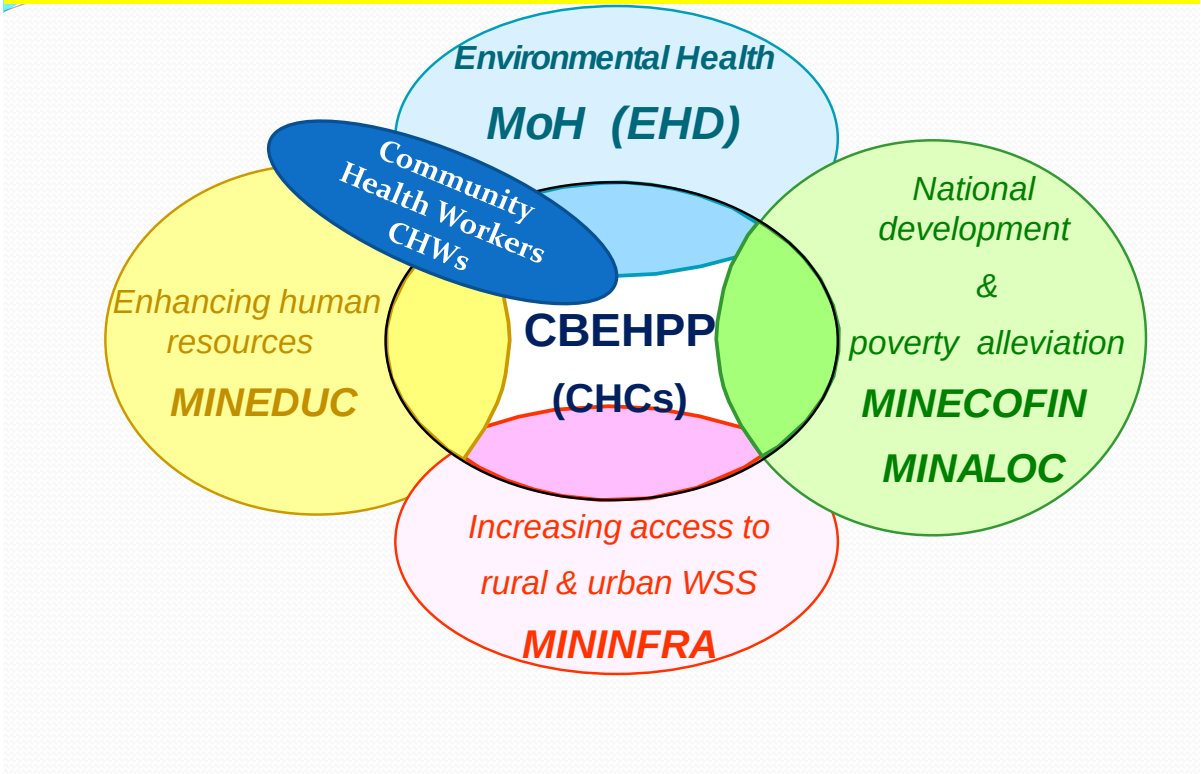
REPUBLIC OF RWANDA

MINISTRY OF HEALTH
Environmental Health Desk

COMMUNITY-BASED ENVIRONMENTAL HEALTH PROMOTION PROGRAMME (CBEHPP)



ROADMAP for CBEHPP

OCTOBER 2009

What is CBEHPP?

The Government of Rwanda, through the Ministry of Health, is launching the **Community-Based Environmental Health Promotion Programme (CBEHPP)**. The purpose of this programme is to significantly reduce, by 2012, the debilitating national disease burden that currently exists and, in so doing, will contribute significantly to poverty reduction outcomes. CBEHPP will strengthen the capacity of all 45,000 Community Health Workers (CHWs) through the adoption of the holistic **Community Hygiene Club (CHC)** methodology as a means to rapidly achieve hygiene behaviour change that is both sustainable and cost effective.

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

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

Whilst safe water can reduce diarrhoea by 15%, health promotion can reduce diarrhoea by 35% and frequent hand-washing with soap is estimated to reduce diarrhoea by 47% (Curtis & Cairncross, 2003). It is for this reason that health promotion is now considered an indispensible aspect of every water and sanitation programme. Without this vital component of hygiene behaviour change, W&S programmes inevitably fail in their enormous potential to improve the health and welfare of the nation and opportunities and resources are unnecessarily wasted. CBEHPP is adopting the CHC approach that is well proven to empower communities, especially the women, to take responsibility for village-level operation, maintenance and management (VLOMM) of rural water facilities like hand-pumps, protected springs and piped supplies, thus ensuring their long-term sustainability. CBEHPP thus complements the efforts of **MININFRA** to provide safe drinking water and sanitation.

Why is CBEHPP also vitally important to Local Government?

CBEHPP provides a practical opportunity for **MINALOC** to achieve greater inter-ministerial and inter-sectoral collaboration at the district and sub-district levels that will result in increased synergies through efficient mobilisation and use of existing human and material resources. CBEHPP focuses on basic development right down at the level of the family and the CHC approach has been proven to strengthen social capital and build trust and cohesion within communities.

