygiene and sanitation.

The CBEHPP was launched in 2009 with the aim of facilitating WASH-related implementation towards Millennium Development Goals (MDGs) and Economic Development Poverty Reduction Strategy (EDPRSI) targets. In response to global and national development progress and transformation, the CBEHPP Roadmap, training manual, and toolkit was reviewed to result in this revised roadmap. During the review of CBEHPP one of the critical sustainability issues identified was that the program was not tethered to any government systems or structures, thus when NGO support concluded the CHCs were no longer supported and subsequently became nonfunctional. This revision provides governance structures for the delivery and monitoring of the program, which will hopefully optimize sustainability of the community dialogues, monitoring of environmental health outcomes, and practice of targeted behaviours.

CBEHPP VISION, MISSION, AND OBJECTIVES

This revised CBEHPP Roadmap 2020-2025 presents the vision, objectives, essential components, and implementation methodology required to foster and sustain targeted environmental health behaviours. It builds on the collective work and expertise of government and partners using available information to develop the agreed strategies and methodology. From the start of this activity, the Technical Working Group and other interested stakeholders were invested in the development of a tool for improved national environmental health.

The result is a living roadmap and action plan that should evolve through collaboration and learning. It is a tool that should draw partners together to collaborate under common approaches towards shared objectives.

Vision

A nation in which people have the knowledge, skills, goods and services, agency, and finance to practice targeted environmental health behaviours that will lead towards an environment that fosters health and well-being.

Mission

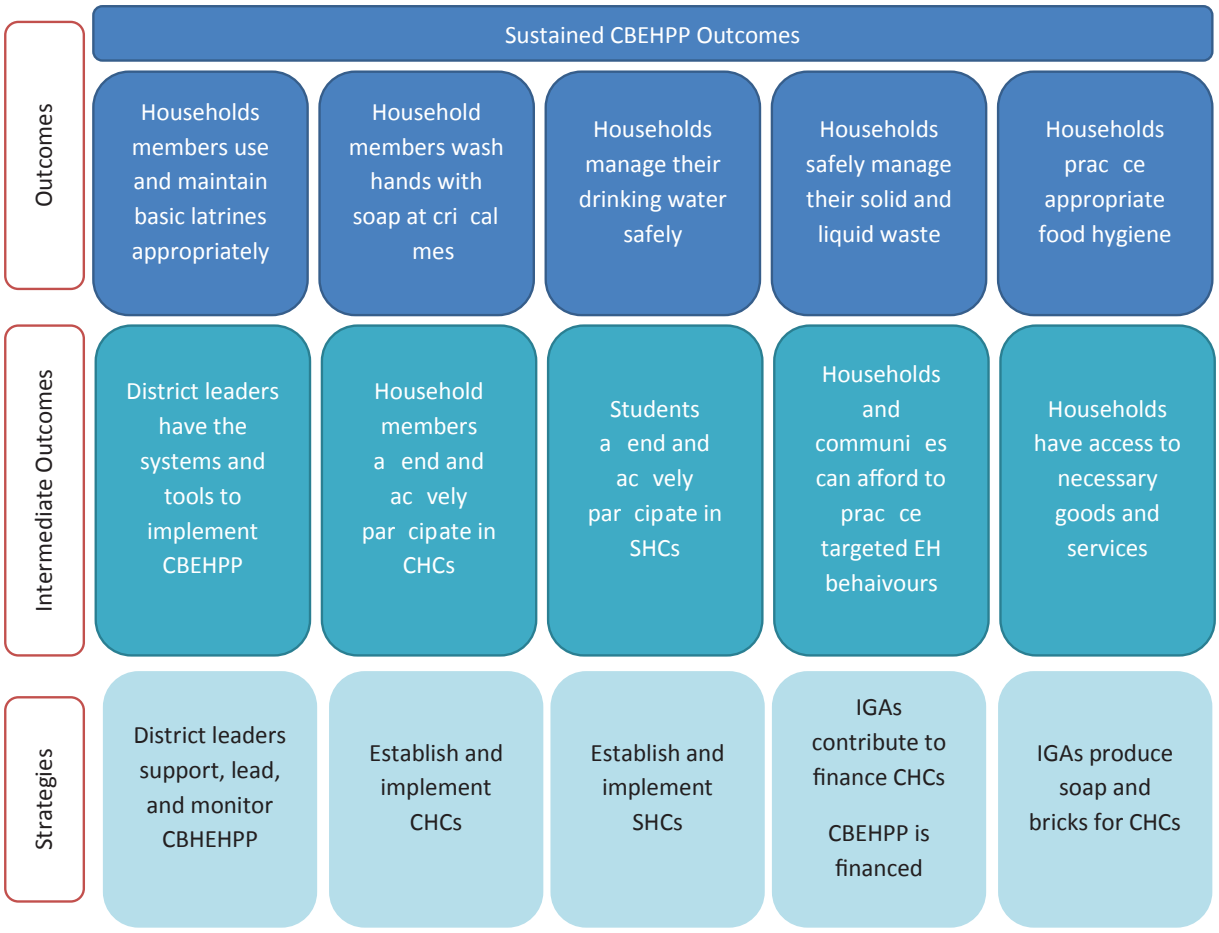
To enhance the sustainable functionality of CHCs, to promote hygiene and sanitation behavioral changes for the wellbeing of individuals and communities through improved CBEHPP governance, community-based promotion, and monitoring mechanisms.

