BLF REPORT

PARTICIPATORY HEALTH AND HYGIENE EDUCATION (PHHE)

BUHERA DISTRICT – WARDS 1,2,8,10&31

CHIPINGE WARDS - 24,25,26 & 27

BUDGET –USD74 980

PERIOD : APRIL 2007 TO MAY 2008

INTRODUCTION

ZimAHEAD in partnership with Mercy Corps undertook to provide the vulnerable population in Chipinge with greater access to Health and Hygiene Education through the establishing of 27 Community Health Club(CHCs) and the promotion of using the PHHE methodology. To this end ZimAHEAD undertook to do the following activities:

1. Introduction of CHC methodology to Mercy Corps
2. Build capacity of MoH
3. Establish 27 new community health clubs in Chipinge
4. 2015 community health club members trained in 10 preventable diseases, and over 12000 beneficiaries practicing improved hygiene at their household.
5. Over 50% of CHC members graduating after completing all 20 CHC topics.
6. Advocate for acceptance of CHC methodology in MoH and Rural District Council.
7. Hold graduation ceremonies for CHC graduants.
8. Promote the following at CHC households: zero open defeacation, pot racks, rubbish pits, hand washing facility, safe drinking water and safe storage of food.
9. Conduct a quantitative survey of achievements in hygiene behaviour change

The CHC methodology was successfully introduced to Mercy Corps, Chipinge Rural District Council, Ministry Of Health, Government stakeholders and 12 community chosen facilitators at a workshop held at Rupangwana Training Centre from the 23rd to the 28th of April 2007. This workshop was important that it enabled all the players to gain insight to the theory and practice of the CHC methodology which was the vehicle for developmental activities that ZimAHEAD was to undertake in the area.

The CHC/AHEAD methodology acknowledges that development is a process whereby social capital is seen as a prerequisite for sustainable development. Social capital is built through the regular co-operative efforts in Community Health Clubs which are the entry points for successful community development. Thus the introduction of the CHC methodology appeals to a pyramid shift in development work where people are urged to buy into a model which argues that for an meaningful development to take place there must be a sustained effort at meeting the same group of people over a period of time who are committed to a process of on going learning and practice.

The traditional method of community development which most of the stakeholders are familiar with is not rooted in the club model which allows for continuos assessment. The AHEAD methodology assumes a participatory method where the trainer assumes the role facilitator rather than a teacher. The promotion of interactive learning is critical to the AHEAD methodology. It is important to note that most of the stakeholders come from a framework of teaching/learning where the teacher assumes an authoritative role and the learners assume a submissive role of absorbing the information from the teacher. Another important learning that the stakeholders went through the AHEAD methodology is the close link of theory and par axis ie. Enabling both the trainer and the participant appreciate the importance of practically applying the knowledge gained in a classroom setting into touchable, practical behaviour change. To this end the stakeholders were introduced to the membership card a tool that traces learning done and behaviour change on the ground.

It is very exciting to report that the response from the stakeholders is very affirmative in that they felt that this methodology was an answer to the challenges they had be facing for many years. The CRDC has since urged other NGOs and partners working in the district to use the AHEAD methodology in their development endeavours.

CAPACITY BUILDING

In order for sustainability to be ensured it is important to capacity build local institutions, local structures and the community who will inturn continue the process in that locality there after because they have the skills and intrinsic motivation. Hence ZimAHEAD trained EHTs and facilitators from the project area and 2 more EHTs from surrounding area ie. Wards 27 & 29. Although it was a challenge for us getting just 1 EHT for the 4 wards we hope that in the long run EHTs from the neighbouring wards will also spread the knowledge thereby achieving total development in Chipinge.

Establishment of 27 CHCs

The initial target for Chipinge was 12 CHCs. This was later adjusted to 27 CHCs because work in another targeted district- Buhera was not undertaken. Each CHC was suppose to have at least 75 members, giving a total of 2015 expected members for the project. 50% of the 2015 were expected to graduate. There was an overwhelming response which saw the establishment of 37 CHCs with 4516 registered members of which 2892 are very active, 99%

of these were women and just 1% men. The initial response to increase the number of CHCs from 12 to 27 came about both as a response to Mercy Corps request and the community demand, which went further to see that increase go up to 37 CHCs. This indeed is a what is termed 'community driven development' where the community sets the pace and the development agencies responds- a challenge to the traditional development models where development programs are imposed on the community- top bottom approach.

