

Scaling Up Community Health Clubs: An Appeal to Funding Agencies

It is now over a decade since the first Community Health Clubs were started and their effectiveness in creating a demand for sanitation and rapid uptake of recommended hygiene practices is beginning to be appreciated in the academic world following recent research at the London School of Hygiene and Tropical Medicine (Waterkeyn and Cairncross, 2005). Looking at comparative programmes it is clear that Community Health Clubs are one of the most cost-effective methodologies for achieving hygiene behaviour change in rural areas of Africa (WSP, 2004), and that the highest rate of change can be expected in the less developed areas. In 2004, Africa AHEAD Association was founded by the author, to replicate and adapt the CHC Approach throughout Africa by starting pilot projects in as many countries as possible to provide first hand models for the development community. The following three examples show the ability of this methodology to go to scale and challenge development agencies to provide resources to scale up this proven methodology in order to meet the MDG targets for water and sanitation.

Community Health Clubs in Central Africa

Community Health Clubs were first pioneered in Zimbabwe in 1995, in a small pilot project in Makoni District, Manicaland, funded by Unicef to test out the author's contention that promoting hygiene through health clubs could effectively change people's high risk practices and develop a strong demand for sanitation, based on knowledge and peer pressure to conform to recognised club standards. From the start, the health clubs attracted a strong response from the community with clubs of between 50 to 200 members. Furthermore it was estimated that approximately 70% of the members in each club continued to attend the weekly health sessions for over six months, demonstrating high uptake of recommended hygiene practices. The demand for health clubs from other communities prompted the author to found an NGO specifically to scale up this approach. By 2001, there were 472 health clubs in Zimbabwe, with 27,784 members in 6 districts.¹ In all districts the intervention was successful with Environmental Health Technicians, from the Ministry of Health responsible for facilitating the health club sessions, thus institutionalising the approach within the government structure. Furthermore the approach has been able to demonstrate some of the highest percentages of behaviour change, with an average of 47% for 16 observable proxy indicators, all with p values of <0.0001 (Waterkeyn and Cairncross, 2005). Demand for sanitation was borne out by the construction by health club members, of a record number of 3,600 latrines in two of the districts within 18 months, i.e. almost half of the 8,000 latrine constructed in the entire country that year. The health promotion needed to stimulate this strong demand was achieved at a cost of only US\$0.55 for 12,630 beneficiaries in Tsholotsho District, and US\$0.21 in Makoni District for 68,700 people. Based on these outputs, the CHC approach would have undoubtedly gone to scale but for the unprecedented socio-political collapse of Zimbabwe prompting an immediate withdrawal of all major funding agencies in 2001, and the consequent loss of support of the NGO concerned. With inflation in Zimbabwe rising from 300% in 2002, to 1000% in 2006 most subsistence farmers are derelict and dependent on food aid. Despite minimal external support the health clubs are surprisingly resilient and continue to prosper (Waterkeyn, 2005). The health clubs, having started with health promotion, water and sanitation programmes have continued to provide a structure enabling the community to solve a wide range of local problems. Despite inflation in the last five years, there has been substantial self-supply of water and latrine building by health club members who without donor support have been sorting out their own basic necessities. More research is needed to establish if the health clubs in Tsholotsho, Gutu, and Lupane have fared as well as those in Makoni District, although some insights have already been documented in the early stages which showed the success of health clubs in Bikita District (Mathew & Makuwe, 1999).

Scaling up the CHC Approach could be said to depend on funding for three issues: the availability of appropriate participatory training materials, as well as sufficient trainers and transport to ensure each trainer can access five health clubs per week (Waterkeyn, 2006). With the MoH in Zimbabwe having Environmental Health Technicians based in most wards, there exists a good structure to enable the CHC approach to scale up. The ability of the country to provide countrywide training was demonstrated in 1996-7 when PHAST² Training was conducted in most of the 57 districts,

¹ Zimbabwe AHEAD Organisation was implementing the programme in Tsholotsho and Gutu Districts (funded by DFID), and Makoni (funded by Danida), whilst providing training for (DFID funded) Integrated Water Supply and Sanitation projects through the Rural District Council in Bikita and Lupane, and for CARE international in Masvingo Districts.

² PHAST: Participatory Hygiene and Sanitation Transfer, an initiative by UNDP-WSP/AF to pilot the use of participatory training methods in: Zimbabwe, Kenya, Tanzania, Uganda, Botswana, Mozambique and Ethiopia

supported by Unicef. There is a general understanding of PHAST principles and the necessary training kits are still available. If training to start health clubs could be done in every district, the CHC approach would have the power to enable the MDG targets to be met in Zimbabwe. Given a functional economy, it has been calculated that by using health clubs to create a demand, over 51,000 latrines could have been constructed per year, and the MDG targets for sanitation could have been met with by 2015. With the collapse of Zimbabwe, it has become important to document the lessons learnt from the CHC programmes and a 'Research and Dissemination Project' was undertaken in 2001 (funded by DFID) detailing the Zimbabwe Project (Waterkeyn and Waterkeyn, 2002.a).