How will CBEHPP be implemented?

The implementation strategy is through strengthening the capacity of all 45,000 Community Health Workers (CHWs) under close mentoring and supervision by Environmental Health Officers (EHOs) who are based at Health Centres. The CHWs will facilitate formation of Community Hygiene Clubs (CHCs) in every village in order to achieve practical hygiene behaviour change in every homestead. Institutions (schools, clinics and prisons) will be especially targeted under this programme that seeks to change hygiene behaviours and place Environmental Health firmly on Rwanda's Development Agenda.

(Refer **APPENDIX 1 : Detailed Implementation Strategy**, page 7)

What is the Community Hygiene Club (CHC) Approach?

The CHC Approach appeals to an innate need for health knowledge, which is then reinforced by peer pressure to conform to communally accepted standards of hygiene, thereby creating a ***'Culture of Health'***. The CHC Approach addresses a wide range of preventable diseases within an holistic framework of development that understands health promotion as

an entry point into a long term process of transformation of social norms and values that ultimately leads to poverty reduction outcomes.

Based on an assessment of the priority environmental health threats to the Rwandan population and internationally recognized effective preventive and promotive healthcare interventions to achieve EDPRS, Vision 2020 and the MDGs; the following will be the main CBEHPP priorities:-

- ✓ **Improved household and institutional (schools, clinics and prisons) hygiene and sanitation:**
  - **Safe excreta disposal with zero open defecation (ZOD) and hygienic use of toilets**
  - **Hand-washing with soap and water**
  - **Safe water handling in homes, schools and other public Institutions**
  - **Safe disposal of solid and liquid wastes**
- ✓ **Food safety and improved nutrition**
- ✓ **Indoor air pollution**
- ✓ **Vector Control**

What are the; '7 Golden Indicators' to be achieved by CBEHPP?

(as per HSSP II Log-frame; baseline taken from RDHS 2005; refer APPENDIX 3, p.13)

1. Increased use of hygienic latrines in schools and homes from **28%** to **80%**
2. Increased hand-washing with soap at critical times from **34%** to **80%**
3. Improved safe drinking water access and handling in schools and homes to **80%**
4. Establishment of CHCs in every village from 0% to **100%**
5. Achieve Zero Open Defecation (ZOD) in all villages to **100%**
6. Safe disposal of children's faeces in every household **28-100%;**
7. Households with bath shelters, rubbish pits, pot-drying racks and clean yards to increase to **80%**

The strength of the CHC approach is not only its ability to engender hygiene behaviour change but it is also able to ***quantify behaviour change*** using community monitoring tools as an integral part of the process of change. The health promotion training focuses on the most common diseases dealt with by local Health Centres as long as they are preventable: these tend to include diarrhoeal diseases, acute respiratory infections (ARIs), skin diseases, eye diseases, intestinal worms, bilharzias and malaria.

How will the anticipated Hygiene Behaviour Changes be Monitored?

Each CHC is charged with monitoring the changes within in its own village membership (usually consisting of between 50 and 150 households). When a CHC is first formed, a Chairperson and Secretary are elected, who keep a register of attendance of all the CHC members. They are responsible for ensuring that levels of hygiene are monitored together with the CHW facilitator, who visits each house and observes the living conditions. These observations, known as a 'household inventory' are conducted on a regular basis and the information is then entered into an exercise book, thus enabling each CHC to identify exactly when the agreed behaviour and lifestyle changes have been made. If a CHC is too large for one CHW to monitor, it can be broken into clusters of 10 households, so that a cluster leader is made responsible for conducting this monthly monitoring. This low-cost, simple and effective method enables communities to track their own progress and to 'own' their own information, and consequently manage their own health. Any 'problem' households are soon spotted by the CHC committee and remedial action can be taken locally. Each CHC encourages all members to improve their hygiene through group consensus and peer pressure. House to house visits by CHC members reinforce the selected target practices. People tend to change if they know they are being noticed. In addition, some districts may opt to add impetus by providing recognition, rewards and prizes for the best CHC and model homesteads, based on the

percentage of behaviour change achieved between start and finish of the six months of CHC training.

What is the way forward?

After CBEHPP has been officially launched on **5th November 2009**, a series of activities will be carried out to ensure an appropriate start of the programme is immediately taken up. These activities will include development and printing of CHC training materials, building on previous behaviour change experiences and lessons learnt in Rwanda including the use of the PHAST approach; the holding of National and Provincial Orientation Workshops that will identify 'start-up' districts (at least one per province). Thereafter a national core team of Principal CHC Trainers will be established and trained in the CHC approach that is based on the familiar PHAST methodology. This core team will then go around conducting Training of Trainers (ToTs) for all the EHOs and School Health Officers in every district starting with the selected 'start-up' districts in January 2010. The team of Principal CHC Trainers will become the backbone of the programme, by training, mentoring and supervising district EHOs who in turn will train and support their local Community Health Workers and School Health Officers to initiate and facilitate the school and village CHCs. Their overall mission will be to create an environment for sustainable behavioural change and hygienic practices among all rural and high-density urban communities.

