



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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International Water Association Conference, Mexico City



ABSTRACT

Most countries in Africa will fall short of meeting the MDG targets for the provision of water and sanitation due to lack of financial and institutional capacity (WSP-Africa, 2006). Although safe sanitation has been found to be the most effective single intervention in reducing diarrhoea (Esrey, et al.1991), this does not necessarily mean the building of latrines, as these can become a fly breeding ground if they are not sealed properly, and further compound the spread of diarrhoea. The faecal-oral route can be broken much more easily and a lot more cost-effectively through faecal burial and hand washing with soap (Curtis & Cairncross, 2003). After more than a decade of pilot projects in many countries in Africa the Community Health Club (CHC) Approach can reasonably predict behaviour change, and ensure zero open defecation and handwashing with soap. By creating a strong demand for safe sanitation and a 'Culture of Health' that insures good hygiene (Waterkeyn & Cairncross, 2005) Community Health Clubs can become a potent mobilisation strategy in emergencies not only in rural areas but, as this case study shows, in urban areas as well. During the cholera outbreak that affected 12,700 people and claimed 420 lives in Zimbabwe, the a high density suburb of Sakubva, in Mutare, only had 4 cases and no deaths. This has been attributed to an environmental clean-up and improved the hygiene behaviour due to the efforts of 5,400 members in 36 Community Health Clubs.

COMMUNITY HEALTH CLUBS IN URBAN AREAS

Whilst for many years health clubs were recognised as appropriate for rural areas with semi-literate communities, it was questionable whether they would work in towns. In the past five years the CHC Model has been effectively used in urban and peri-urban areas, including high density suburbs, informal settlements and internally displaced peoples camp (IDPs). It has been found that whether in rural or urban situations, CHC deliver the highest levels of behaviour change wherever there is a low educational level, and in the least developed areas, where high risk behaviours are common. It is less relevant in more sophisticated communities, such as areas of council houses or with city-dwellers with in-house water connection and flushing toilets. However, it is clear that many people living in towns are often new arrivals, living as they would in the country. They tend to be as unsophisticated as their rural relatives, and are often out of their depth in a new environment, so that the community cohesion to be found in a CHC can fill a void. Regular gatherings like CHCs have been found to increase in Social Capital and as a result can reduce stress (Kawachi and Berman, 2000) and provide social support for working mothers. CHCs become the main reference point for dealing with living conditions and improving life skills, particularly in informal settlements where the urban migration from villages to seek work is causing a massive strain on resources. Zimbabwe provided the perfect case study as to how CHCs can be used to stem a national emergency in the cholera outbreak.

THE CHALLENGE

One of the worst outbreaks of Cholera occurred in Zimbabwe between August 2008 and May 2009. To appreciate the seriousness of this epidemic it is salutary to compare a regular cholera outbreaks where it is usually estimated that 0.21% of the local population will contract the disease and die, compared to Zimbabwe where it was estimated that 4.5% of the population of around 11 million had contracted cholera by the time it peaked in February. After eight years of mismanagement, the principle cause of the outbreak was the collapse of the urban water supply, sanitation and garbage collection. Municipal water supplies were often cut off for days on end and there were no chemicals in the country to treat urban water supply. Urban populations were reverting to collecting surface water, but with

the onset of the rains in November 2008, raw sewerage was washed into water sources, used for drinking water. When the epidemic started, there was a shortage of emergency purification tablets for household water treatment. In the high density suburbs, few households could afford fuel (wood or charcoal) to boil their water. Ignorance as to how to prevent cholera was a further factor and when city dwellers visited their rural homes at Christmas, cholera spread to the rural areas, fanning out to every one of the 57 districts in the country. At this point the economy collapsed with hyper inflation at 231 million %. This further aggravated the MoH ability to respond as hospitals could not buy medicines, and three of the four major hospitals had shut down. On top of the cholera outbreak, the burden of disease in Zimbabwe is one of the worst in Africa, with 24.6% of active adults infected with HIV/AIDS and 300,000 children under 14 infected.

PROJECT AREA: Mutare, Manicaland

By March 2009, a total of 89,018 Zimbabweans out of 11 million had contracted cholera and 4,011 had already died. In Manicaland, a Province with a population of 1.6 million, there were 12,700 cases with 420 deaths. Of this number Mutare with a population of 195,300 in 2009 recorded 'only' 198 reported cholera cases and 8 deaths from December to April 2009. Mutare is only 10 kms from the Mozambique border, where cholera is endemic, and Sakubva (pop. 23,600) is the oldest and most dilapidated high density suburb where commuter bus stop from Mozambique stop at the sprawling open market. In March, 2009, there had been no collection of garbage for four months, and some roads in Sakubva, were literally sealed off with metre high piles of rotting garbage. Old sewerage systems from the 1940's were unrepaired and were overflowing in the rains and mixing with broken water mains. It was expected that of all the areas in Mutare, Sakubva would be black spot for cholera. But there only 4 reported cholera cases and no deaths in Sakubva.

Community Health Clubs in a Time of Cholera

The standard emergency response by international aid agencies was to distribute emergency NFI kits containing aquatabs and a plastic container to vulnerable households, to chlorinate drinking water. Zimbabwe AHEAD, was contracted by OXFAM to distribute kits operated in Mutare. Adapting the CHC methodology to the cholera emergency, the NGO mobilized communities in Sakubva and 10 trainers were deployed. They in turn trained local facilitators who rapidly formed up 36 Community Health Clubs, each with an average of 150 members. Within weeks 5,400 committed members, mainly women, were mobilized to rapidly take control of potential health hazards providing health education to the population as fast as possible. They attended weekly health sessions which focused on all the high risk practices responsible for the transmission of cholera and diarrhoea. With the reality of cholera, members were focused on the seriousness of the threat and responding above expectation, following all recommended hygiene practices. Hand washing with soap, clean kitchens and safe sanitation were all part of the homework.

As it was an emergency there was no time to do a base line survey, so as to monitor the changes. However the very fact that cholera was contained in one of the projected high risk areas, was an indicator that the CHCs had had an impact. The majority of households in Sakubva were practicing the recommended hygiene known to prevent the transmission of Cholera. A highly visible indicator of the changes that had taken place in Sakubva was the disappearance of the vast mounds of rotting garbage that were blocking entire streets. The CHC members, mainly women, divided up the settlement, with each household taking responsibility for clearing the debris and ensuring the storm drains along the road were maintained, which kept rain water flowing. Rubbish in the streets was separated, burnt and recycled and within days Sakubva was unrecognizably free from solid waste. It was estimated by the incredulous City Council that the clean up done by the CHC members would have cost US\$ 20,000 if they had used their dump trucks and six months of manpower. They are now finding ways to give contracts for solid waste disposal to the health clubs. In June the emergency programme was completed with 2,400 people receiving certificates for full attendance of the 20 health sessions. The empowerment of women through this method is ensured, as a critical mass of people have endorsed public health standards to ensure that cholera does not re-emerge in the forthcoming rainy season, when cholera is expected to reappear in Zimbabwe.