Consensus and a Culture of Health: Cost-effective Health Promotion through Community Health Clubs

UCT Medical School

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Presentation plan

Slide	
4-6	Definition of terms in title
8-10	Changing behaviour related to prevention of diarrhoea
11-17	6 strategies for changing hygiene behaviour
18-20	Results from PHAST Approach in Uganda
21-23	Difference between PHAST and Consensus Approach
25-28	Results from AHEAD Strategy in Zimbabwe
29-34	Decrease in reported cases
35-37	Conclusion and references

This paper demonstrates that …

If a ‘Culture of Health’ has been established …

by a critical mass of people

practicing good hygiene…

this behaviour is likely to become permanent…

and can reduce communicable diseases.

C O N S E N S U S

‘In Africa we sit under a tree, ‘til we agree.’

Julius Nyerere, the first President of Tanzania


COMMUNITY
COMMON-UNITY

A Community Health Club

is an active group of members in an area

dedicated to developing a Culture of Health
in their community

by providing a regular forum for learning
about disease prevention

encouraging safe hygiene practices

thereby addressing the determinants of health

and providing social support to the vulnerable.

C U L T U R E

of

H E A L T H

Beliefs:
interpretation of truth

Norms:
habitual behaviour

Values: importance attributed to choices

HABITUAL BEHAVIOUR PATTERNS

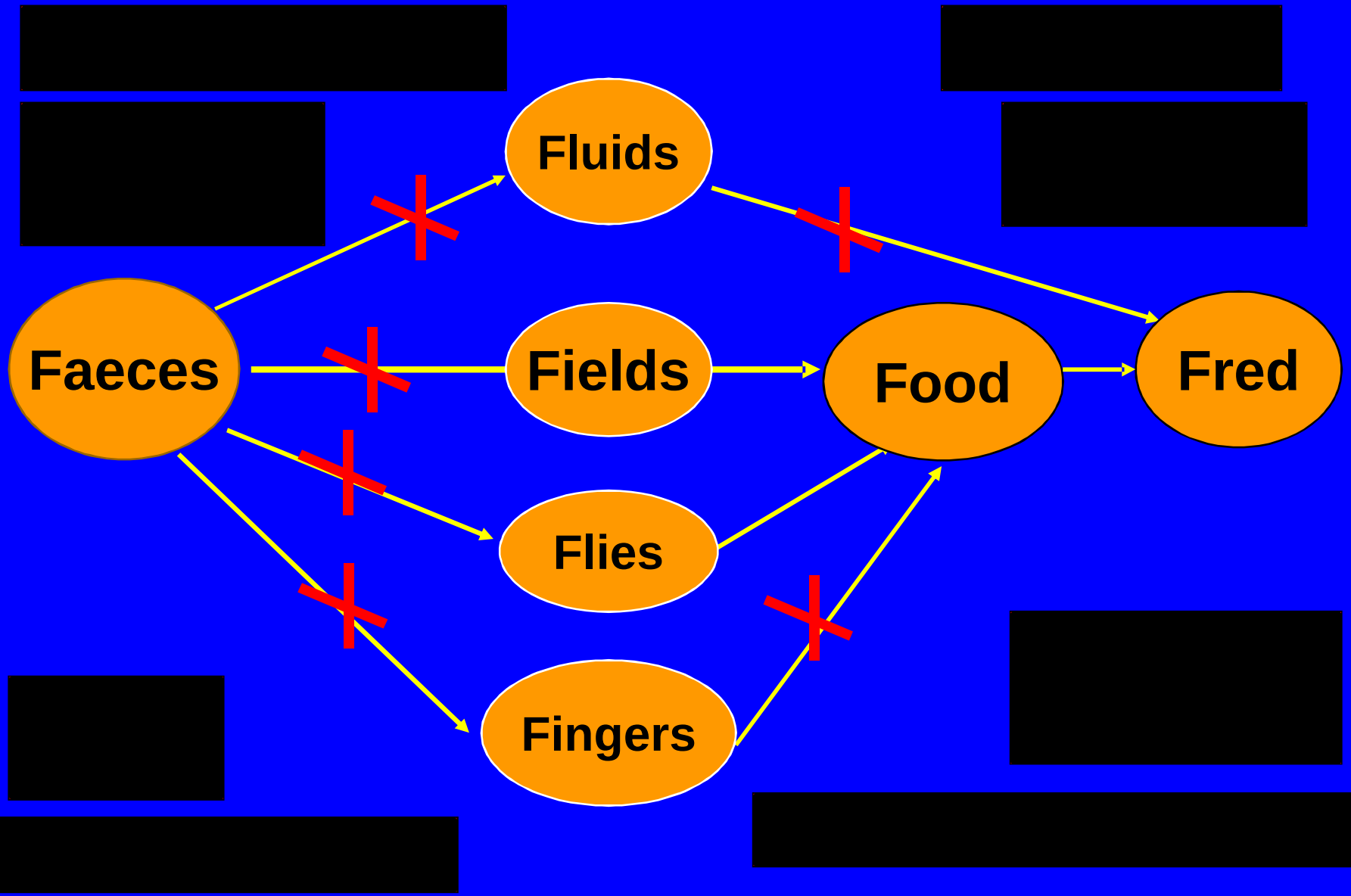
Focus on prevention of Diarrhoea

High risk behaviour:

- **Poor home hygiene**
- **Contaminated food and water**
- **Open defecation**
- **Lack of hand-washing with soap**