CBEHPP Main Objectives

1. To empower all members of communities with knowledge and skills in relation to water, sanitation and hygiene practices leading to sustainable positive behavioral changes at the community and household levels.
2. To achieve equitable access and use of household basic latrines for all people in all villages in Rwanda.
3. To achieve equitable access and use of household handwashing facilities with soap and water for all people in all villages in Rwanda.
4. To promote hygienic behaviours, including safe household water management, proper food hygiene practices, informed and supported menstrual hygiene management (MHM), and safe management of solid, liquid and animal wastes.
5. To promote inclusion in CBEHPP implementation and in WASH outcomes.

CBEHPP IMPLEMENTATION FRAMEWORK

The resulting CBEHPP Implementation Framework is based on the Environmental Health Framework and employs strategies, which can be implemented at the community level, for each of the four pillars to achieve environmental health outcomes. However, complementary sector wide strategies are required to ensure that environmental health outcomes are achieved through CBEHPP are sustained.



Implementation of the CBEHPP Framework

To effectively influence household engagement for sustainable environmental health outcomes at scale requires integrated strategies throughout and beyond environmental health implementing partners. The Roadmap brings together institutions from government, civil society, and private sector engaged in environmental health related activities in order to establish coherence, pool resources and promote coordination and collaboration. The general oversight and overall policy guidance and steering of the Roadmap should be led by the Ministry of Health and its Health Promotion and Environmental Health Technical Working Group.

ROLES AND RESPONSIBILITIES FOR THE IMPLEMENTATION OF THE FRAMEWORK	
Stakeholder	**Roles and responsibilities**
Central Level: Provides overall guidance for the management of CBEHPP and ensures annual planning and budgeting for all components of the Framework.	
Ministry of Health	▪ Coordinates and oversees the program implementation ▪ Plans and finances technical support of the program ▪ Organizes Training of Trainers workshops and oversees cascading of CBEHPP training at all levels ▪ Program quality assurance ▪ Monitors progress and reports on the achievements of CBEHPP
Ministry of Local Government	▪ Ensures management and implementation of CBEHPP at the district and local levels ▪ Includes CBEHPP in District Performance Contract ▪ Ensures CBEHPP budget inclusion in district's overall budget ▪ Reports and monitors the progress of CBEHPP implementation
Ministry of Infrastructure	▪ Leads water and sanitation infrastructure sector ▪ Advocates for capital investment required to ensure access to water and sanitation services
Ministry of Education	▪ Responsible for implementation of SHC ▪ Ensures provision of WASH supplies in schools ▪ Reviews and integrates SHC education curriculum
Ministry of Trade and Industry	▪ Facilitates and supports engagement of private sector that promotes supply chain of WASH products and services
MINECOFIN	▪ Allocates funds at national and district levels for implementation of WASH activities
MIGEPROF /NECDP	▪ Ensures that targeted environmental health behaviours are promoted through early childhood development activities ▪ Prioritizes funding and planning for critical environmental health infrastructure when planning and resource centers

Development partners	▪ Provide technical, financial, and implementation support
Local Administrative Entities Development Agency	▪ To contribute to sensitizing population and building their capacities in analyzing and solving WASH problems ▪ Facilitates engagement of local government entities in WASH services
Rwanda Development Board	▪ Facilitates engagement of private sector that promotes supply chain of WASH products and services. ▪ Supports private sector in creating business that promotes sanitation marketing
Rwanda Cooperative Agency	▪ Assisting Community Health Worker cooperatives strengthen their capacity through trainings and seminars
District & Sector Level: Provides oversight and technical guidance for the implementation **Cell Level: Coordinates the implementation of CHCs, competitions, verifications, and reporting**	
CHC Coordinator (Head of Village)	▪ Establish of village CHCs and registration of members ▪ Identify CHDS Facilitators ▪ Attend CHC Executive Committee meetings ▪ Approve and sign CHC reports
CHC Executive Committee	▪ Manage overall implementation of CBEHPP at the village level ▪ Organize and conduct verifications certify household completion of homework ▪ Approval of CHC reports prior to submission to Head of Village
CHC Supervisor (CHW)	▪ Coordinate CBEHPP activities at village ▪ Assist Head of Village with establishing CHC ▪ Supervise and support CHDS facilitators ▪ Conduct home visits to check completion of the homework ▪ Compile reports from CHC Session Facilitators ▪ Participate in CHC verification achievements ▪ Attend CHC Executive Committee meetings
CHDS Treasurer	▪ Ensure safety of CHC financial savings ▪ Report on financial status to CHC Executive Committee on monthly basis

CHDS Facilitator	▪ Facilitate CHDSs ▪ Follow up on homework, in collaboration with CHC Executive Committee ▪ Sign membership cards ▪ Prepare CHC reports
CHC Members	▪ Attend and actively participate in CHC sessions. ▪ Timely implementation and completion of the assigned homework. ▪ Share acquired knowledge from CHC sessions with all family members. ▪ Encourage other village members to join CHC sessions. ▪ Participate in planned CHC competitions. ▪ Cooperate in CHC performance evaluations.