As per HSSP II, EHOs are required to ensure that all CHWs are trained and supervised to facilitate ***Community Hygiene Clubs (CHCs)*** that cover a six-month course of weekly, 1-2 hour Health Topics, using PHAST participatory techniques, as per typical example of a ***CHC Membership Card*** shown below:-

Illustrative Example of a Community Hygiene Club (CHC) Membership Card

No.	Topic	Date	Signature	Homework	Signature
1.	Safe Water Chain			Safe storage & use of water	
2.	Safe Food Chain			Pot rack; hanging basket etc.	
3.	Sanitation Ladder			Avoid faecal : oral diseases	
4.	Sanitation Planning			Improve household latrines	
5.	Diarrhoea ORS			Improve Sanitation facilities	
6.	Hand washing			Hand-washing Facility	
7.	Cholera/ typhoid			Water Source Cleanup + Sanit.	
8.	Skin/eye disease			Bedroom & personal hygiene	
9.	Worms			De-worming	
10.	Nutrition			Nutrition gardens & orchards	
11.	Hygienic kitchen			Fuel-efficient stove +ventilation	
12.	ARI			Sleeping mats/ room ventilation	
13.	Environment			Garbage pits & faecal-free yard	
14.	Malaria			Drainage & clearing	
15.	Infant care			Infant hygiene & weaning foods	
16.	Bilharzia			Bathing Shelter & ZOD	
17.	Drama and songs			Practice health drama & songs	
18.	CHC Banner / Map			Village Map & CHC banner	
19.	Self Monitoring			CHC Monitoring Tools in use	
20.	CHC ExecCom			Constitution & Project Bank A/c	

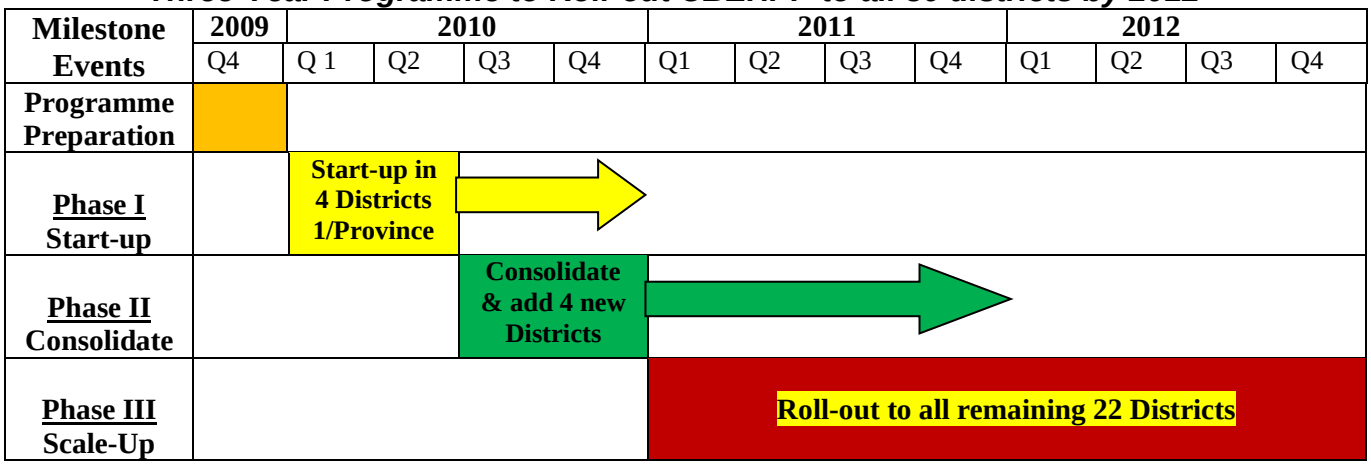
NOTE:- The back-side of this CHC Membership Card has the name and number of each CHC Member, plus Club name, village, etc. Ideally it could also include the member's ID photo.

The CHC Facilitator (i.e. CHW) should sign off and date the health topics as soon as they have been completed. So too should the CHW have his or her own CHC Membership Card signed off by the CHC Chair so that their own attendance as Facilitator can also be verified. This procedure certainly empowers the Community and strengthens the 'contractual obligation' to mutually follow through with the whole syllabus until completed. CHC Executive Committees (Chair, Treasurer

and Secretary) should be established just as soon as all members in a Club feel confident enough to vote for those members who are trusted and well respected by the whole community.

When every Health Topic plus related 'Homework' have ALL been completed by CHC members (each representing a household) then they will be eligible to receive a ***CHC Graduation Certificate*** at a Graduation Ceremony that would normally be officiated by high-ranking district and provincial dignitaries. Other than this Certificate there are **NO subsidies** provided.