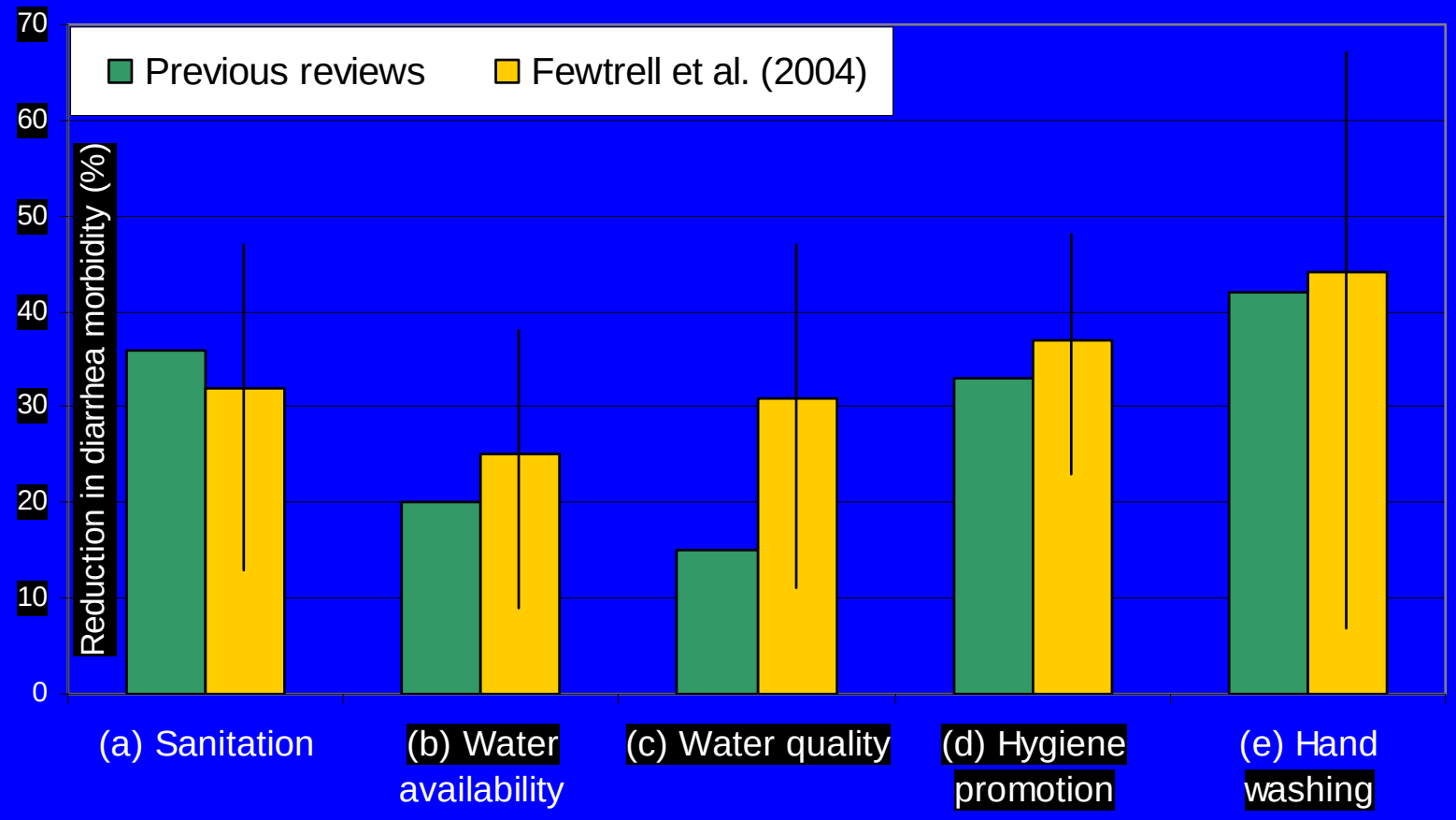
Objective : to break the Faecal-Oral transmission route

Faecal-Oral Transmission Route



Source: The F Diagramme: PHAST Step-by-step Guide 1998

% Reduction of Diarrhoea Morbidity by sole Intervention



Previous reviews:

a – d	Esrey SA et al. (1991) Bull WHO 69 (5): 609-621
e	Curtis V, Cairncross S (2003) Lancet Inf Dis 3: 275-281.

Source: Cairncross S, 2005.The Impact of Sanitation. World Bank presentation

Question:

Can Health and Hygiene Promotion persuade people to change their hygiene behaviour?

HOW?

1. SOCIAL PLANNING PERSPECTIVE — Authority

2. COGNITIVE – RATIONAL PERSPECTIVE
   - Appeal to Reason — Understanding

3. PSYCO-SOCIAL PERSPECTIVE

APPEAL TO

Self Respect	Collective Shame
Status	Subliminal approach
Self Worth	Personal Involvement
Group Security	Consensus

Social Planning / Inspection & Control

People only change when they are forced to do so by authority.

Government planning, local by-laws

Fines for breaking laws

Inspecting homes and public outlets

Licenses for food stalls, bars, schools

Source: A Waterkeyn.2005. 31st WEDC conference, How to Achieve Sustainable Behaviour change: Busia Example

Cognitive-Rational Perspective : APPEAL TO REASON

Health Belief Model

People will improve their hygiene if they know the reason

- Community Meetings
- School campaigns, health education in curriculum
- Counseling at clinics, anti-natal instruction
- House-to-house instruction and research

Photo: Waterkeyn, J. (2004) ACDI/Voca HIV Supplementary Feeding Programme, Uganda

Psycho-Social Perspective: APPEAL TO STATUS SUBLIMINAL METHOD

People are more interested in being smart than healthy

Social Marketing

- National health days
- Radio and TV programs
- Flyers and pamphlets
- Advertising on posters
- Celebrity advertising

Source: Curtis et al. (2001) Photo: Matthews B. 2005. Malawi Sanitation Programme

Psycho-Social Perspective: Collective Shame

People will change their behaviour out of self respect

Community Led Total Sanitation (CLTS)

Village walk

Faecal-oral Demonstration

Public shaming

Village disciplining /fines

Control by Village Leaders

Source: Kar, K & Pasteur, K. (2005) Subsidy of Self-Respect? Community Led Total Sanitation. An Update on Recent Developments. IDS Working Papers - 257.

