

# Implementation challenges for Community Health Clubs in Rwanda



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## SEI brief

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## Key messages

- Community health clubs (CHCs) aim to address sanitation and hygiene behaviour change, while strengthening social cohesion and commitment to common goals.
- The implementation of CHCs in Rwanda needs better coordination. Implementation is fragmented and predominantly donor driven. As a result CHCs are implemented, monitored and evaluated differently across the country.
- Although there is strong political will behind the CHC model in Rwanda, its impact may be compromised if the current funding gap is not addressed.
- Accountability mechanisms, ownership by districts, and harmonized monitoring of progress are needed to improve the sustainability and functionality of CHCs.
- Vulnerable groups and communities risk being left behind under the current CHC programme implementation if proper measures are not taken to emphasize inclusiveness.

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Rwanda is one of the very few countries in sub-Saharan Africa to have made good progress towards the Millennium Development Goals (MDG) targets for water and sanitation. However, critical challenges prevent Rwanda's poorest people from obtaining sustainable access to safe water and sanitation services.

In 2009 the Government of Rwanda launched the Community-based Environmental Health Promotion Programme (CBEHPP), aiming to “reduce the national disease burden through community-based hygiene behaviour change and improved sanitation” and make important contributions to poverty reduction (Ministry of Health 2010). The CBEHPP is administered by the Ministry of Health as part of the Health Sector Strategic Plan (Ministry of Health 2009; Ministry of Health 2012; Ministry of Health 2018).

The CBEHPP adopted the Community Health Clubs (CHCs) methodology with the aim of attaining rapid, sustainable and cost-effective sanitation and hygiene behaviour change. Rwanda has adopted the CHCs approach as a national strategy.

One of the reasons CHCs was chosen is that, unlike other water, sanitation and hygiene (WASH) approaches, it provides an opportunity to address linked health risks, including from inadequate sanitation, in a holistic way. This is particularly important in tackling infections related to WASH, given their contribution to childhood undernutrition and stunting (Cumming and Cairncross 2016).

### Photo (above):

**A community health club meeting in  
Rusizi district, Rwanda**

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This brief presents insights and experiences on implementation of CHCs in communities in Rwanda, provided by water, sanitation, and hygiene practitioners in a multi-stakeholder dialogue held in 2018. Aimed chiefly at practitioners and decision-makers in Rwanda, it can hopefully provide pointers to improve the functionality and effectiveness of CHCs implementation. However, it could also hold lessons for similar programmes elsewhere.

Such a study of CHC implementation in Rwanda is timely. The full roll-out of the programme to all communities, urban and rural, clearly has some way to go.

## **Rwanda's Community-based Environmental Health Promotion Programme**

Rwanda has set ambitious targets for water supply and sanitation, with the vision of reaching universal access to at least basic services by 2020. The CBEHPP programme was given a boost by the Health and Sanitation Presidential Initiative requiring all villages in Rwanda to start CHCs. CHCs involve entire communities and promote a “culture of health” through altering norms, increasing social capital, and alignment with cultural values.

An implementation Roadmap for the CBEHPP outlines the process for implementing CHCs in all villages of the country (Ministry of Health 2010). The seven targets for the CBEHPP cited in the Roadmap cover:

- Increased use of hygienic latrines in schools and homes
- Increased hand washing with soap at critical times
- Improved safe drinking water access and handling in schools and homes
- Establishment of CHCs in every village
- Zero open defecation in all villages
- Safe disposal of children's faeces in every household
- Households with bath shelters, rubbish pits, pot drying racks and clean yard (Ministry of Health 2010).

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### **BOX 1: THE COMMUNITY HEALTH CLUBS APPROACH**

CHCs is a behaviour change approach that empowers communities to address hygiene, sanitation and environmental health issues (Waterkeyn and Waterkeyn 2013; Waterkeyn and Cairncross 2005). It involves establishing “clubs” that include entire communities and promote a “culture of health”, through altering norms, increasing social capital, and alignment with cultural values. The CHCs approach has been implemented in several places beyond Rwanda, including in rural Zimbabwe, conflict-affected villages in Sierra Leone, and camps for internally displaced people in Uganda. CHCs have generally achieved cost-effective behaviour change and built rural demand for sanitation (Waterkeyn and Cairncross 2005).