Three-Year Programme to Roll-out CBEHPP to all 30 districts by 2012



In order to achieve the ambitious targets as set out in the HSSP II (2009-2012) that aims to ensure that basic hygiene practices improve in all 14,000 imidugudu across the country, it will be necessary to exponentially scale up CBEHPP from the initial start-up districts in each province to all remaining districts within 36 months.

The basic mechanisms for CBEHPP exponential scale-up to be achieved **are already in place**:-

Phase I

EHOs are located in all district Health Centres; after receiving just one-week of training in the CHC methodology, these same EHOs will be able to introduce on-the-job training to all village CHWs that are located within the catchment area of their respective Health Centres. Within 6-months (by July 2010) all CHWs in the start-up districts should be able to replicate CHCs in their respective villages. By the end of year-one (Dec 2010), every village in the 4 start-up districts should have active CHCs in place.

Phase II

Meanwhile, in July 2010, the programme will expand in exactly the same way to 4 new districts so that now there will be at least two active CBEHPP districts in every province giving a total of 8 active districts by December 2010.

Phase III

Over next two years, January 2011 to December 2012, the programme will keep scaling up in order to reach all remaining 22 districts so that all 30 districts are running with CBEHPP by December 2012.

Capacity Building for EHD. In order to implement the three phases of CBEHPP as reflected above, it is important to ensure that EHD is provided with the means. A Core Team of 5 Principal EHOs will be trained in the CHC methodology so they in turn can roll out training of trainers to all other EHOs across 30 districts. They will need to be provided with adequate transport and running costs and other logistical support as explained in the Budget below.

Indicative Three-Year Budget (Jan 2010 to Dec 2012)

Per capita cost for CBEHPP = US$ 0.50

This Indicative Budget is based on experience gained in establishing CHCs in several other similar countries to Rwanda. Refer Joint Agency Paper by 19 major Development Agencies including: WHO, UNDP, UNEP, EU, World Bank, DFID, ADA, GTZ, etc. (June 2008*)*:- ***"Poverty, Health, & Environment – Placing Environmental Health on Countries Development Agendas"***:- (page 33, Box 6: *'Behaviour Change can be Cost-effective':-* CHCs improved a raft of hygiene behaviours at a cost of **$3.33 per household**).

Target population: 80% of total population (9 million) living in rural areas = 7,200,000
7,200,000 beneficiaries x US$ 0.50 = US$3,600,000

Refer to APPENDIX 1 : Detailed Implementation Strategy

		US$
1	**Preparation Phase: (Oct-Dec 2009)** 1.1 Official Launch of CBEHPP 1.2 Develop CHC Training Materials in Kinyarwanda 1.3 Pre-test, amend & print Training Materials (Visual Aids, Tool Kits etc.) 1.4 Hold National Inception Workshop 1.5 Hold Provincial Orientation Workshops (x4)	**300,000**
2	**First-Phase: Implement in 'Start-Up Districts (Jan-Jun 2010)** **Establish 'First Round' CHCs under EHOs** 2.1 District Orientation Workshops 2.2 Train EHOs and School Health Officers to facilitate CHCs. 2.3 Ensure adequate mobility for EHOs to reach all villages (e.g. motorcycles) 2.4 Household Inventories and Baseline Surveys 2.5 Monitoring & Evaluation by MoH 'Core Team'	**350,000**
3.	**Second Phase: Consolidation and Expansion (Jul-Dec 2010)** **Establish 'Second-Round' CHCs under CHWs**	**350,000**
4.	**Third Phase: Roll-out to all 30 Districts (Jan 2011- Dec 2012)**	**2,600,000**
	Cost for Implementation	**3,600,000**
5.	**Capacity Building Support to EHD to execute CBEHPP**	**700,000**
	SUB TOTAL:	**4,300,000**
	Add 15% Contingency:	**645,000**
	TOTAL INDICATIVE 3-YEAR BUDGET:	**US$ 4,945,000**

NOTE: "Capacity Building Support to EHD to execute CBEHPP"
EHD will establish a **Core Team** of 5 dedicated EH Officers who will provide the backbone to CBEHPP. As experienced Trainers of Trainers this Core Team will be responsible for rolling out the training for CHCs to all EHOs as well as overseeing the quality of training the EHOs in turn pass on to the CHWs. The Core Team will ensure quality base-line and post-intervention surveys are conducted and that CHC behaviour change is tracked from month to month using the cutting-edge Mobile Research Platform (i.e. use of mobile phones for data capture). The budget for this Core Team will ensure transport and other logistical issues are covered in order to ensure that exponential scale up CBEHPP to all 30 districts can be achieved within 3 years.