Psycho-Social Perspective: Personal Involvement

PHAST

(Participatory Hygiene and Sanitation Transformation)

People will change if they participate

- Village meetings and gatherings
- Water and sanitation provision
- Participatory activities
- Drama and radio
- School health clubs
- Local health days

Source: Srinavasan, L. (1990); WSP-AF /World Bank(1999); PDG (2004)

Psycho- Social Perspective: Group Consensus

Consensus Approach (AHEAD Methodology)

People change through peer pressure

Community Health Clubs

PHAST activities

Weekly health sessions for 6 months

Membership cards provide a structure

Graduation days: public recognition

Source: Waterkeyn, J and Cairncross, S. (2005)

PHAST UGANDA STUDY

Intervention period : 1993-2003

32 districts beneficiaries= 4 million
5 programmes (4 Gov & WaterAid)
Total Cost: over US$ 12 million

Pop.15,357,429 h/holds = 2,722,236

Cost per beneficiary: US$3 (.49c p.a)

24 observations/reports :
only 7 showed significant difference
between intervention and control ($p>0.05$)

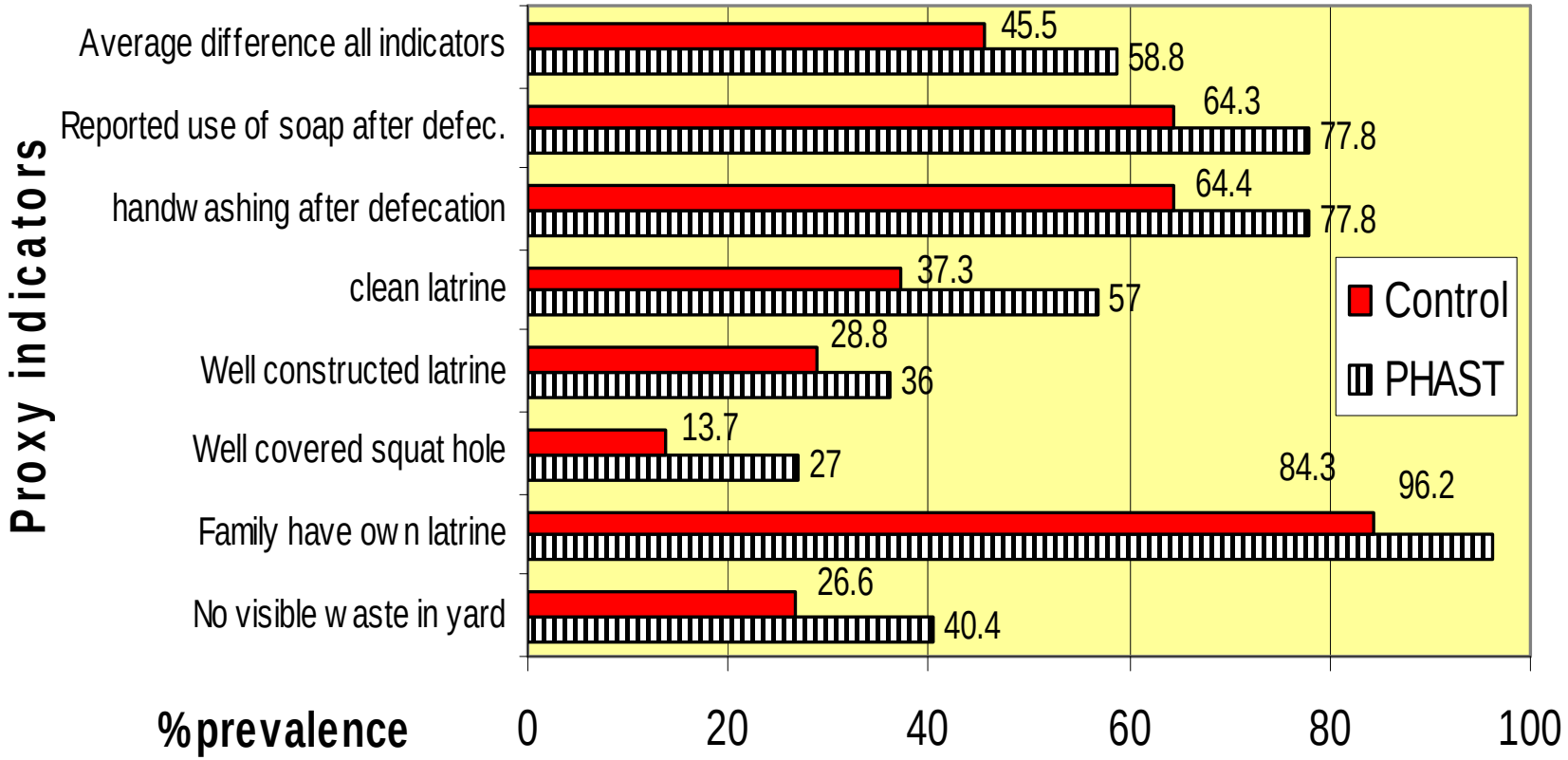
Source: PDG/ WSP-World Bank (2004)

BEHAVIOUR CHANGE IN UGANDA: PHAST STUDY

Only 7 out of 24indicators showed significant difference (p >0.05)

Average = 13.3%

Proxy indicators of behaviour (p>0.05)



Source: (PGA, 2004)

Group Consensus

By meeting regularly the group creates:

K a common unity of understanding: shared knowledge

A Accepted attitudes are developed by the group

B A shared set of beliefs based on sound knowledge

P Accepted ways of behaviour and hygiene practice

Shared norms and values
= A CULTURE OF HEALTH

PhD Syndrome: Pull her Down

C O N F O R M I T Y

Two Survival Strategies

Behaviouralist Analogy:

Carnivores

Individualist

Independent

Herbivores

Group

Safety in numbers

Past development programmes have
made their appeal to people as individuals

FAILURE!