In order to implement the four core pillars of the CBEHPP roadmap, it is important to ensure that there are sufficient resources, systems, and capacity. For each of the four pillars the Ministry of Health and partners will have to learn, share, and coordinate to ensure that a common approach is being implemented across different partners, districts, and pillars. Currently each of the pillars is at different levels of development, with an evidence-based model for **District Leadership and Monitoring**, an implementation and training guide for **Community-Based Promotion**, and recommended actions for developing the **Financing** and **Supply** components of the CBEHPP framework.

Roadmap Implementation Plan

Milestone Events	2020				2021				2022				2023				2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
District Leadership and Monitoring																				
Development of guide to integrate district leadership and monitoring into the orientations and trainings																				
National Workshop to introduce new roadmap																				
Community Based Promotion																				
Design, Production and Distribution of Tools																				
District and Sector Level Orientations																				
Trainings																				
Implementation of using tools																				
Financing																				
Workshop to explore existing systems & mechanisms for financing vulnerable HHs to improve EH																				
Supply																				
Environmental Health supply market analysis																				
Working Group – Approach to supply strengthing																				
Evaluations																				

1. District Leadership and Monitoring

By positioning district and local authorities as the leaders in engaging communities in environmental health improvements, while leveraging a range of activities and diverse stakeholders, we can achieve sustainable change in behaviour, improved facilities, and operation and maintenance, that reaches all levels of society.

The Government of Rwanda has adopted traditional values, such as volunteerism, unity, selflessness, and responsibility and community channels, like umuganda and isibo, as tools for development. This use of cultural values and channels provides an effective platform to leverage district and local authorities to mobilize community leaders and households to initiate efforts to improve household sanitation. With District and Local Authority leading and monitoring community change, a far greater number of people in a much shorter amount of time can be mobilized, than through the implementation of projects that are only community based.

The key components of district leadership that are essential to sustainable environmental health outcomes include:

- **VISION.** Building a common vision for improving household and community environmental health that actively engages everyone, including district leaders, private sector, community leaders and members, including women, children and people with disabilities. The District Authority has the influence to rally district stakeholders together around common environmental health targets and approaches to achieving those targets.

- **COORDINATION.** Ensuring that the CBEHPP components are being supported, implemented, and reviewed appropriately to maximize the sustained uptake of desired behaviours. Regular district reviews will provide leaders with an opportunity to adapt and support the program for the biggest impact.

- **HOUSEHOLD AND COMMUNITY MOBILIZATION.**
  Mobilizing households to build/upgrade hygienic latrines and handwashing facilities through existing district and community channels and events. Community-Based Promotion, which will be addressed in the next section, will reinforce District Authority mobilization efforts with interpersonal communication through the CHCs, which should maximize the uptake of sustained practice of targeted behaviours.

- **MONITORING.** Monitoring sanitation and hygiene improvement progress and verifying community achievement of 100% household coverage of hygienic latrines and handwashing facilities with soap and water. Existing district monitoring systems, complemented by the CBEHPP monitoring, will provide District Authorities with sufficient evidence for prioritization, planning of district support and budgeting.

Action Points

- Develop an implementation guide and subsequent training manual to support district and local authorities in leading their communities towards improved environmental health behaviours.
- Hold a national workshop to share roadmap and tools with district authorities and partners, providing an opportunity to link financial and technical support to districts that are committed.
- Advocate to ensure that funds are included in annual budgets and plans for the implementation of CBEHPP.
- Establish standard district meeting mechanisms to review and advise on CBEHPP progress, providing a system for reporting resulting action plans to the national level.

2. Community-Based Promotion

Promoting change through Rural Community Hygiene Clubs

1. National Level

Identifying Districts. The Ministry of Health, in collaboration with the Ministry of Local Government and the Ministry of Infrastructure, identifies the districts for CBEHPP implementation.

The Ministry of Health conducts orientation meetings with district officials on the new CBEHPP training modules and dialogue tools.

Training Implementors. The Ministry of Health will nominate and establish a national team of CBEHPP Master Trainers and be responsible for certifying each member of the team as a Master Trainer. The Ministry of Health will provide refresher trainings for the Master team as needed.

2. Partners

CBEHPP implementing partners will support the program through the provision of required funds and technical expertise. Partners implementing CBEHPP will coordinate with the Ministry of Health to define implementation plans and agree upon budgets.

Partner Principles for Implementing CBEHPP

- **District-wide approach.** If this is not possible cover administrative areas like sectors and focus on one district.
- **Capacity.** Prioritize building district and local capacity of authorities to implement CBEHPP.
- **Community Directed.** Environmental health problems should be identified and solved by households and CHCs themselves.

3. District Level

Management. The District Authorities are responsible for establishing, overseeing, and monitoring CBEHPP. Monitoring of the CBEHPP implementation and progress should be shared and discussed at regular district meetings.