APPENDIX 1 Detailed Implementation Strategy

Step 1. Analysis of Existing Behaviour Change Strategy in Rwanda using PHAST

Analyse the current situation with regard to :- (i) existing health education methods (e.g. PHAST); (ii) existing training materials; (iii) existing disease patterns and priority areas of concern for local Environmental / Community Health officials; (iv) existing attitudes by local government and especially the target communities towards hygiene education programmes. This phase would also identify suitable locations (i.e. districts and imidugudu) where the CHC methodology is likely to have rapid success and uptake with strong and supportive local leadership. It is vital that the 'start-up' phase achieves some 'quick wins' from the start. Appreciating that 'nothing breeds success like success', convincing and measurable improved hygiene behaviour change within the first six months of start-up is critical; not only to have a good story to tell and to demonstrate but to be sure that the CHC methodology is eventually taken up enthusiastically and confidently by all districts across the country.

This Research and Analytical work would require an experienced local TA to EHD/ MoH (with active support from an external CHC consultant) to spend about 2-3 weeks with Community and Environmental Health officials at central and district levels as well as with interested Stakeholders including Development Partners (e.g. UNICEF, DFID, Austrians, Belgians, SNV, WaterAid etc.); District Mayors and Deputy Mayors (Social Services) in the process of selecting suitable locations for the 'start-up' phase. During this phase the volume of work required to develop the necessary Training Materials, Training Manual and design of the Membership Cards (all to be translated into the Rwandese language) will be determined.

Step 2. Development of Training Materials

The duration of this phase will be determined by the quantity and quality of existing PHAST training materials, their appropriateness, and also determining how many gaps there are that will need to be filled with carefully developed graphic training materials so that all 20-25 health topics (as per the CHC Membership Cards) are well catered for with ethnographically sensitive training materials (i.e. rural Rwandan specific); and the amount of work required to develop the actual Training Manual that will provide specific guidance for all CHC Facilitators and their Supervisors within the Rwandan context. And of course, the time required for the whole lot to be translated into Kinyarwanda. This Step 2 should be undertaken immediately after completing the initial analysis and fact-finding stage under Step 1 above.

Step 3. Pre-testing and Printing of Materials

Once developed, the Training Materials (now in kinyaRwanda) will need to be pre-tested in order to ensure over 80% comprehension by the target groups. Some adjustments may still be necessary before printing the materials in sufficient quantities so as to cover the pilot implementation phase of the programme.

Step 4. Training of about 15 Principal CHC Facilitators (5-10 days)

As soon as all the CHC Training Materials have been printed then the Training of the so-called Principal Facilitators Workshop can begin. This training phase has been carefully packaged to cover rationale, explanation and training for the CHC methodology within 3 Modules:-

Module 1: **Rationale for the CHC Approach (One-Day Workshop)**

Target group: Local Government officials (incl. District Mayor), programme planners, professionals, district stakeholders and opinion leaders.

Objectives:
- An introduction to Community Hygiene Clubs and how they work
- To provide a rationale for the CHC approach
- To provide reasons why CHCs are popular and effective

- To stimulate speculation within districts as to whether this approach is feasible in project area.

Module 2: **Planning (How to start a CHC Project) (2 – 3 days)**

Target group: Local government officials, programme planners, managers, district hospital & health centre personnel, stakeholders and opinion leaders from the community where health clubs may be started.

Objectives:
- To identify priority issues and how to adapt the CHC methodology to fit new area.
- To plan how Community Hygiene Clubs can be started in each area
- To design / adapt the Membership Card for the particular needs of the project in that location
- To provide monitoring & evaluation tools to ensure hygiene behaviour is quantified and base-line data is captured.

Module 3: **Training (5 days)**

Target group: CHC Facilitators (i.e. EHO's as trainers/supervisors of CHWs and School Health Officers)

Objectives:
- To train CHC Trainers to train Community Health Workers (CHWs) how to establish and facilitate Health Clubs using updated PHAST Tool Kits and to eventually supervise, mentor and monitor all CHWs that work within the radius of the Health Centre where the EHO is based.

Depending on the amount of experience with the PHAST tool-kit and how much primary health-care training that the EHOs have already experienced, the training required for this cadre of CHC Supervisors and Trainers of Community Health Workers would normally require a full-time workshop of around 5 days.

Ideally the Workshop should cater for about 25-30 EHOs and School EH Officers. One such workshop will be required in each of the 'start-up' districts.

It is important to stress that in order for the CBEHPP to succeed, the EHOs need to be able to reach all villages within their respective areas of responsibility on a very regular basis so as to supervise, mentor and monitor the activities of the CHWs and their respective Clubs. For this to be achieved, the EHOs will need to be provided with reliable motor cycles, safety equipment and basic training in maintenance in order to achieve 'zero down-time' for their motor cycles.