GROUP APPEAL

A dedicated group of people (a Club versus a Gathering)

Provide correct information (weekly health sessions)

Group decision to endorse change

The individual takes less personal risk

Zimbabwe : 2000- 2001

3 districts

382 health clubs

18,044 members

108,264 beneficiaries

Over 60% of members

- completed weekly health sessions
- on 20 different health topics
- 50 recommended practices
- addressing most preventable diseases
- Health Promotion cost 22c per beneficiary

TWO YEAR PROJECT

1st YEAR: COMMUNITY COHESION

Health promotion as an entry point

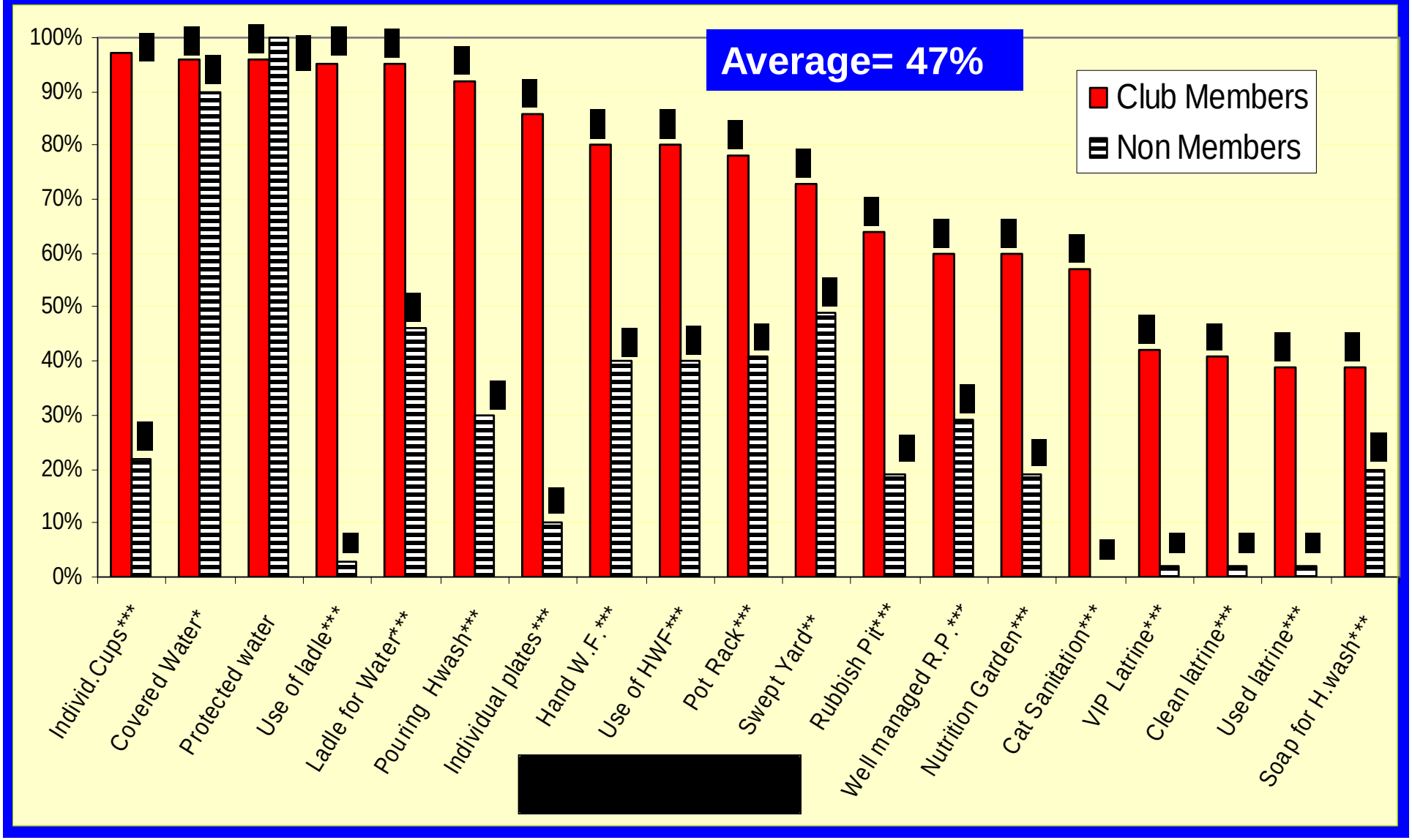
Knowledge of all communicable diseases

- Diarrhoea
- Bilharzia
- Worm infestations
- Skin diseases
- Eye diseases
- Malaria
- Acute respiratory infections
- HIV/AIDS

2nd YEAR: SANITATION PROGRAMME

1,800 latrines built in 18 months

Difference of Prevalence of Observed Hygiene Indicators between Community Health Club Members and non Members in Tsholotsho District, Zimbabwe. 2001



Difference in behaviour (Tsholotsho District) between health club members & control group