4. Training.

District. The Master Team trains the District Sanitation and Hygiene Officer (SAHO), District Hospital Environmental Health Officer (EHO) and the Disease Prevention and Health Promotion Officer (DPHPO) in the CHC methodology, who in turn cascades the training down to the sector level by training the Health Center Environmental Health Officer (CEHO), the In-Charge of Social Affairs.

Sector Level. The sector team cascades the training down to the cell level and trains CHWs, Social Economic Development Officer (SEDO), Heads of Villages, and CHC facilitators in their catchment areas. The sector level team has the responsibility of ensuring that the cell level implementors are equipped with the capacity to implement the program.

Cell Level – Village Level. The trained team at the cell level will facilitate one- to two-hour community dialogues through the village CHCs once every two weeks over a 12-month period, using participatory techniques. The homework given to the CHC members accumulates to create model homesteads that enables household member to practice good hygienic behaviours.

5. Community Hygiene Clubs

Community Hygiene Dialogue Sessions

CHC members will attend a one-to-two hour dialogue session twice a month. The dialogue sessions will be conducted by the elected and trained CHDS facilitator. The CHDS facilitator will introduce the topics, using picture cards and the dialogue tool kit, as described in the CBEHPP training manual. During the CHDS, CHC members will be given priority to exhaustively share their views in regards to the present topic. This means that CHDS facilitators will talk less than CHC members, ultimately allowing the CHC members to devise solutions to their problems.

CHC Registration

CHC coordinator will call for a village meeting to introduce the CBEHPP and to mobilize the households to register for CHCs. However, joining the CHCs will be voluntary. The village Head will ensure that the community understands the purpose and advantages of the program, and the Head of Village will use opinions and religious leaders to continue mobilizing and encouraging the community members to register for CHCs. A registered CHC member will be given a membership card and be directed to attend the CHDS as well as implement the given homework.

At the end of each dialogue session, all CHC members will be given homework related to the topic covered. Each time a CHC member attends a CHDS, the membership card is signed by the facilitator of that session. The CHC Executive Committee is responsible for following up on the implementation of homework assigned after the dialogue sessions and signs off on the membership card after verifying successful completion of the homework.

CHC Executive Committee

- The committee is comprised of: Head of Village (Coordinator), a CHW (Chairperson), and Village Social Affairs (Executive Secretary).
- Meets once a month to review progress in implementing the CHCs.
- The CHDS facilitators must be present to ensure the harmonized and successful implementation of the CBEHPP, guided by the revised training manual.
- On quarterly basis the CHC executive committee will call together village CHC members for a meeting.

Topics per Membership Card

No	Topic	Date	Signature	Homework	Signature
CLUSTER 1: DISEASES					
1	Prevalent diseases/ conditions			• Identify preventable, prevalent diseases/ conditions in the *Isibo* catchment area.	
2	Diarrheal disease transmission and prevention			• Install hand washing facilities. • Provide soap and water at handwashing facilities.	
3	Intestinal parasites/worms			• Wear shoes to protect from hookworms.	
4	Skin diseases			• Keep body and clothes clean.	
5	Respiratory tract infections			• Ensure adequate ventilation and use of improved cook stoves.	

6	Malaria			• Clean bushes around homes. • Drain out stagnant water near homes. • Use treated mosquito nets.	
CLUSTER 2: WATER AND SANITATION					
7	Water point Sources			• Maintain water point source.	
8	Household treatment of drinking water, storage and proper usage			• Treat drinking water. • Store drinking water in clean and properly covered containers.	
9	Sanitation ladder			• Construct and improve household latrines. • Identify and report any Open Defecation practice in the village.	
10	Waste management			• Provide rubbish pits and ensure waste segregation. • Provide controlled wastewater pits. • Generate one liter of compost.	
CLUSTER 3: HYGIENE					
11	Personal hygiene			• Construct a bathing shelter.	
12	Handwashing			• Install handwashing facilities. • Provide soap and water at handwashing facilities.	

13	MHM			• Educate adolescents on MHM. • Households make sanitary pads.	
14	Baby WASH			• Use clean potty and diapers. • Make clean mats for a child to play on.	
15	Food hygiene and safety			• Install a utensil drying rack.	
CLUSTER 4: INCOME GENERATION FOR WASH ACTIVITIES					
16	Income-generating activities			• Join and contribute to income-generating activities. • Invest in sanitation and hygiene products and services.	
CLUSTER 5: WASH INCLUSION					
17	WASH and disability			• Provide PWD-friendly WASH facilities.	
18	Role of gender in WASH promotion			• Involve men in CHC activities.	
CLUSTER 6: ECOHEALTH					
19	Indoor air pollution			• Construct kitchens with ventilators • Use improved cooking stoves.	
20	Disasters and emergencies			• Create a community resilient plan for disasters and emergencies.	

The back of this CHC Membership Card has the name and number of each CHC member, village, etc.

