



**ZOD for all – 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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NORTHERN UGANDA: COMMUNITY HEALTH CLUBS IN IDP CAMPS

From 1987 to 2007, the Acholi people in Northern Uganda suffered from one of the most violent rebel insurgency forcing 1.6 million people to leave their homes to seek protection in IDP Camps in the vicinity of the main towns where they could be guarded by the army. In Gulu District, this displacement accounted for 89% of the population in 33 IDPs camps all of which had over 15,000 internal refugees. These settlements were badly congested, with scarcity of basic sanitary facilities, shortage of water, poor drainage and poor sanitation habits practically no sanitation and contaminated boreholes. Emergency portable latrines had been placed by Unicef along the perimeter of the IDP camps, but there was no awareness creation and facilities were unmaintained. The IDP huts were so closely built together and authorities were told by residents that there was no space for latrines, as few appreciated the value of safe sanitation. Most people relieved themselves on the edge of the camps where the ground was so littered with faeces that it threatened security as the soldiers guarding the camp objected to sentry duty!

The normal high incidence of diarrhea became an escalated emergency when, in 2004, there was an outbreak of cholera in Pabbo, the largest camp, where over 68,000 people were at risk as all the boreholes were contaminated with *e coli*. An eight month emergency project by Care International (funded by Gates Foundation) was launched with the over ambitious target of constructing 10,000 latrines within six months As previous projects had failed to get consumer cooperation, there was doubt that this ambitious target could be remotely achieved.

METHOD

Using the CHC Methodology it was possible to not only to meet this target of 10,000 latrines. Working backwards from the target it was calculated that at least 200 health clubs were needed each with around 100 members with at least 20 facilitators had to be trained. This would allow for a 50% buy in by members so that in each CHC, allowing for sharing of households and existing latrines, it was expected around 50 latrines would be built. Within two months Africa AHEAD had developed a toolkit of training materials and NGO facilitators from an indigenous NGO, Health Integrated Development Organisation (HIDO) were trained and stationed at 15 IDP Camps, where they were scheduled to conduct 20 sessions with each health club, meeting once a week. Membership cards were distributed and a total of 14,282 people signed up to join 116 CHCs in 15 IDP camps with an estimated number of 71,400 beneficiaries (counted as 5 per household). Those households with CHC membership amounted to 38% of the households in those camps (50,392 households in total). Weekly sessions were started in all 116 health clubs and the response was overwhelming with large crowds squeezed between the temporary shacks of the camp. A total number of 1,795 health promotion sessions were held by 23 facilitators in 7 months.

RESULTS

When the project started in December 2004, there was only 5% sanitation coverage in the CHC membership (Waterkeyn & Okot, 2005; Mpalanyi & Mukama, 2006). Detailed monitoring by the facilitators assisted by Community Health Club members showed the following quantifiable achievements by May 2005:

- 11,932 latrines had been constructed (of which 1,790 were pits at time of survey)
- Of the 10,142 stances in the latrines, 1,792 had been properly covered
- 58% of CHC members (8,342) had constructed pot racks
- 43% of CHC members had built (6,192) wash shelters
- 25% had constructed hand (3,633) washing facilities
- an estimated cost of 76c (US\$) per beneficiary.

DISCUSSION

These cases studies in Zimbabwe and Uganda, have demonstrated the popular support for Community Health Clubs, not only in rural but also urban areas, where women in particular have flocked to join. Naturally, in times of emergency such as the outbreak of cholera, there is more incentive to join forces with one's neighbour if one is to survive. It is clear that CHCs are not only a popular strategy but that they do in fact produce hygiene behaviour change at levels that other health promotion strategies find hard to match. Whilst training usually takes at least 6 months in development programmes this can also be achieved in a fast track programme of half that time for emergency programmes with equal effect.

COST-EFFECTIVENESS AND SCALING UP:

As the CHC Approach relies completely on dedicated facilitators to run health sessions every week, the cost of the programme depends on the type of facilitator, and the mobility and transport that is made available which determines how many clubs facilitator can run. This varies in different countries depending on how well resourced the Ministry of Health is in the field. If there are existing field staff who can run CHCs as part of their normal duties this is the most obviously way to scale up. this is happening in Rwanda and Vietnam where the CHC system is being integrated into the Health delivery system. Eventually it is planned that all 25,000 villates in Vietnam will have health clubs run by resident Village health Workers. similarly in Rwanda a programme is starting which will eventually enable all 4,000 village Health Workers to run a community Health Club enabling primary health messages to be monitored at household level throughout these two countries. In other countries where government has not integrated this approach into the Ministry of Health, the methodology is being used by international NGOs, such as WaterAid in Uganda, CARE in Sierra Leone and ISWD in Zimbabwe to capacity build local NGOs to roll out this approach. The pioneering NGO Zimbabwe AHEAD is assisting in training through a DFID funded initiative to disseminate training of the CHC strategy but unless this is done through government systems it remains at best, a patchy response to the enormous need for sanitation.

CONCLUSION

CHCs can be successfully replicated in a variety of contexts: urban and rural, informal and high density, underdeveloped and partially developed as well as within both Christian and Moslem societies. It has also been demonstrated that the Community Health Club Approach is particularly cost-effective when it is scaled up and that family health can be improved for as little as 33 cents per beneficiary (Waterkeyn & Cairncross, 2005). There is now no doubt that the CHC approach can achieve high-impact and sustainable hygiene behaviour change but it is questionable whether scaling up can be achieved fast enough through local NGOs or international agencies. As it is unlikely that the water & sanitation MDG targets will be achieved in many African countries, it is perhaps more realistic to invest in health promotion for self reliance and halve the number suffering from many preventable diseases through improving family hygiene. As demonstrated by countries like Rwanda and Vietnam, it should be possible to roll out health promotion through existing health extension staff and, at a minimal cost, introduce Community Health Clubs into every village in the country. If using this process, the minimal standard of Zero Open Defecation is the target in every village, the MDGs could in fact be achieved to some limited extent.

'You can build a man a toilet but you cant make him sit' – aim for ZOD (Zero Open Defecation)