



Scaling up the Community Health Club Model to meet the MDGs for Sanitation in rural and urban areas:

Case Studies from Zimbabwe and Uganda

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The concept of Community Health Clubs (CHCs) was first started in Zimbabwe in 1995, and by 2001 there were 297 CHCs with over 13,555 members and 81,330 beneficiaries in three districts of Makoni, Gutu, and Tsholotsho. Within one year, this first CHC programme demonstrated high levels of behaviour change (see Fig 1. below) with the most outstanding area in Tsholotsho District showing a 47% average for 17 indicators ($p > 0.001$) (Waterkeyn and Cairncross, 2005).

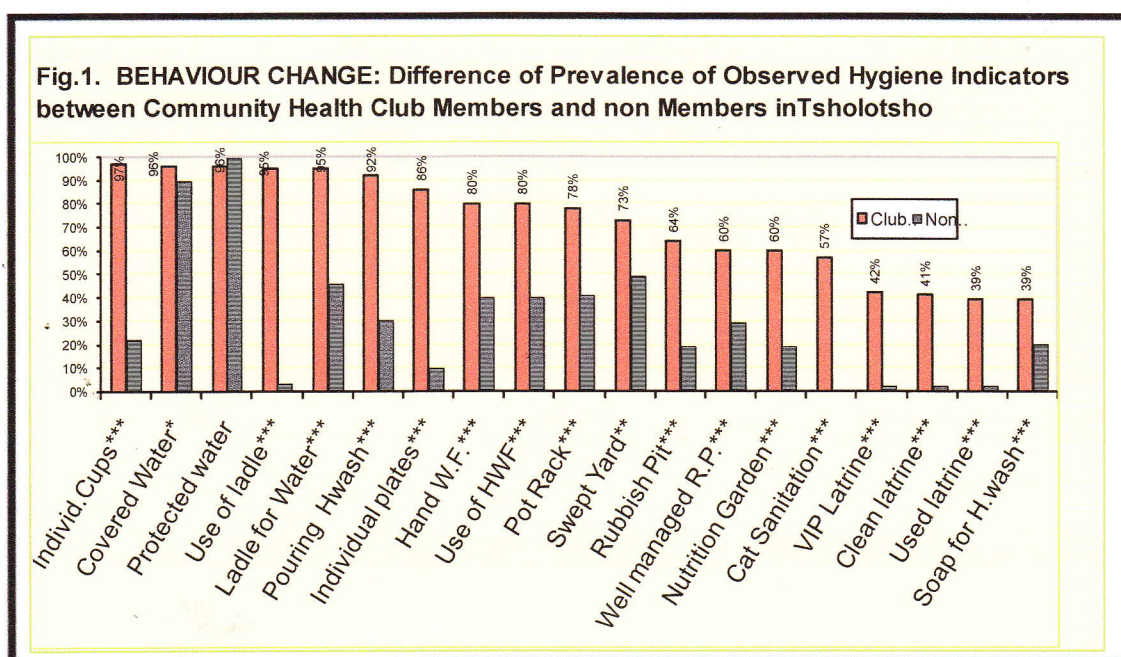


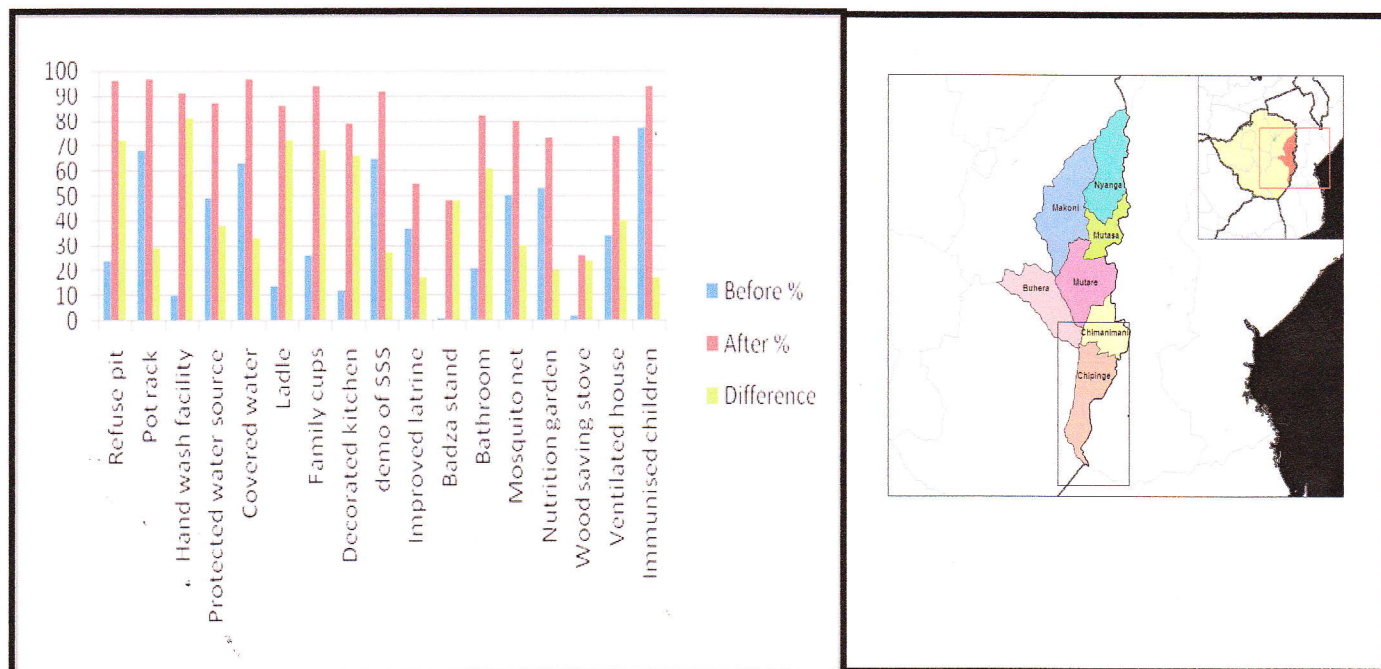
Fig.1: Behaviour Change: Difference of prevalence of observed Hygiene indicators between CHC members and non members in Tsholotsho District, Zimbabwe, (2001)

RURAL CHCS IN ZIMBABWE

Since 2006, the programme has spread to Chipinge, Buhera and Chiredzi Districts with the same popular uptake (Zimbabwe AHEAD/ Mercy Corps / Oxfam). There are now 115 CHCs with an additional membership of around 12,500. In 2007, levels of behaviour change were measured after the six months of health promotion in Chipinge District, where there were 37 CHCs with 2,388 members. The data showed that there was an average of 44% change by measuring 17 indicators before and after the project (See Fig.2.). All the targeted activities were practised by over 80% of the CHC households and six of them by over 90%. In terms of sanitation, 55% of households had a latrine at the end of the project and the balance were using cat sanitation (faecal burial) as evidenced by the construction of a badza stand, (a support for the hoe which is used to dig a hole instead of practicing open defecation). This means there is in fact Zero Open Defecation in all CHC areas. ZOD was a popular terms used to define an area where all members have either a covered latrine, VIP or use cat sanitation. It should be noted that there was no subsidy for the construction of latrines, thus demonstrating the potential for Community Health Clubs to stimulate the self supply of facilities (Zimbabwe AHEAD, 2008).

