



Quantifying the Cost-effectiveness of the Community Health Club Strategy in the Rural Areas of Zimbabwe.

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An Intervention Study: Tsholotsho District, Matebeland North

INTRODUCTION:

This Intervention Study forms part of a larger report of a Health Education, Water and Sanitation Programme that took place in three Districts of Zimbabwe between 1997 and 2000. Between the three areas approximately 500 Community Health Clubs were established of which 32 were formed in Tsholotsho. Although it was the smallest and the most underdeveloped of the three areas, it was in this District that the community responded to the Health Clubs most vigorously and indicators of behaviour change were exceptionally high. The research was conducted in the second year of the project and the findings show a high demand for sanitation and strong adherence to recommended hygiene practices. At the time of the survey 70% of the Members had attended 20 or more health education sessions held weekly in the programme. Whilst sanitation is traditionally resisted by rural communities this project was able to demonstrate an almost unanimous uptake of improvements amongst Health Club members, with 57% constructing latrines by the second year; the remainder using the 'cat sanitation' method of burying their faeces with a hoe, as an interim measure until the project could meet the demand. The Community Health Club's impact is shown by these recommendations that were unique to the project being the highest in difference between members and non members. These new ideas included the use of a ladle to take drinking water and the use of individual plates and cups rather than the traditional method of eating together from a communal plate. Others practices that showed less change are either traditionally practised (like covering water) or had been recommended for some years by Ministry of Health. (Use of a pot rack) The higher coverage of protected water source is due to facilities being better in more advantaged non project area and not to individual choice.

METHOD:

Study Type: Intervention Study
Sampling Method used: Two-stage random sample
Enumerators: Two Trained local Hlbedels
Population: 2105 club members 32 Clubs
Sample: 360 members (17%) 24 clubs (75%)
Control: 60 non members from non project areas
Survey Date: 1.5 years after start of project

• QUANTITATIVE:

Individual Data: 360 households: Survey including 20 Structured Observations and Health Knowledge Interview on 8 preventable diseases and how to make ORS

Group Data: 24 Health Club Questionnaires

• QUALITATIVE:

Group Data: 24 Focus Group Discussions
 24 Club Records
 24 Club Histories
 Participatory Matrix Evaluation
 District Focus Group Discussion

Individual: 24 Personal Histories

RESULTS:

- The hygiene practices of Community Health Club members have been significantly improved as a result of the health education and hygiene promotion intervention that has taken place in the project areas.
- The Health Club Strategy has produced a high demand for sanitation.
- Using proxy indicators of improved hygiene proven to reduce diarrhoea, we can assume that the activities of the Community Health Clubs will reduce child morbidity and mortality.
- The Community Health Club Strategy is a cost effective method of improving family health

Observed Behaviour between Groups with 20 Health Education Sessions compared to those without training

92% more use of a ladle for taking drinking water

76% more use of individual plates

75% more use of Individual cups

62% more pouring of water for hand washing

57% more use of Cat Sanitation (covered faeces)

40% more VIP Latrines were built

41% more Nutrition Gardens were made

37% more use of Pot Racks

24% more well swept yards

COST EFFECTIVENESS:

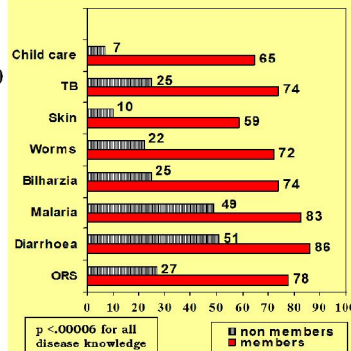
The recommended practices for improved hygiene do not involve much extra expenditure on the part of the members, except for the major investment of building a latrine. In this project the members contributed 60% of the cost of construction in terms of materials and labour, whilst three bags of cement were donated at a cost to the project of US\$15 per latrine.

The cost of health education is calculated by the expenditure on the initial training of the Government trainer and provision of a motorbike which together cost US\$2,366, as well as monthly allowances and running costs of a motor-bike which amounted to approximately US\$850 per month. Thus a total cost, including capital outlay for the first year would be US\$12,866 per trainer.

In Tsholotsho (1999) the cost of Health Education training was US\$38,598 for 3 trainers. If this is divided by 11,577 beneficiaries (2105 families of 5.5 members each) it amounts to only US\$ 3.33 per beneficiary. This excludes the cost of the NGO's project office, which may not always be required in areas with entire implementation by the Government.

Cost of Health Education US\$ 3.33 per member

Health Club Members Knowledge of Diseases and how to make Oral Rehydration Solution Compared to Non Members



General Demography of the Respondents

	Members	Non Members
Female	97%	75%
Married	79%	75%
F headed h/holds	96%	70%
H/hold mean (5-6)	35%	24%
Christian Religion	44%	34%
Apostolic Religion	46%	46%
Traditional Religion	6%	18%
Protected water	96%	100%
Sanitation Level	16%	16%
Income US\$ p.a	347	263
Average Age (F)	43.2	41.9
Average age (M)	63.4	44.9
Education		
< 2 years	20	17
2-4 years primary	26	29
Completed Primary	40	42
Secondary	12	12

CONCLUSION:

- Rural Communities are not at all 'resistant to change' but they do require an appropriate training strategy if positive behaviour change is to be achieved and sustained.
- Health promotion is the most appropriate 'entry point' into a community and should precede the provision of water and sanitation.
- Community Health Clubs achieve sustainable improvements in home hygiene by establishing a 'culture of health' and a 'common unity' of purpose between members, which leads to further development.

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N.B. The centre column summarises the differences in prevalence of observed hygiene behaviours between Health Club members, and the control group, from an adjacent non-project area. This is extracted from the graph below which shows the observed difference of levels of the two groups.

Difference of Prevalence of Observed Hygiene Indicators between Community Health Club Members and non members in Tsholotsho