Emphasizing positive peer pressure, CHCs differ from other widely used approaches to sanitation behaviour change, such as Community-Led Total Sanitation (CLTS), which use shame-based messages to trigger change, and negative peer-pressure to maintain it.

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**Figure 1. Illustrative example of a Community Health Club membership card**

No.	Topic	Date	Signature	Homework	Signature
1.	Safe water chain			Safe storage and 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 clean-up and sanit.	
8.	Skin/eye disease			Bedroom and personal hygiene	
9.	Worms			De-worming	
10.	Nutrition			Nutrition gardens and orchards	
11.	Hygienic kitchen			Fuel-efficient stove and ventilation	
12.	ARI			Sleeping mats and room ventilation	
13.	Environment			Garbage pits and faeces-free yard	
14.	Malaria			Drainage and clearing	
15.	Infant care			Infant hygiene and weaning foods	
16.	Bilharzia			Bathing shelter and ZOD	
17.	Drama and songs			Practise health drama and songs	
18.	CHC banner and map			Village map and CHC banner	
19.	Self monitoring			CHC monitoring tools in use	
20.	CHC Executive Committee			Constitution and project bank account	

Source: Ministry of Health (2015)

The CHC approach begins with community mobilization using standardized training materials. Trained facilitators deliver weekly training covering a series of 20 topics on different aspects of health and hygiene – including safe sanitation, safe water storage and home-based treatment, personal hygiene, food hygiene, nutrition, and waste management. Participation is voluntary and open to all (although at least one member from each household is recommended), and participants are given homework assignments. Attendance at meetings and achievement of homework assignments is recorded on a membership card (see Figure 1).

While the focus of CHCs is primarily on behaviour change, the homework assignments include tasks such as constructing a home latrine and “tippy tap” (a hand-washing station made from a plastic bottle or jug). No financial support is provided to residents through the CBEHPP. CHCs have been linked to income-generation, savings schemes and other economic activities in many districts to help residents complete the required tasks.

Once the initial training is completed after six months, the expectation is that the CHCs will continue to operate, sustaining the healthy behaviours and contributing further to poverty reduction (Ministry of Health 2010).

According to the Roadmap, district environmental health officers oversee CHC implementation, as well as monitoring and evaluating progress. However, in practice there is insufficient government funding for districts or communities to establish and support the CHCs (Ministry of Health 2012), and thus CHCs in many districts in Rwanda rely on development partners.

## Exploring CHC implementation in Rwanda with stakeholders

In 2018, a range of stakeholders were invited by SEI and the College of Medicine and Health Sciences of the University of Rwanda to take part in a dialogue event in Huye district in the South-West region of Rwanda. The aim of the dialogue was to allow practitioners to share their experiences of CHC implementation. It built on previous research examining governance challenges to CHCs implementation Rwanda (Ekane 2018).



**Participants from district health offices, NGOs and the University of Rwanda in the stakeholder dialogue © SARAH DICKIN / SEI**

Participants included 35 practitioners, among them CHC implementers with on-the-ground experience from Huye, Kamonyi, Gisagara, Nyaruguru, Nyanza, Ruhango, Muhanga and Nyamagabe districts, and environmental health officers from the respective district hospitals. In addition, there were representatives of non-governmental organizations (NGOs) implementing CHCs, donor organizations, the Rwandan Ministry of Health and the Rwandan Ministry of Infrastructure, as well as sanitation researchers from the University of Rwanda, SEI, Lund University Centre for Sustainability Studies (LUCSUS) and KTH Royal Institute of Technology, Stockholm. Facilitation tools including Strengths, Weaknesses, Opportunities and Threats Analysis (SWOT) and Gap Analysis were used to engage participants in group discussions and elicit information about their experiences and perspectives.

The participants discussed barriers to the functionality of CHCs within four themes: the current sanitation policy context; achieving behaviour change with a focus on hand-washing; monitoring sanitation in the context of the Sustainable Development Goals (SDGs); and ensuring no-one is left behind in terms of service provision and access to facilities.

### **Gaps between policy and implementation in Rwanda**

Overall, the discussions indicated that the implementation of the CBEHPP through the CHCs approach faces a number of challenges that need to be addressed in order to improve functionality. These include inadequate financial resources at the national and district levels, and a lack of clarity about roles and activities for different actors supporting CBEHPP, leading to poor coordination and limited implementation timeframes.