The average number of members per club is 75 has given rise to a lot of critical development where some argues that it is to large however the CHC approach allows for open membership so clubs can range from as little as 20 to as many as, in Chipinge some clubs which were as big as 150 had to be split. It is important to note that the club members should come from the same vicinity and attend at venue within walking distance and these factors were taken on board in splitting the groups. The debate on how big or how small a club is bound to go on among people depending on the various experiences that people have with clubs and club activities.

GENDER CONSIDERATIONS

As noted 99% of the members were women, this affirms the perception that health activities are a gender-related phenomenon. However no probing it was found that some men who could have alternative member had other engagement away from home or indicated that they would be involved if the clubs involved other income generating activities. ZimAHEAD will continue grappling with the imbalance to enable the creation of an environment that will involve men, women, boys and girls both able boded and disabled in health issues. It is only when the whole community is involved in health issues can it become truly sustainable. It is however encouraging to note that the few who were involved did so with passion and at par with women. These clubs have created a platform for women to develop leadership skills who may not have had that opportunity before.

CLUB ACTIVITIES

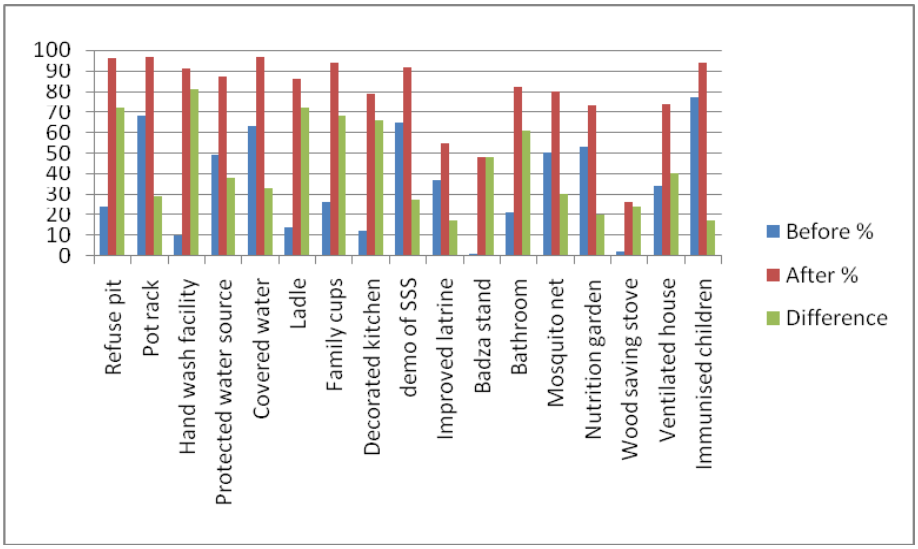
The 2 hour weekly meetings were attended at least 90% of project life and they all trained in the 10 communicable disease. The initial household inventory was administered to all CHC member households by the facilitator and the club committee. Using the participatory approach to collect baseline data is very important in creating a program that is wholly owned by the community because of their involvement right at the beginning of the project. This enables the community to self monitor the process of change. The household inventory is a tool was developed by Dr Juliet Waterkeyn as a basis which can measure hygiene behaviour changes.

In the initial stage only 24% of the members had refuse pits- a very small percentage which meant the majority were haphazardly disposing rubbish. Those who had so form of a pit it was discovered that they were a very high source of contamination. It is interesting to note that in the baseline revealed that younger mothers turned to use potracks other that the

older mother and this can be attributed to expose. Of great concern is the use of the ladle, where 14% used an acceptable utensil to draw drinking water from the bucket whereas the rest fell way below the acceptable hygiene standards. The lack of popularity of the traditional utensil- the ladle has left people with no alternative modern substitute in the form of a metal cup with a long handle thereby exposing people to contaminating water in the process of drawing water. Of very great concern is the non prevalence of the handwashing facility at the initial stage which is an overt indication that people are not washing their hands after using the toilet. The baseline information on the immunisation of children is very encouraging which bares witness that MoH has done a lot of work around this area, however findings are rather compromised around malaria prevention. The immunisation results are an indication that we can work closely with MoH as partners in development as results in children's immunisation have showed that the community has accepted their teaching and leadership.