Fig.2. Chipinge District, Zimbabwe, (Sept 2007) $p > 0.001$ % difference in hygiene behaviour in CHCs as shown by proxy indicators before and after 20 health promotion sessions in 8 months.

Fig. 3. Map of Zimbabwe showing Manicaland Province and Chipinge District



METHODOLOGY

The key design factors that are the signature of the CHC approach are the same in each project, namely:

- The formation of a Community Health Club with a dedicated membership (50-100)
- The use of the Membership Card to monitor attendance
- The use of participatory activities with visual aids in a wide range of 20 topics
- Six months of weekly health promotion sessions
- Reward of active members in a public Graduation Ceremony
- The use of observable proxy indicators to identify behaviour change
- Community monitoring of hygiene behaviour changes in a Household Inventory

It is clear that CHCs are not only a popular strategy but that they do in fact produce high levels of hygiene behaviour change. Zimbabwe is not the only country to report good case studies of the CHC approach. In West Africa, Community Health Clubs are being used to rebuild society after a devastating civil war. In Guinea Bissau CHCs in remote rural villages complement an intervention to improve infant mortality, and in Uganda, CHCs have been used to improve home hygiene and create a demand for sanitation in the war torn IDP camps of the north. Whilst in these examples the CHC approach is being done through NGOs on a fairly small scale, in Rwanda the Ministry of Health is planning to introduce health clubs into everyone of the 14,000 villages in the country. In Asia, Vietnam leads the way with training through the MoH which aims to start CHCs in all 25,000 villages. Countries where this can be scaled up may well be able to meet the MDG targets, given the power of CHC to stimulate demand led safe sanitation.