As noted above, CHCs are predominantly funded by donors and rolled out mainly by development partners such as internationally funded NGOs. Although district health units officially have coordination responsibilities under the CBEHPP, there is a need for resources to support implementation, including adequate training materials, sufficient skilled staff, and means to transport environmental health officers to communities. The community health workers have yet to be able to take full ownership of CHC implementation activities, in terms of follow-up and backstopping in villages and households.

Related to this are problems inherent in relying on time-bound donor-funded projects. Participants reported that once projects end, CHC activities tended to slow. Also, as implementing partners

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had been in charge of the clubs, it was difficult for the districts to then take over responsibility and ownership. Participants also said that there was sometimes duplication of efforts between implementing partners and district or community health workers, due to the lack of coordination, and little or no sharing of data and information between them.

## **Promoting sustainable behaviour change within CHCs**

Participants in the workshop were positive overall about the CHC model. They said that the CHC approach's focus on using positive peer pressure and consensus – rather than shame – to change sanitation practices and hygiene behaviours was a good fit with Rwandan cultural norms, which emphasize politeness, respect for privacy, and fostering of community cohesion. By aligning and reinforcing these cultural norms within CHC activities (through dialogue sessions, demonstrations, songs, dancing, home visits and competitions) community-wide ownership, group consensus, mutual accountability and assistance could potentially be strengthened within the clubs to motivate changes in both household sanitation conditions and hygiene behaviours. Further, the participants said the CHC approach also emphasized key aspects of community development, notably empowerment and participation.

CHCs promote a number of hygiene behaviours, especially handwashing at critical times. The fact that the CHC model calls for – and records – the construction of handwashing facilities (“step-and-wash” or “tippy taps”) outside homes and close to latrines and kitchens is particularly important, not only from a health perspective but also as it aligns with the global indicator for SDG 6.2 (“Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water”; United Nations 2017), for which there is limited data in most countries. It thus opens up the possibility of monitoring and of comparing progress between different parts of Rwanda and at global level.

However, participants said that while the CHC process requires households to build handwashing facilities, there were a number of challenges in promoting long-term behavioural shifts towards handwashing. Inadequate time was one, as behaviour change can require more time than the six-month training period under the CHC model.

Another was that while the CHC approach encourages people to use soap, in the majority of communities represented in the workshop there are problems with the availability and affordability of soap. In some cases, the CHCs had overcome this by establishing or linking village savings and credit groups to CHC activities, to help members to buy soap – something envisaged in the CBEHPP Roadmap in order to contribute to poverty reduction (Ministry of Health 2010).

Availability of water, especially in hilly areas, was also identified as a challenge, and participants said that when faced with water shortages residents often deprioritized hygiene in favour of other water uses. Theft of tippy taps and low availability of used plastic containers to construct them were also highlighted as barriers to handwashing behaviour change.

Participants noted that because the training tools do not focus only on sanitation and hygiene behaviour change but on 20 different environmental health topics, club members may be overwhelmed with information, which could compromise the effectiveness of the training they receive.

Looking beyond the household, there are many other locations where sanitation needs are not being met, and this can limit behaviour change and its effectiveness in preventing disease. One issue highlighted was the lack of toilets and handwashing facilities in public places such as markets, workplaces and farms. The CHC approach does not focus on these locations, a limitation that must be addressed to reach universal access.

Without strategies to overcome these challenges, sustaining handwashing and other hygiene behaviours promoted by the CHCs are likely to be difficult, and could limit long-term CHC functionality.

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## Monitoring and evaluation

A system for monitoring CHCs is outlined in the CBEHPP Roadmap (Ministry of Health 2010). It is partly the responsibility of environmental health officers at sector level and district level. The Roadmap recommends that a baseline survey be done at the start of club activities and six to nine months after, in order to measure impact.

The CBEHPP Roadmap recommends careful supervision and monitoring especially at the early stages of a club's development, to enable members to get acquainted with all the training tools (Ministry of Health 2010). The indicators for this monitoring correspond to the 20 homework tasks, and consist mainly of a measure of attendance of training sessions and accomplishment of homework and recommended practices. These are supervised by CHC committee members, who are leaders selected by the community.