76%

individual plates

75%

use of a ladle

75%

use of Individual cups

40%

more VIP Latrines were built

57%

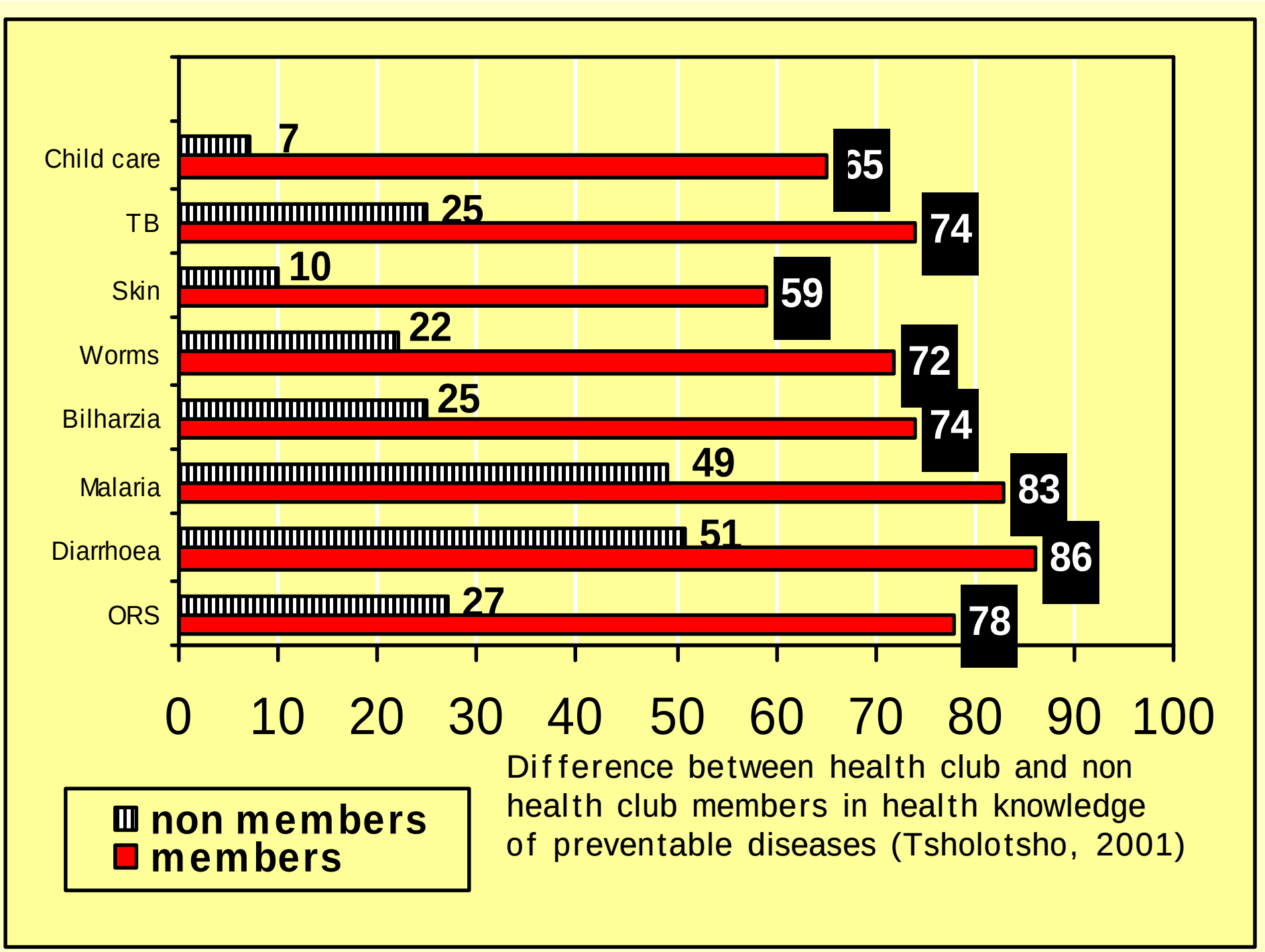
Cat Sanitation (covered faeces)

62%

more pouring of water for hand washing

41%

more Nutrition Gardens were made



Difference between health club and non health club members in health knowledge of preventable diseases (Tsholotsho, 2001)

Figure 3. Tikwiri Ward. 1995-2003.
Reported cases of communicable diseases

Number of health clubs	Period of Health Promotion	h/hlds	coverage
6 health clubs	1998 - 2001 :	516	68 %