Ministry of Health

Community-Based Environmental Health Promotion Program

Province	District	Sector	Cell	Village	CHC	Household

NAME OF CHC:

PRINCIPAL MEMBER:

DEPUTY MEMBER:

PROVINCE:

DISTRICT:

SECTOR:

CELL:

VILLAGE:

STARTING DATE:

DATE OF COMPLETION:

Monitoring and Evaluation

The CHC Executive Committee, together with the respective CHDS facilitator, is responsible for ensuring that CHC activities are monitored in each household and for observing the implementation of the homework by way of house-to-house visits. The CHC Executive Committee will provide guidance around any homework that households are struggling to achieve. Upon achievement of all homework in a CHC, lessons learnt around the implementation will be documented by the CHW and CHDS Facilitator.

CHCs are also charged with conducting quarterly household inventories to track progress and sustainability of the uptake of key environmental health outcomes. The Ministry of Health, in collaboration with the development partners, will develop a digital monitoring mechanism to track these environmental health outcomes. In addition, mid-term (two years) and end-line (five years) evaluations will be conducted for future revision of the CBEHPP.

Reporting of CHC Activities

CHDS facilitators will submit progress reports to the CHC Coordinator (Head of Village), who will compile and send them to SEDO at the cell level. The reports will be sent to the Executive Secretary at the sector level and CEHO at the Health Center for compilation and analysis. The Head of Health Center will send it to the district hospital, and the EHO will compile and analyze the reports and send it to the Ministry of Health. The Executive Secretary of the Sector will send the reports to the district for compilation and analysis. The district will then send the report to Ministry of Local Government (MINALOC).

Verification, Certification, and Celebration

Verification of outcomes, certification, and re-verification are major components of the CBEHPP. They are methods used for assessing the achievements, quality, and sustainability of hygiene practices.

1. **Meeting with the CHC Executive Committee.** The SEDO, CEHO, and Partner WASH Officer will organize a meeting with the CHC Executive Committee to agree on the plan and indicators for verifying CBEHPP achievements. The CHC Supervisor, in collaboration with CHC Session Facilitators, will be requested to prepare a list of members to be verified.

2. **Village Evaluation.** The CHC Executive Committee is divided into groups and assigned households to conduct internal household verifications using the following tools and methods:

    - Membership cards
    - Community transect walk
    - Observations to check CBEHPP homework outcomes, especially improved latrines, handwashing facilities, and safe drinking water storage

Based on the verification results, the CHC Supervisor will prepare a report and request, signed by the Head of the Village, to the Cell Executive Secretary for a CHC certification and celebration.

3. Notifying the Sector Authority. After review of documentation, the Cell Executive Secretary informs the Sector and Health Center that the CHC in village X is ready to be verified for celebration. The verification should be conducted within one week of the request.

4. CHC Verification (Level 1 - Sector). The sector team—comprised of the SEDO, the CEHO, the SAHO at the sector level, and PWD representatives—holds a meeting to respond to the verification request from the Cell Executive Secretary. The CHC coordinator should be notified within three working days about this exercise. The team will meet with CHC members in their usual CHDS sites and check membership cards. Afterwards, the team will visit 30% of the households (randomly selected) to assess compliance. The team will then compile a report and share feedback with the CHC members and district. If the CHC attains the expected criteria for celebration, the district will request to conduct the same evaluation.

Minimum criteria for Verification:

- 80% minimum active members
- Household members have access to an improved latrine
- Absence of feces near latrine and in compound
- Presence of handwashing facility with water and soap in the compound
- Presence of clean kitchen
- Presence of clean container for storage of drinking water
- Clean compound
- Presence of drying rack and line
- Presence of bath shelter

5. CHC Verification (Level 2 - District). The district level team—led by the office of the Vice Mayor of Social Affairs (comprised of the Director of Health, the SAHO, the DPHPO, the EHO, and the Partner WASH Officer)—conducts the Level 2 verification.

Similarly, the CHC is notified within three working days about this exercise. The team visits 20% of the (randomly selected) households—which are different from the Level 1 households—and checks membership cards and verifies the implementation of homework. On behalf of the team, the EHO compiles a report and sends it to the Vice Mayor of Social Affairs, who in turn denies or grants a celebration of CBEHPP achievements. The CHC will be eligible for celebration only if all of the randomly selected households have implemented 100% of the homework and maintained the recommended practices detailed in the training manual.

6. Celebration. For CHCs fulfilling 100% of the criteria, the district, in collaboration with development partners, will be awarded a certificate and provided a celebration. CHC members from other communities will be invited to this ceremony in order to hold the celebrating CHC accountable for sustaining its sanitation and hygiene improvements as well as to model the CHC

achievements to the visiting CHC members. The district will invite high government officials, including the Ministry of Health, governors, and other development partners, to participate in the ceremony. Details of CHC certification, including a checklist, are available as separate documents. Celebration at this level is used as a tool to continue motivating the CHC to sustain and continue to improve its hygiene and sanitation practices.

Promoting change through Urban and Peri-urban Community Hygiene Clubs

Urban and Peri-urban CHCs

Rwanda's population has drastically grown in the past twenty years and now has one of the highest population densities in Africa. This rapid growth has resulted in expanded urban and peri-urban areas, which face emerging environmental health problems and challenges in reaching target populations with community health programs. In densely populated urban areas, crowding prevents the construction of basic sanitation and obstructs critical services to manage waste. Crowding combined with poor waste management also threatens the quality of ground water, increases exposure to vermin, and fosters vectors that transmit new diseases. In addition, air quality is often lower in urban environments, which contributes to chronic respiratory issues. CHCs can still mobilize households to improve environmental health practices, but the CHC dialogues must be adapted to addressed the issues that are relevant to the urban / peri-urban situation.