Step 5. Implementation of Community Health Clubs (CHCs)

Immediately after the training has been completed the EHOs would return to their respective Health Centres and begin establishing and running CHCs in 3 - 5 nearby villages. The EHO would meet each CHC just once per week for about 1-2 hours in order to eventually cover all of the 20 health topics as scheduled on the Membership Card as per the example below. During this initial phase (i.e. "First Round CHCs under EHOs") of the programme, all Community Health Workers (CHWs) within the catchment area of the Health Centre would be expected to participate in these 4 or 5 initial CHCs per EHO in order to participate and learn about each of the 20 Topics. Once having received this 6-months of 'on-the-job' training, the CHWs will be able to go out and initiate CHCs of their own in their respective Imidugudu and the EHO's role will revert to supervision, mentoring and monitoring of the CHCs within the catchment area of the Health Centre.

Example of a Membership Card with 20 Health Topics and 'Homework'

No.	Topic	Date	Signature	Homework	Signature
1.	Safe Water Chain			Safe storage & use of water	
2.	Safe Food Chain			Pot rack; hanging basket etc.	
3.	Sanitation Ladder			Avoid faecal : oral diseases	
4.	Sanitation Planning			Improve household latrines	
5.	Diarrhoea ORS			Improve Sanitation facilities	
6.	Hand washing			Hand washing Facility	
7.	Cholera/ typhoid			Water Source Cleanup + San	
8.	Skin/eye disease			Bedroom & personal hygiene	
9.	Worms			De-worming	
10.	Nutrition			Nutrition gardens & orchards	
11.	Hygienic kitchen			Fuel-efficient stove +ventilation	
12.	Drama and songs			Practice health drama & songs	
13.	Environment			Garbage pits & faecal-free yard	
14.	Malaria			Drainage & clearing	
15.	Coughs and colds			Mats and ventilation	
16.	Bilharzia			Bathing Shelter	
17.	TB			Community Project	
18.	HIV/AIDS			Community Project	
19.	Home based Care			Community Project	
20.	Family Planning			Community Project	

The course usually takes about 6 – 9 months to complete all 20 health topics (at the rate of one per week), as there are usually repeat sessions to cater for the late-comers to the Clubs and also to provide for reinforcement of particular topics where necessary. Each topic has the requirement of some 'homework' following the session. This might be to make a simple hand-washing facility (e.g. a 'tippy tap') or a compost pit, a pot drying rack or a bathing shelter and of course a suitable hygienic latrine. The required homework is listed on the Membership Card but frequently CHC members go well beyond this requirement and start improving their homes in all sorts of ways, usually starting with a properly ventilated kitchen with fuel-efficient stove and then going on to ensure bedrooms are properly ventilated, that mosquito nets are used properly, that yards are kept clean and usually a nutrition and herb garden will be started as well. These household improvements will all come about WITHOUT any form of material subsidy!

Later a whole range of income-generating activities are likely to be taken up by the Community Hygiene Club that, within a year or so, should have its own constitution, a democratic leadership structure and even a bank account for new Community–based projects. Such well-structured CHCs quickly gain a reputation for credit worthiness and may then be more likely to gain access to supplies of such items as seed and fertilizer or bags of cement on credit from local Suppliers. These Community Hygiene Clubs will have taken on the characteristics of CBOs and may well become eligible to benefit from micro-credit schemes.

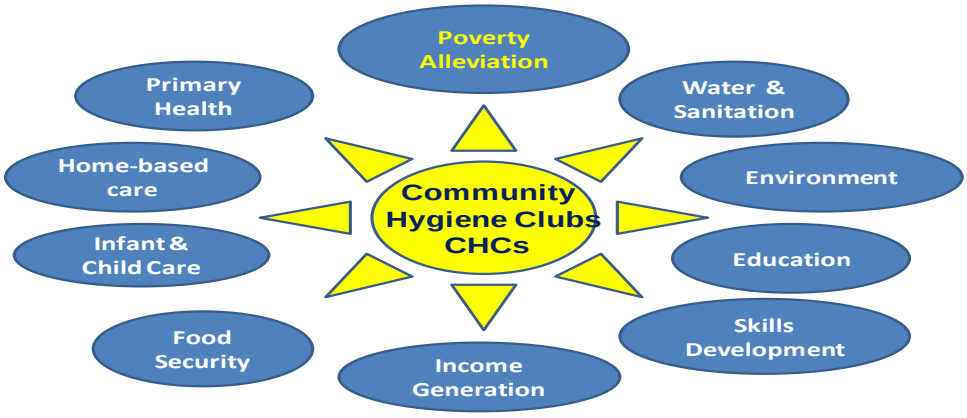
Once the CHC members have completed all topics as listed and signed off by the Facilitator on their Membership Cards, there should be a Graduation Ceremony to acknowledge their accomplishments. This ceremony is usually a joyous occasion attended by district dignitaries at which Graduation Certificates are awarded to those CHC members who have completed all 20 health topics together with the required home improvements.

It may also be a good strategy, within the Rwandan tradition of *'imihigo'* (performance contracts), to acknowledge and reward those CHCs that perform particularly well and to establish local district-based competitions for Model Homes, Model Villages and even model districts as

this all adds to the enthusiasm and dynamics for the hygiene behaviour changes that are so urgently required.