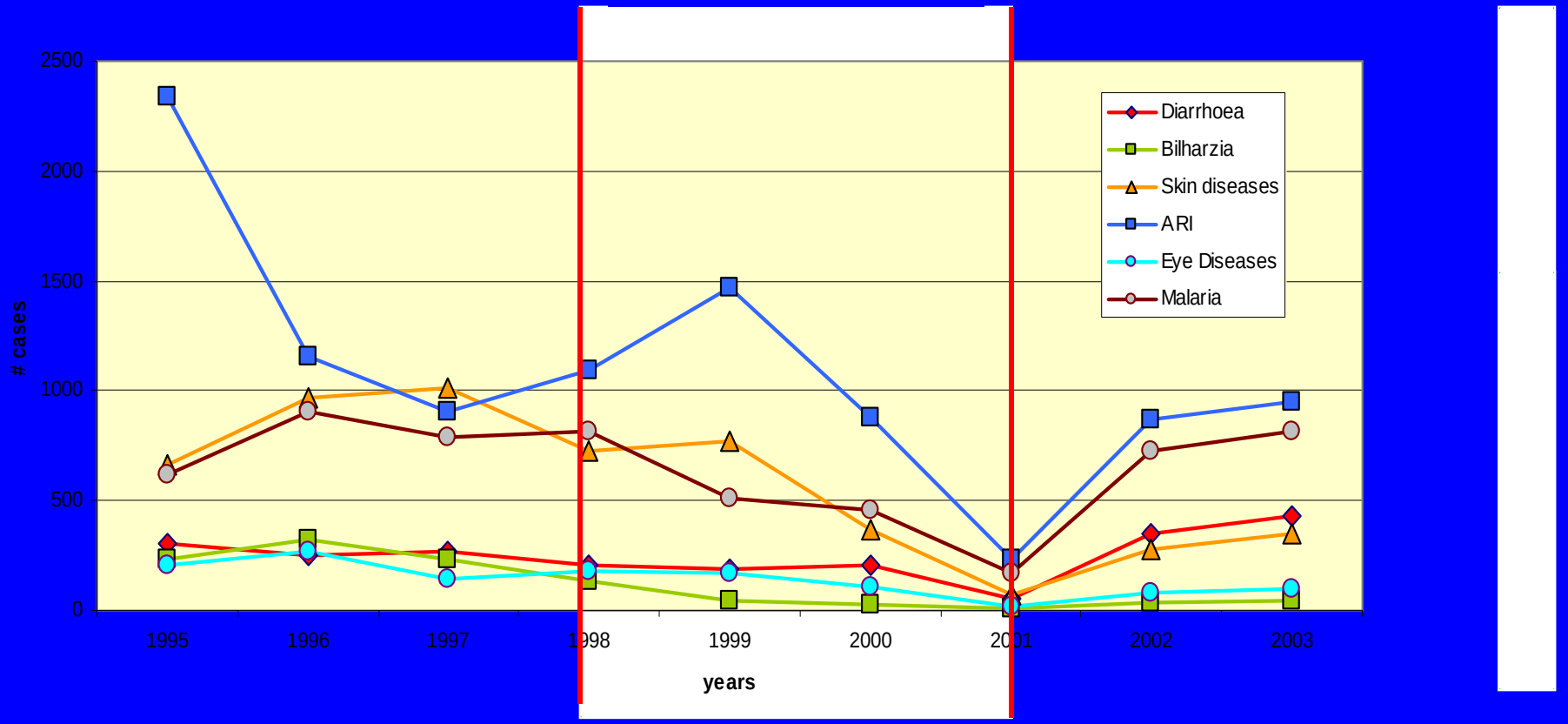
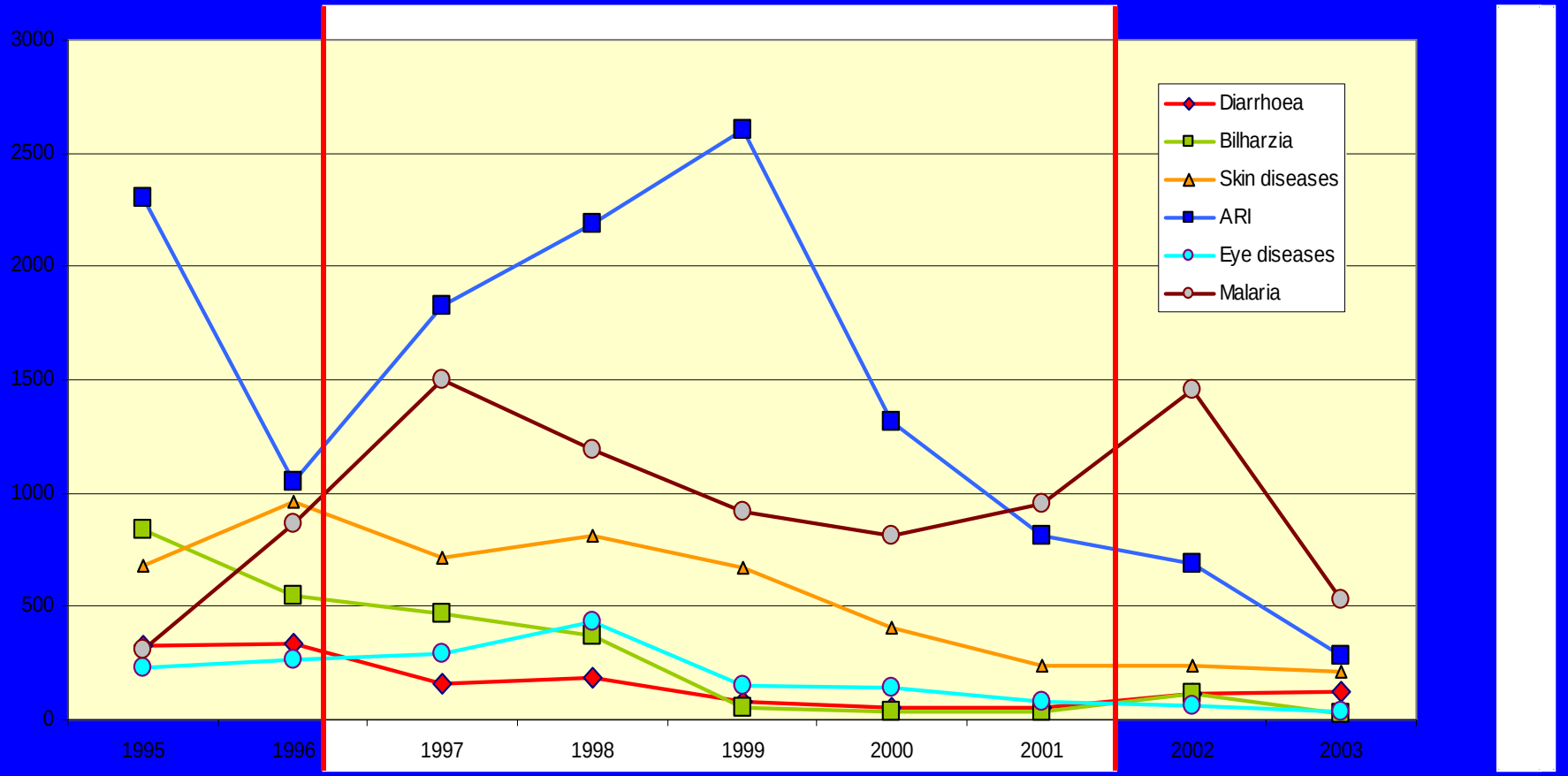