BEHAVIOUR CHANGE in Chipinge District, Zimbabwe

INDICATOR	Before CHC %	After CHC %	% Difference
Refuse pit	24	96	72
Pot rack	68	97	29
Hand washing facility	10	91	81
Protected water source	49	87	38
Covered water	63	97	33
Ladle	14	86	72
Family cups	26	94	68
Decorated kitchen	12	79	66
SSS	65	92	27
VIP	37	55	17
Badza stand	1	48	48
Bathroom	21	82	61
Mosquito net	50	80	30
Nutrition garden	53	73	20
Wood saving stove	2	26	24
Ventilated house	34	74	40
Immunised children	77	94	17
Average	35.6%	79.47%	43.71%



From the weekly sessions they learnt the hygiene theory and were to apply this in there home setting- indicators of behaviour change-learnt. Not all participants were able to do this, however a short coming on ZimAHEAD was lack of follow up on drop outs and clearly articulating reasons and use these for future programming. Attendance of neighbouring EHTs was very encouraging as they also helped the wards which were not in their due restriction. The EHT in the Project area did not show much interest in the program and this could be seen in the challenges faced by facilitators in his area. For this program to achieve it goals it is critical to recruit and involve committed personnel who can form models which can be replicated elsewhere. Involving civil servants, who it is known are poorly renumerated at the moment eg. EHTs in very demanding NGO development work (which should be their work anyway), with no extra incentive maybe de-motivating because those civil servant involved with NGOs may feel they are work far much more than their counterparts elsewhere. However on the other hand rewarding them financial has its challenges in that the program becomes unsustainable as soon as the incentives are terminated. It is the whole debate of ownership, accountability and governance.

A DISCUSSION AROUND THE CHANGE OF BEHAVIOUR

Handwashing facility showed a very significant change of 81% showing that the community clearly understood the link between hand washing and communicable diseases or it is a behaviour change emanating from being embarrassed about clearly being know for not washing hands after defecation? While they might be no readily available ladle it is encouraged to note that some community members have come up with income generating project to modify metal cup to have long handle and sell to CHC members.

The badza stand an indictor of cat sanitation show a some how suppressed change which could be explain by many family opting to building toilets some of which are temporary structures in the hope of building VIPs as they develop. The shift away from the cat method straight to the temporary toilet could be an indication of the lack of privacy when someone is seen carrying the hoe. On further investigation around the none acceptance of the cat

method community members revealed that culturally in their area being seen carrying a hoe other than for agricultural practice is an indication that you are a herbalist looking for herbs which can only be accepted by a registered herbalist.

Comment:
Development has to be culturally accepted for people to buy in otherwise it becomes unsustainable through overt or caveat rejection. Hence community needs assessment is very important so that development is not imposed on people.

CHALLENGES / LESSONS LEARNT

1. Widen the stakeholders base to include nurses and teachers.
2. Importance of having adequate transport for monitoring and follow up purposes.
3. Selection of facilitators need to be done with a lot of consultants in order to involve effective people.
4. It is important to balance the stakeholders and implementing actors in order to manage the power relation for effective program management.
5. Finances should be made available way before training event for effective planning.
6. Planned targets can be surpassed by community demand as evidenced by the establishment of 37 instead of 27 CHCs resulting in a total of 2388 members graduation versus the target of 1007.
7. Manual analysis of such voluminous social data is cumbersome ideally it is more effective to use the SPSS package designed to work with social data enabling us to extrapolate various data.

CONCLUSION

The effectiveness of the CHC/ AHEAD methodology has been evidenced by the tremendous behaviour change which has been affirmed by the acceptance by the CRDC and the subsequent invitation by the CRDC to ZimAHEAD to enable other NGOs in the area to adopt the AHEAD methodology. ZimAHEAD has since started linking with other NGOs in the area in order to have more partners to buy into the CHC/AHEAD methodology in development work.