In urban and peri-urban areas social constructs are also significantly different. Careers that require leaving the home five days a week during standard work hours are more prevalent and will conflict with programs that are implemented during those times. Attendance at CHCs in urban and peri-urban areas has been found to be lower than that in rural areas. In response to this, the new revised CBEHPP roadmap must also incorporate strategies to best reach the target population with relevant urban / peri-urban CHC topics.

Action Points

- Conduct a review to identify and assess existing Rwandan structures / systems for providing financial support to vulnerable households.
- Conduct a working group to explore the following issues:
    - Evidence about the existence and performance of national and global environmental health financing options for private sector and community members;
    - Possible intervention mechanisms and systems (both existing and theoretical) for financial/government institutions in sanitation financing; and
    - Models for environmental health financing options.
- Advocacy to ensure that relevant ministries are planning and budgeting to support CBEHPP and community environmental health improvements.
- Develop a guide for CHC implementation of Income Generating Activities.

3. Financing

The Need. In Rwanda over half of households still do not use an appropriate treatment method before drinking, 34% of households still do not have their own improved latrine[3] and 95% of households do not have facilities established in their homes to wash their hands with soap and water[4]. While some of this can be attributed to lack of knowledge or attitudes, poverty cannot be ignored as a barrier to improving environmental health practices. 38% of the country is categorized as living in poverty, 16% in extreme poverty[5]. While the world has declared the use of improved water sources, improved latrines, and handwashing facilities a right, for these households the practice of targeted environmental health behaviours is a luxury, which they can often not afford.

Pro-poor Environmental Health Financing. Rwanda has established strong systems for identifying and supporting vulnerable households. Rwanda should be capitalizing upon existing systems to channel financial support, whether through targeted subsidies or direct provision of supplies, to vulnerable households. For this to happen the Ministry of Health will have to collaborate with ministries engaged in vulnerable household support to ensure that all people in Rwanda can afford to practice desired environmental health behaviours.

Running costs of CBEHPP. In addition to establishing pro-poor systems to ensure that all people in Rwanda can access and afford the supplies needed to practice targeted environmental health behaviours, financing CBEHPP is essential. Finances at the national level are required to enable monitoring and technical support for quality assurance of CBEHPP. And at the district level, finances are needed for training, implementation, monitoring, verification, and celebrations.

Community-based Income Generating Activities. CHCs can also facilitate Income Generating Activities to raise funds to support household and community environmental health improvements. The income generated will help CHC members access loans for buying sanitation and hygiene products and services. CHC decisions to use the income for rehabilitation/reconstruction of WASH facilities and supporting vulnerable families will enhance the sustainability of the CBEHPP. Income Generating Activities can also be targeted to produce environmental health related items like soap and bricks that communities and households can purchase to build latrines and practice handwashing with soap.

[3] EICV5, 2016-17.
[4] RDHS, 2016-17.
[5] EICV5, 2016-17

4. Supply of Goods and Services

In order to achieve environmental health targets and support the people of Rwanda to practice desired behaviours it is essential to strengthen the delivery system to not only provide access materials and services, but to also provide the required technical guidance for the effective use. Community members need easy access to a consistent choice of products that are affordable and desired.

Currently there are a number of partners who are working with the private sector to introduce sanitation innovations and products, as well as to make access of these products easier for communities.

However, these efforts are localized and project based, thus Rwanda has not seen private sector take up the reins for supplying sector and cell level outlets with environmental health products and services at scale across the country. For this to happen the sector must jointly review of current approaches and agree on a suite of approaches that can be prioritized by government and partners to build a sustainable chain of supply.

Supply Innovations

District Sanitation Centers. Establishment of district level centers to feature sanitation and hygiene products, which community members can visit for inspiration and guidance around improvements that they can make on their household sanitation and hygiene infrastructure.

Cell Level Outlets. Private sector outlets are increasing the supply of sanitation and hygiene products at the cell level because of the demand that households are expressing.

Latrine Options. Various options for latrine slabs, including the Satopan, cement slabs, and plank slabs are being introduced by different partners throughout the country.

Water Filters and Clean Cookstoves. New technologies have been introduced and are now being trialed and assessed for consumer desirability.

Action Points

- Hold a joint review of partner and government work with private sector on environmental health product and service chain supply to explore:
    - Supply chains and barriers in reaching rural communities
    - Existing supply support mechanisms and their effectiveness
    - Existing sanitation supply and innovations and consumer demand
- Agree on a suite of approaches that sector partners will unite around scaling out.
- Create an Ministry of Health led working group to lead the prioritization of the creation of a sustainable supply chain.

Sustainability of CBEHPP

The sustainability of the CHC dialogues is contingent upon effectively resourcing the existing government structures to implement and monitor the program as indicated in this roadmap. The Ministry of Health is fortunate to have a district, sector, cell, and village-based structures and positions that can appropriately execute responsibilities that are critical for the implementation of the program. Incorporating CBEHPP into district authority mechanisms and systems, budgeting processes, performance contracts, and Human Security monitoring will optimize the sustainability of the program.