Step 6. Supervision and Monitoring

Once the CHC Facilitators return to 'their' communities and start up CHCs in their areas they will require careful supervision and monitoring (and mentoring), especially during the early stages as these new and inexperienced CHC facilitators build up their confidence to cover all of the 20 selected health topics. This supervision should be the responsibility of the Environmental Health Officer (EHO) with additional back-up from the district hospital Technical Supervisor. Systems need to be put in place by district authorities to carefully ensure that the whole process is kept on track and that progress is carefully monitored. It is essential that a detailed and accurate '***baseline survey'*** is completed in every area at the very beginning and before the health club facilitation begins. This is especially important in order to accurately measure hygiene behaviour change over a period of six – nine months and then again later over the next few years so as to be able to measure the all important issue of *sustainability* of the new hygiene practices. Rates of change can then be measured against a number of control groups who do not undergo the CHC process.



PLACING THE COMMUNITY AT THE CENTRE OF INTEGRATED DEVELOPMENT

APPENDIX 2 *Programme Preparation and Roll-Out*

Programme Preparation (October-December 2009)

To begin implementing CBEHPP by January 2010 as intended by the MoH (EHD) there is urgent need to focus on the following critical activities during the remaining months of 2009 :-

1. Arrange for the Official Launch of CBEHPP by Minister of Health
2. Ensure availability of appropriate CHC Training Materials
3. Arrange National Inception Meeting and four Provincial Orientation Workshops (possibly consider merging these into one event)
4. MoH and Provincial Governors to engage in identifying the start-up districts (at least one start-up district per province)
5. Engage with start-up districts to develop budgets and work-plans and plan ToT workshops
6. Arrange for the training of the Principal CHC Trainers who will then go on to train the district EHOs. For this initial Principal Trainers workshop it will be necessary to have external support from experienced CHC Facilitators.

Soon after the official Launch on 29th October 2009, there will be a national Inception Workshop to introduce CBEHPP to the relevant Ministries:- MoH, MININFRA, MINEDUC, MINALOC, MINECOFIN as well as relevant Development Partners (DPs) and other Stakeholders. This Inception Workshop is scheduled to take place within one month of the Launch (i.e. before 15 November). This will be followed by Provincial Orientation Workshops (one-day in each of the four provinces) during which the start-up Districts will be identified with the formal endorsement by the Provincial Governor and MoH (EHD).

The estimated total indicative budget for CBEHPP over three years is under US$ 5 million with a per capita unit cost of just 50 cents. When this is compared to the average budget for Roads or Infrastructure then, for such high returns for environmental health and poverty reduction outcomes, this is extremely good value for money!

It will be during the Provincial Orientation Workshops that those DPs already supporting Water & Sanitation Programmes will be expected to contribute funding and logistical support to CBEHPP in the all-important 'start-up' districts. In order to initiate the programme in the 'start-up' districts, it will be vital to ensure that there is adequate financial and logistical support made available. Already there are strong indications of such support from MININFRA and the Water & Sanitation Sector. With an already existing budget of the order of **US$150 million for ongoing W&S projects**, the relatively modest amount of under US$ 5 million that is required to achieve significant hygiene and sanitation behaviour change outcomes should not prove too elusive, especially as CBEHPP would add tremendous value and sustainability to all existing WS programmes.

The W&S Working Group under the Chairmanship of the AfDB has already expressed particularly strong support and backing for CBEHPP and has even proposed that a MoU should be drawn up between MININFRA & MoH. In particular, the PEPAPS WS programme (Belgian Aid) have indicated that they will support CBEHPP in at least one district in Southern Province and the same goes for UNICEF in Northern Province where there has already been mention of at least 5 or 6 districts being included.

District selection for the 'start-up' will need to be undertaken in such a way that the programme can rapidly expand to all other districts in each of the four provinces as well as Kigali as quickly as possible. Being a 'national' programme, CBEHPP is expected to cover all 14,000 Imidugudu by 2012 as per the Logical Framework of HSSP II. It is therefore important to ensure that those districts that are NOT included in the first six-months of Phase One (Jan-Jun 2010) are reassured that the CBEHPP will be coming their way soon and must be informed exactly what is required of the District Mayor and his/her staff in order for this to come about at the earliest opportunity. This is where MINALOC will provide a vital role in mobilising **existing** resources, personnel, transport and budgets within their respective districts in order to rapidly implement CBEHPP down at village level and at all schools.

Another critical aspect to consider is that, for the programme to even begin to work effectively, all EHOs in the start-up districts (and eventually in all 30 rural districts with a combined total of almost 14,000 villages) will need to be provided with reliable motor cycles and safety equipment plus have motor cycle running costs covered. Unless EHOs are mobile they simply cannot undertake their role in training, supervising and mentoring all of the 45,000 Community Health Workers (CHWs) under their 'command' and within the catchment area of their respective Health Centres.