**A step-and-wash handwashing unit**

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Although following up on CHCs over the long term is the role of environmental health officers, group discussions revealed that in practice most monitoring of CHCs is done by implementing partners. District environmental health officers reported challenges due to inadequate financial and technical resources, such as data collection and management systems, to support effective follow-up and monitoring. Furthermore, different implementing partners use different monitoring tools and reporting systems, and limited sharing of data and inconsistent data collection reduce reliability. This results in poor harmonization and coordination between implementing partners and district officers, contributing to the lack of ownership of CHCs on the part of districts.

The government has well-established reporting systems for monitoring sanitation coverage specifically for the purposes of global bench-marking, notably the Demographic and Health Survey and the Integrated Household Living Conditions Survey, which are linked to the WHO/ UNICEF Joint Monitoring Programme for Water Supply and Sanitation and are aligned with SDG indicators. Sanitation and hand-washing are monitored at the national level to track progress towards SDG target 6.2.

The participants noted, however, that in practice there are gaps in terms of harmonized indicators of improved sanitation and hygiene to monitor coverage at the national level. Since the CHC approach has been adopted nationally to promote sanitation and hygiene, its monitoring could help fill these gaps.

### Reaching those left behind

As noted above, participants indicated that the CHC approach is culturally appropriate for the Rwandan context, but should be more inclusive.

However, participants noted that there is still a risk that some individuals, communities and districts could be left behind unless conscious steps are taken to be inclusive in CHC implementation; for example when people live far away from meeting sites, have mobility issues or have only recently moved in to the area. This is important as without community-wide adoption of safe hygiene and sanitation practices, the potential health benefits – particularly reducing the risks of communicable disease outbreaks – are limited.

Participants observed that in their experience, attendees of CHC meetings are predominantly women, as women play a central role in household sanitation and hygiene in Rwanda. Thus, although men may be involved in improving sanitation and hygiene conditions within the household, they risk missing out on CHC training and awareness building. Ensuring boys and men are included can make CHCs more effective and help in addressing gender disparities in WASH, participants suggested.

Participants also noted that some households may have difficulty paying for soap or materials such as slabs for latrines at their own expense, or constructing facilities such as toilet pits with their own labour. Official categorization of individuals by income level helps identify the poorest

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households that may require support, but adequate resources are needed to support the poorest and most vulnerable.

However, participants reported good experiences regarding mutual assistance. This includes help given to the elderly and very poor households to install improved latrines and handwashing facilities, and pay for bedding and school fees for children. For example, they noted that some CHCs have initiated income-generating projects, giving some households extra resources. Furthermore, a culture of cooperation in some CHCs sees members helping the poorest and most vulnerable households to construct toilets or handwashing facilities. However, how far such measure can be relied on to address the barriers for poor and vulnerable people requires further research.

The uneven implementation of the CBEHPP, caused by the dependence on non-government partners and the lack of coordination, sometimes results in incomplete and unequitable CHC coverage, participants said. They suggested that, as CHCs is a community-led approach, the district should own it and allow planning from the village up to the sector, and then, prioritize and coordinate implementation, monitoring and evaluation.

## Policy considerations

Some key insights and policy implications emerged from the workshop discussions. Overall, the participants agreed that CHCs play an important role in providing an integrated approach to tackle challenges related to health, water, sanitation and hygiene in Rwanda, but barriers to functionality should be addressed to ensure targets can be achieved. In particular:

- There is a need to coordinate efforts between the implementing partners and country actors involved in CBEHPP implementation. In particular, a harmonized nationwide monitoring and accountability platform should be adopted for CHCs, and all implementing partners should be encouraged to use it, in order to improve long-term performance and continuous improvement.
- The political will manifested at the highest level of government in support of the CBEHPP must be matched with adequate financial resources and support to allow district-level actors to fulfil their responsibilities in CHC implementation.
- CHCs must be strengthened to ensure that no one is left behind. Further research should be carried out into how CHC-linked savings groups or income-generating activities can assist poor, vulnerable households to install sanitation and hygiene facilities and keep up good hygiene practices.
- The roles and responsibilities of actors involved in CHC implementation must be clear. Non-government implementing partners should seek to strengthen country systems in order to ensure local ownership and sustainability of CHCs after their projects are complete.
- Government authorities at the district level should own the CHC approach and allow planning from the village up to the sector level, and then prioritize and coordination implementation, monitoring and evaluation.

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