The continuous process of monitoring and verifying CBEHPP achievements will inform local leaders to identify gaps and then plan actions to address them, as well as hold CHCs accountable for the achievements that they have made through CBEHPP. The CHC Executive Committee, facilitators, and CHW all play a key role in ensuring that environmental health outcomes are monitored regularly and that feedback is provided to households and communities to trigger actions for further improvements.

The Ministry of Health recognizes that CBEHPP is just one tool – albeit a critical one – aimed at improving the environmental health of Rwanda. To enable and sustain environmental health outcome, a number of strategies that address the four main pillars of the Environmental Health Framework are needed, not only at the community level, but at from the national level down to the community level. As districts and partners plan to implement CBEHPP they should also consider complementary strategies that will contribute to long term sustainable environmental health outcomes.

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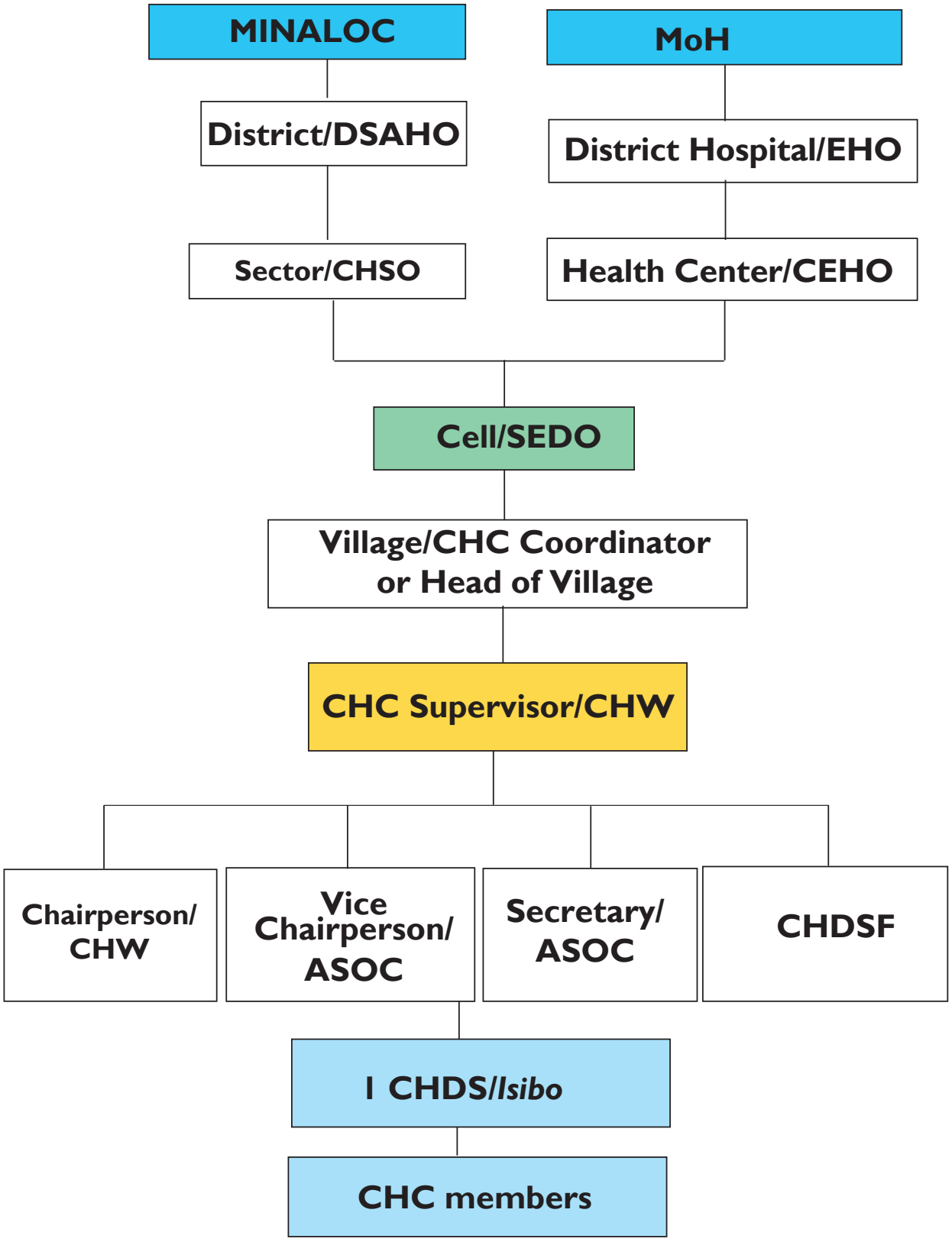
ANNEXES

CBEHPP Organogram



Reporting Templates

REPUBLIC OF RWANDA

MINISTRY OF HEALTH

REPORT FORMAT OF COMMUNITY HYGIENE CLUB COMPILATION AT HEALTH CENTER LEVEL

IDENTIFICATION

1 Name of Health Center.....

2 Sector.....

3 Total Number of Households.....

4 Total Population.....

Number of Men..... Number of women.....