Within one year of start-up (i.e. by January 2011) MoH should have statistical evidence from Health Centres within initial catchment areas of CBEHPP that clearly demonstrates improved health outcomes (reduction in diarrhoea, intestinal worms, ARIs, etc.). This will provide additional validity and support for advocacy efforts for the exponential roll-out of CBEHPP to all villages throughout Rwanda over the remaining two years of the programme.

APPENDIX 3 CBEHPP WITHIN CONTEXT OF HSSP II

The importance being afforded by the Government of Rwanda (GoR) to the CBEHPP is revealed in the Health Sector Strategic Plan (HSSP II: 2009–2012) that was recently signed into effect by the Minister of Health, Dr Richard Sezibera, after it had first received full Cabinet approval in July 2009. HSSP II (page 16) states the following:-

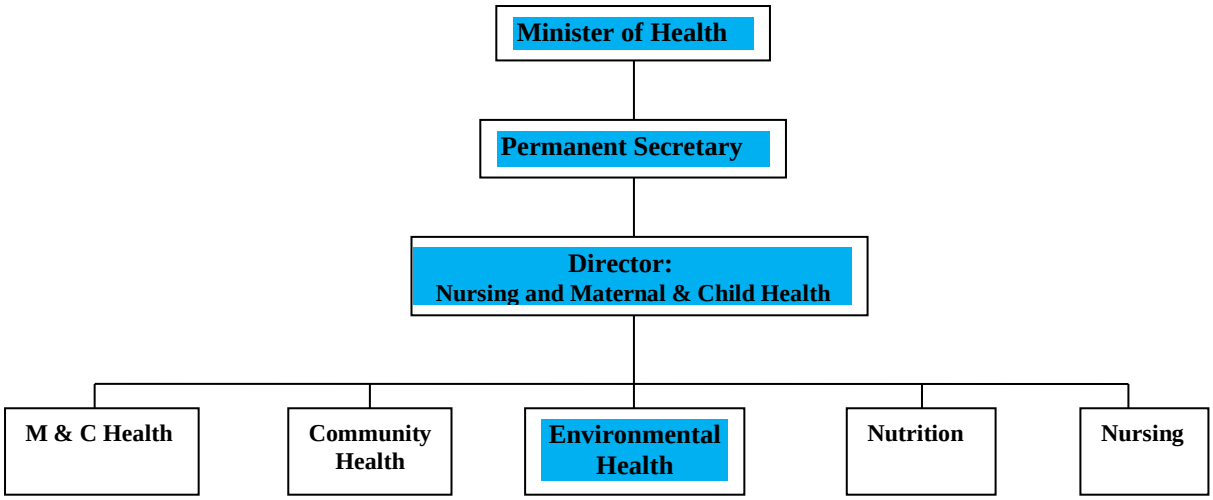
> ***"In 2009, MoH will be launching a National Community Based Environmental Health Promotion Programme (CBEHPP). This aims to strengthen the capacity of all 45,000 Community Health Workers under close mentoring and supervision by Environmental Health Officers based at Health Centres. CBEHPP plans to adopt the internationally validated Community Health Club methodology (in the Rwandan context they will be called Community Hygiene Clubs – CHCs) in order to achieve rapid and sustainable behaviour change and poverty reduction outcomes".***

HSSP-II also lists the following CBEHPP **Verifiable Indictors**:-

- ***% of households and institutions using hygienic latrines and hand-washing with soap;***
- ***% of households and schools exercising safe drinking water handling;***
- ***Number of CHCs put in place in Imidugudu.***

In addition, HSSP II includes CBEHPP in the **Logical Framework** as follows from the section extracted from page 36:-

Program Objectives	Strategic Interventions	Outcomes	Indicators	Target 2012 (baseline)
2. To consolidate, expand and improve services for the prevention of diseases and promotion of health	**Health Promotion and Healthy Lifestyles**			
	Improvement of the environmental health and hygiene conditions of the population	**The use of hygienic latrines and hand washing facilities in households and institutions are promoted**	**% of households and institutions using hygienic latrines and hand-washing with soap**	**Target**: **80%** for latrines and hand washing (baseline: hand-washing with soap 34%, hygienic latrines: 28%, 2005 RDHS),
		Improved drinking of potable water in households and schools	**% of households and schools exercising safe drinking water handling**	**Target: 80%** (baseline: to be set after survey)
		Environmental health data included in HMIS	Environmental health data published on MoH website	Quarterly
		Participatory hygiene and sanitation transformation (PHAST) education ensured	**The number of *Community Hygiene Clubs (CHCs)* put in place in Imidugudu**	**Target: 100%** (Baseline: 0%)



The recent changes within the organisational structure of MoH reflects an elevated position for EHD as indicated above (ref HSSP II : Organisation Chart - Ministry of Health ; extracted from page 71). This indicates the seriousness with which MoH and Government appreciates the impact that improved hygiene behaviour change will have in achieving enhanced national health and poverty reduction outcomes in Rwanda.