Figure 5. Nyamidzi Ward. 1995-2003.
Reported cases of communicable diseases

Number of health clubs	Period of Health Promotion	h/hlds	coverage
13 health clubs	1996 - 2001 :	1,540	100 %

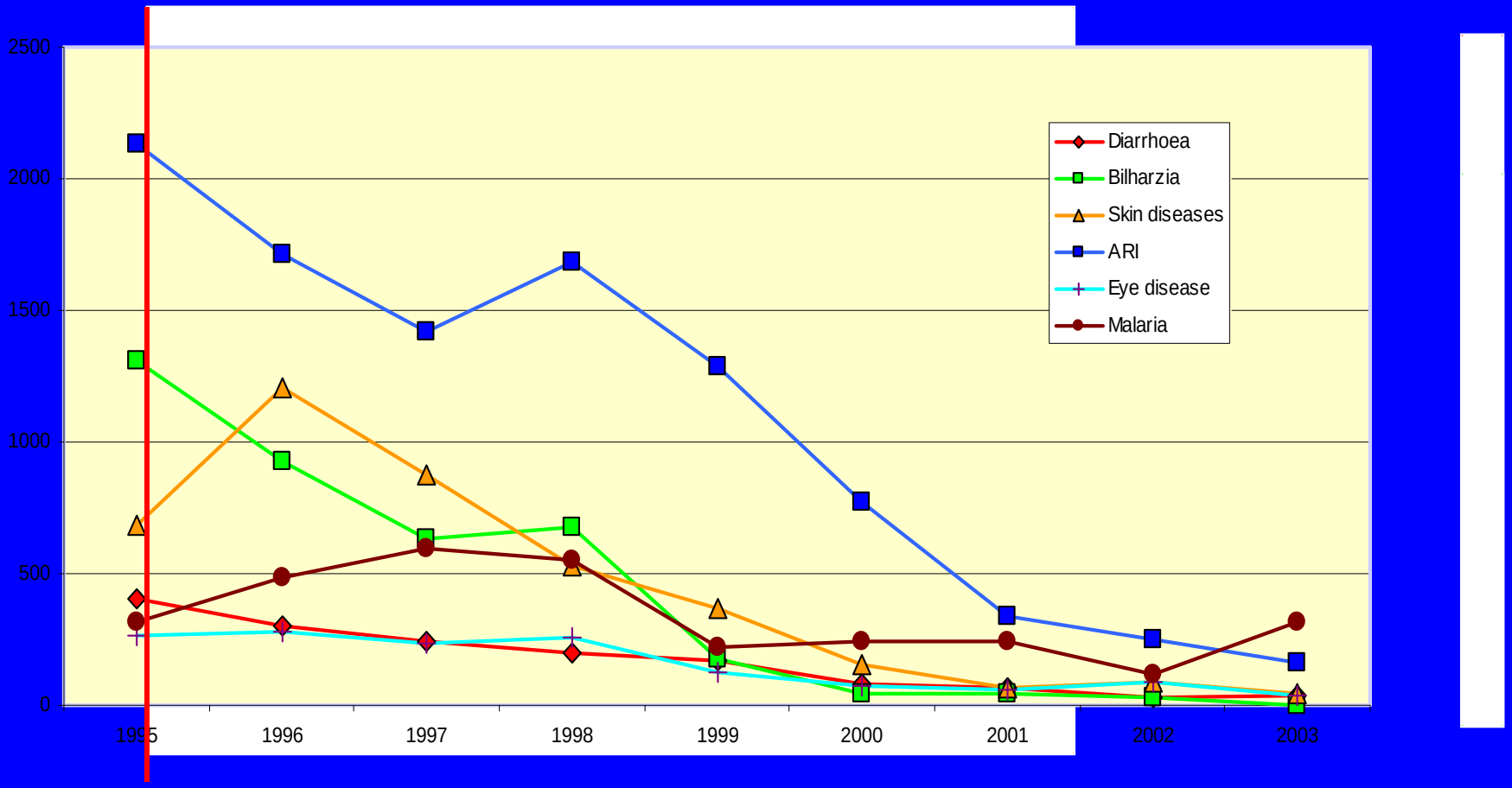


Source: Ministry of Health, Makoni District Hospital, Zimbabwe

Ruombwe Ward. 1995-2003.