Community Health Clubs in West Africa

In 2001, CARE International began the rehabilitation of villages in Sierra Leone following the end of the civil war, and an opportunity arose to try out the health clubs outside Zimbabwe. Fifty health clubs were started in 23 villages, and there was the same rapid uptake by the largely Moslem communities as had been the case in rural Christian households in Zimbabwe. Whilst a base line survey was undertaken there was no post intervention quantification of behaviour change and therefore only anecdotal evidence is available. In a Rapid Rural Appraisal of a sample of the villages it was clear that the Moslem religion lent strength to the level of compliance as all villages were compelled by their Imam to endorse all recommended practices. The population of over 8,000 had moved from the standard practise of open defecation to an almost total acceptance of safe sanitation with over 46% constructing latrines in under one year, and those still using the bush at least burying their faeces. (Waterkeyn and Waterkeyn, 2002.b).

However the CHC Approach as an institutionalised methodology was less sustainable than in Zimbabwe as with the almost total lack government field workers in the Ministry of Health the NGO had to employ its own facilitators. The CHC Approach itself has now been widely adopted by most NGOs and Agencies working in Sierra Leone. CARE has published a training manual with visual aids and issues that are ethnographically appropriate to local conditions and this will provide the training modules that will enable this approach to be taken to scale in this country. The degree to which the health clubs have been successful in meeting the MDGs in Sierra Leone needs to be established with a view to scaling this approach up throughout West Africa. In 2006, in Guinea Bissau, a project by a new NGO, Effective Interventions, has been started using the CHC approach to raise hygiene standards and create a demand for ante-natal facilities aiming to reduce infant mortality rate by 25% in one of the poorest countries in the world where infant mortality is estimated at 300:1000.

Community Health Clubs in East Africa

The opportunity to test out the CHC Approach in East Africa came in 2004 in the notoriously difficult environment of the Internally Displaced Peoples (IDP) camps of Northern Uganda where 98% of the entire population of Gulu District have nominal protection from the ravages of Lords Resistance Army. While most agencies were failing to achieve any 'buy-in' from the community for sanitation, which was estimated at less than 5% in all of the 34 camps, CARE International had procured funding from the Gates Foundation to build 10,000 latrines in six months! The size of each camp ranged from 10,000 to 68,000 people and there was little space to construct latrines between the cramped huts that had been mushrooming for the past 18 years of civil war. The Ugandan army was put off the vital patrolling around the perimeter of camps at night due to the density of human excreta!

The training strategy in the IDP Camps required a different model to both the Zimbabwean model, where MoH workers were facilitators, and in Sierra Leone where the NGO was an independent agent of change. The IDP camps were run by a committee, responsible among other things, for sanitation. A health club was started through the committee in each zone of the 15 camps. CARE supported the establishment of a local NGO, comprising of newly qualified clinicians, backing an initiative by the local hospital. After one week of training by Africa AHEAD, the clinicians were equipped with participatory tool training pack and posted to each of the camps to start five health clubs each. Contrary to expectations vast numbers of members signed up to the clubs and the approach had strong appeal. This was demonstrated by the quantifiable indicators that were evident in all camps: 116 Community Health Clubs were established with 15,522 regular members. Within 4 months, health club members had constructed 8,504 latrines, 6,020 bath shelters, 3,372 drying racks, and 1,552 hand washing facilities, with an estimated 100,000 direct beneficiaries. By 8 months the ambitious sanitation target had been surpassed and almost 12,000 latrines had been squeezed in between the huts, demonstrating that space was in fact not the issue, and that these

demoralised people were able to respond with enthusiasm to practises recommended given an appropriate mobilisation strategy (Okot et al, 2005).

Discussion

Wherever they have been tried: in the rural areas of Zimbabwe, in post conflict villages of Sierra Leone, and in the emergency context of IDP camps in Uganda, Community Health Clubs have achieved cost-effective behaviour change, and the methodology has been emulated by others. This strategy has succeeded in mobilising and engaging the community, in building the understanding, unity and the resolve needed to empower women in particular to pool their resources and solve their own problems with minimal material support for water and sanitation. With much international debate over the methodology that will enable the ambitious MDG targets for sanitation to be met, and despite serious calls for effective solutions by leading donors in the Watsan field, the CHC Approach still awaits the opportunity to scale up. Whilst it was encouraging that with 2,500 applications the CHC proposal reached the final 100 selected at the Development Marketplace Competition for innovative projects in 2005, it ultimately failed to secure the necessary support to widely disseminate this approach.

The scaling up of health clubs is directly related to the number of trainers. If funding is found for enough trainers, appropriate training material and transport for the trainers to access communities on a weekly basis, this approach can be scaled up to district and then national level in most developing countries as explained more fully in a recent article (Waterkeyn 2006). Rather than to continue trying to impress development planners through the literature, seed projects need to be sown on the ground throughout Africa for their results to be witnessed first-hand. The three projects that have been started in Central, East and West Africa can provide a look and learn experience that will enable other countries in each region to adapt and replicate this approach, so contributing to their efforts to meet the MDG target in their own countries.

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