5 Number of Household Members of CHC.....

6 Household Members Registered in CHC:

Men..... Women.....

1	**Topics covered per month (Following CHC membership card)**	2	1
2	**Attendance**		
2.1	Number of men who attended dialogue sessions		
2.2	Number of women who attended dialogue sessions		
2.3	Number of households that attended dialogue sessions		
3	**Homework covered**	2	1
3.1	Number of homework assignments provided this month		
3.2	**Implementation of homework**		
3.3	Number of households that implemented homework		
3.4	Number of latrines that meet basic standards		
3.5	Number of bathrooms that meet basic standards		

3.6	Number of households with tip tap *Kandagirukarabe*		
3.7	Number of households with handwashing facilities with water and soap		
3.8	Number of households with non-functional handwashing facilities		
3.9	Number of households with drying racks		
3.10	Number of households with kitchen for gardens		
3.11	Number of households with waste pits (biodegradable and non-biodegradable)		
3.12	Number of households with clothing racks		
3.13	Number of households that use drinking water treatment methods		
	PUR/PG&Sur eau		
	Filtration		
	Boiling		
4	**Saving**		
4.1	Number of CHCs that have started income-generating activities		
	Social capital		
4.2	Number of households insured in CBHI		
4.3	Number of households given mattresses per the "Dusasirane program"		
4.4	Number of households given iron sheets		
5	**Household supervision**		
5.1	Number of households visited this month		

Challenges met:

Suggestions:

Name and signature of CEHO:

Name and signature of Head of Health Center:

Name and signature of Secretary Executive:

REPUBLIC OF RWANDA

MINISTRY OF HEALTH

REPORT FORMAT OF COMMUNITY HYGIENE CLUB COMPILATION AT VILLAGE LEVEL

	IDENTIFICATION	
1	Name of Village…… Name of CHC……..	
2	Cell…… Sector…..…..…	
3	Total number of households……	
4	Total population.....	
	Number of men……..	Number of women ……
5	Number of household members of CHC.....	
6	Households members registered in CHC:	
	Men..... Women.....	
1	**Topics covered per month (Following CHC membership card)**	
2	**Attendance**	
2.1	Number of men who attended dialogue sessions	
2.2	Number of women who attended dialogue sessions	
2.3	Number of households that attended dialogue sessions	
3	**Homework covered**	
3.1	Number of homework assignments provided this month	
3.2	Implementation of homework	
3.3	Number of households that implemented homework	
3.4	Number of latrines that meet basic standards	
3.5	Number of bathrooms that meet basic standards	
3.6	Number of households with tip tap *Kandagirukarabe*	
3.7	Number of households with handwashing facilities with water and soap	
3.8	Number of households with non-functional handwashing facilities	

3.9	Number of households with drying racks
3.10	Number of households with kitchen gardens
3.11	Number of households with waste pits (biodegradable and non-biodegradable)
3.12	Number of households with clothing racks
3.13	Number of households that use drinking water treatment methods
	PUR/PG&Sur eau
	Filtration
	Boiling
4	**Saving**
4.1	Number of CHCs that have started income-generating activities
4.2	Number of households insured in CBHI
4.3	Number of households given mattresses per the "Dusasirane program"
5	**Household supervision**
5.1	Number of households visited this month

Challenges met:

Suggestions:

CBEHPP M&E Framework - Revised

Suggested Revision

S/N	Objective	Indicators	Baseline	Target for 2024	Means of Verification	Responsibility	Assumptions
1	To empower communities through sustainable and positive behavioral changes regarding improved sanitation and hygiene practices at the household level	% of villages that have a CHC					Baseline and target are available for this.
		% of fully functional CHCs	43.5% (Ministry of Health, 2018)	100%			There is a standard for measuring functionality of CHCs and a system for monitoring
		% of CHCs that have at least one member who visited DSCs and sector outlets in a year	Not available	50%			There are tools and a system for tracking who visits the DSCs
	To increase household access and use of basic hygienic latrines in all villages.	% of HHs that have access to basic sanitation	62% (JMP, 2017)	100%			Change to EIVC data.
		Open Defecation-Free (ODF) communities	98% (JMP)	100%			This may not be relevant for Rwanda.
		% of HHs that properly dispose of children's feces (Reported)	88% (RDHS, 2015)	100%			There is a system for monitoring this
		% of sectors that have an outlet with sanitation and hygiene products	Not available	50%			

	To increase household access and use of handwashing facilities with soap and water.	% of HH with a handwashing facilities with soap and water	4.3% (RDHS, 2015)	20%			
	To promote hygienic behaviours, including 1) safe household water management, 2) proper food hygiene practices, 3) informed and supported menstrual hygiene management (MHM), and 4) safe management of solid, liquid and animal wastes.	% of households that treat of water prior to drinking	44% (RDHS, 2015)	70%			
	To promote inclusion in CBEHPP implementation and in WASH outcomes	% of CHC households with a person with a mobility disability who can access the latrine by themselves	n/a	100%			Monitoring systems can capture this.