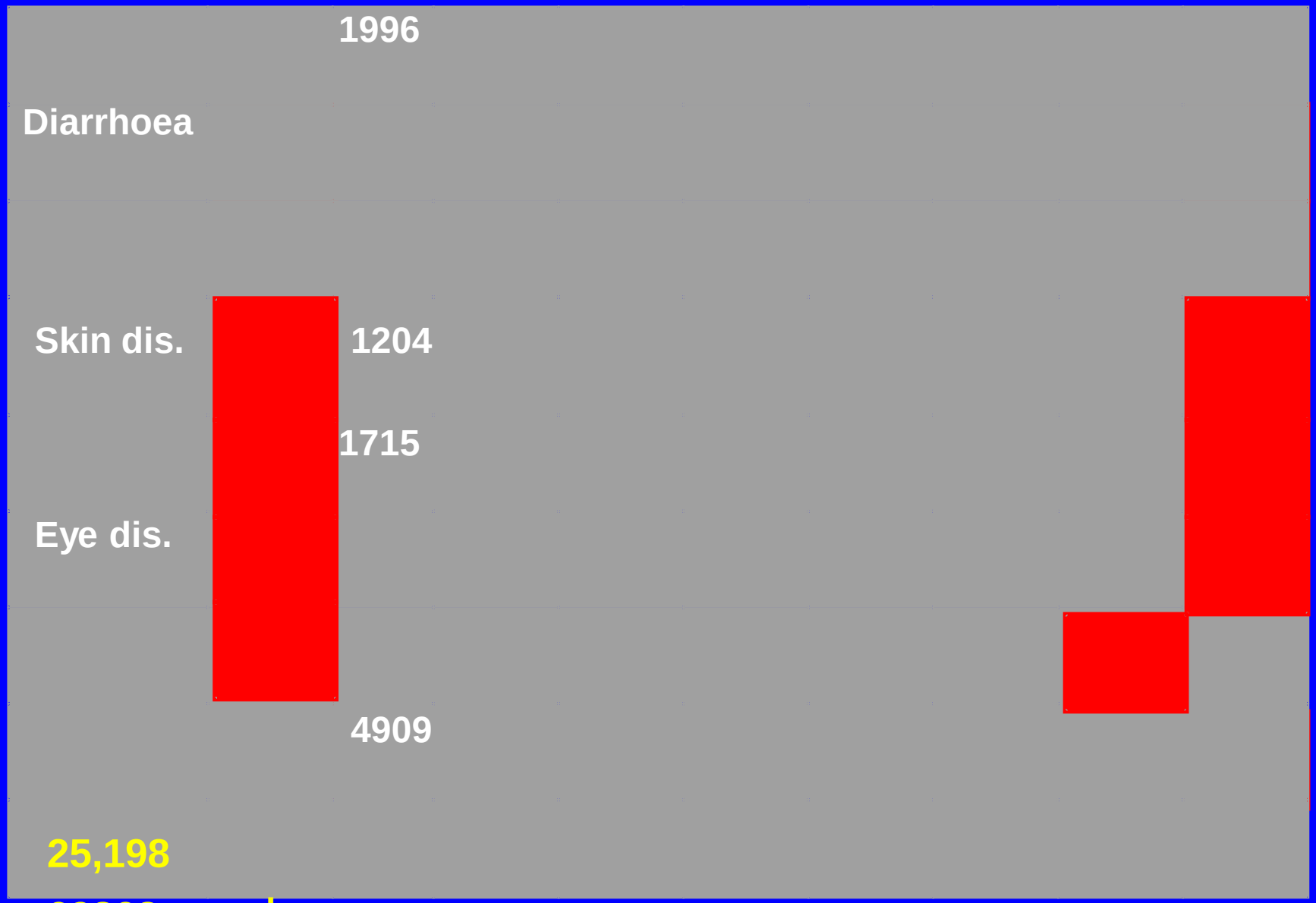
Reported cases of communicable diseases

Number	Period of Health Promotion	h/hlds	coverage
18 health clubs	1995 - 2001	1,777	80 %



Source: Ministry of Health, Makoni District Hospital, Zimbabwe

Ruombwe Ward. 1995-2003. Reported cases



Reported Cases saved in one ward

9 years after the first health clubs were started

25,198 cases saved in Rumbwe ward alone

In most of the 20 wards reported cases at Health Centres declined significantly during implementation period (1999 –2001)

They started to rise slowly thereafter

They still remained below 1999 levels

CONCLUSION

The longer health clubs have been active in an area

and the higher the density of Community Health Clubs

the more there is a likelihood of preventable diseases

being significantly and permanently reduced

This may be attributable to Health Club activities

and positive behaviour change of members

25 Community Health Clubs starting in Khayelitsha

Thank you for your interest

Pre-testing the visual aids for a PHAST activities

Health Belief Model: **Rogers,E.** (1983) Diffusion of Innovation.

Social Marketing:

Curtis, V., Kanki, B. et al. (2001) Evidence of behaviour change following a hygiene promotion programme in Burkino Faso. Bull WHO (79): 518-527.

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Srinavasan, L. (1990) Tools for Community Particiaption. A Manual for Training Trainers in Participatory Techniques. Prowess/UNDP. Tec. Series Involving Women in Water and Sanitation

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Effectiveness of Diarrhoea Interventions

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Fewrell L & Colford, JM. (2004) Water, Sanitation and Hygiene: Interventions and diarrhoea. A Systematic Review and meta-analysis. (HNP) Discussion Paper. Washington.World Bank.

Community Health Club Information www.africaahead.com

2005 **Waterkeyn, J and Cairncross, S. No 61. Soc. Sci. & Medicine. Creating demand for sanitation and hygiene through Community Health Clubs: a cost-effective intervention in two districts of Zimbabwe.**

2006 **Waterkeyn, J. District Health Promotion using the Consensus Approach. Well / London School of Hygiene and Tropical Medicine**

www.lboro/conferences WEDC papers: Waterkeyn et al.

1999: **Structured Participation in Community Health Clubs.**

2000: **Demand Led Sanitation in Zimbabwe.**

2003: **Cost-Effective Health Promotion: Community Health Clubs.**

2005: **Decreasing communicable diseases through improved hygiene in CHCs**

2005: **Rapid Sanitation uptake in Internally Displaced People Camps N. Uganda through Community Health Clubs**

2005: **Waterkeyn A. How to Achieve Sustainable Behaviour Change.**