Name of Agency : ZimAHEAD

Title: Public Health Promotion In Urban Humanitarian Crisis

Location of programme: Sakubva Mutare

Project cost: USD 144 324.00

Timeframe: October 2008-June 2009 (9 months)

Programme Overview

The project had a slow start as it struggled to get funds released and funds were only released at the end of the first quarter but nevertheless managed to achieve its goals.

Community Based and School Based facilitators were identified, trained and deployed into the community and schools respectively and clubs were formed. These ran successfully and a demonstration of improved knowledge,attitudes,practices and perceptions(KAPP) was demonstrated as evidenced by the low cholera incidences and the very low case fatality rate of 3 % of the 211 cases that occurred in Mutare city as well as the massive clean-up campaigns that were conducted by the Mutare residence starting with the club members and spreading until almost the whole city residence got involved in the clean up by the 5th month of the community health club launch.

Programme performance, summary of Project activities:

This highly successful Public Health Promotion project surpassed its set targets. It aimed at building community and local authority capacity to deal with cholera and this was achieved. It also targeted public health promotion in general and this was achieved overwhelmingly as evidenced by the vast change in demonstrable knowledge and practices. The other objective was to avail hygiene enabling non food items to vulnerable members of the community and targets were met in this regard.

Objectives of the operation:

Hygiene Promotion

<u>Co-ordination of programme design with key stakeholders</u>

We held thorough induction of new Public Health Promotion officers on Public Health promotion with special emphasis on cholera.

The **Director of City Health Services** was a close ally during the implementation of the project and was periodically updated of the project activities. His team comprising of the **City Hygiene Officer, Chief Nursing Officer**, and **Senior Nurse Managers** as well as the **City Welfare and Housing Officer** were close parts of our project and were instrumental from the Training of Trainers to the day to day running of club activities. We called on them whenever there was need and they proved very useful. The appreciation they showed of our efforts also spurred us to keep pushing for more.

The same applies to the **Ministry of Education Arts Sports and Culture** district officials and the **school authorities** and **teachers** who took the project as their very own and ran with it.

We trained **10 Community Based Facilitators** who went back and surpassed the 10 community health clubs target and formed 37 clubs

We also trained **40 community volunteers** on public health messaging and these went and did door to door hygiene promotion as well as focus group discussions with small groups of people in the community on cholera prevention and management
And

We also encouraged vigilance on monitoring and reporting of cases and this resulted in swift response to cases thereby reducing the spread of the disease .We worked with key stakeholders on strengthening surveillance systems and this proved to very helpful. This involved liaison with other players in the district and the **District Cholera Coordination Team** which met daily then weekly at the district medical office during the peak of the epidemic

Monitoring and Evaluation

1. **Water**

Protecting existing water sources

We collaborated with our **hardware** implementing partner (**Mercy Corps**) on promoting water point protection and some of the health club members were trained on Community Based Management **(CBM)** of these water points

Link hygiene promotion activities to water points:

We held several **water points** and **water sources** sessions aimed at raising appreciation of the importance of protecting and maintaining the water points and sources as these were integral in the community well being.

2. Sanitation

Cleaning campaigns:

The residence of Sakubva started a massive clean -up campaign that spread and was copied by those from sister location (Hobhouse, Dangamvura and Chikanga) until the whole city residential areas became a beehive of clean-up activities. Roads that were almost impassable owing to refuse hips are now back to their original working condition. Motor vehicles and people can now safely use the roads once again. The compost from the informal dump site was sifted and is now being used as compost in the household backyard gardens as well as for flower beds/pots.

3. NFI distributions

Co-ordinate with key stakeholders with regards to NFI kits:

We liaised with members of the **Joint Initiative** (Mercy corps and DOMCAP) and got our first beneficiary list from them as they had recently registered vulnerable community members for their Vulnerable Group Feeding project.

Beneficiary registration and verification:

The registration and verification was quite a cumbersome process as a lot of the listed beneficiaries could not be located owing probably to the high mobility of urban households especially those who do not have houses of their own in the urban areas as well as typographic errors and recording

inefficiencies. We ended up drawing beneficiaries from the Opportunistic Infection clinic and from the community care givers among other sources to reach the targeted 3000 beneficiaries.

Procurement of NFI items (monthly and contingency requirements):

At times getting stock in time for distribution was quite a night mare but we later worked around this issue where we had to phone continuously to follow up the NFIs

Non Food Items distribution:

Distribution proved a challenge in the first 2 months as we had no experience in NFIs distribution but as time went on we gathered some experiences to go by and we perfected our distribution system. We distributed 3000 items to vulnerable households monthly for the 9 months of the NFIs on the regular programme and 4000 monthly for 3 months for the Cholera response Scale –up.

Monitoring and Evaluation:

<table>
<tr><td colspan="3">Geographical area: Mutare City-Sakubva and Dangamvura High Density suburbs</td></tr>
<tr><td colspan="3">Sector: Hygiene Promotion</td></tr>
<tr><td colspan="2">Beneficiary numbers: 120 000</td><td>Actual numbers reached: +122 340</td></tr>
<tr><td colspan="3">Objective: To ensure communities, affected by the current food security and economic emergency have a safe level of hygiene knowledge, attitude and practice, to reduce their vulnerability to WSRD transmission.</td></tr>
<tr><td>Outcome Indicator (A):</td><td>75% of beneficiaries demonstrating good hand washing practices.</td><td>Achievements:

Baseline data was at 78% hand-washing and this increased to 91% at exit point</td></tr>
<tr><td>Outcome Indicator (B):</td><td>75% of households demonstrating correct water usage practices</td><td>Achievements:

Baseline data was at 41% but this leaped to 100% after PHHE</td></tr>
<tr><td>Outcome Indicator (C):</td><td>Number of hygiene promotion activities carried out in targeted urban areas and schools according to plans or guidelines</td><td>Achievements:
• 80 hygiene promotion sessions held in 10 schools over 5 months
• Inter-schools hygiene week competitions held
• Over 100% target reached on hygiene promotion beneficiary outreach
• NFI beneficiaries 7000 had 10 health promotion contacts with public health promotion activities on distribution days</td></tr>
<tr><td>Output Indicator (D):</td><td>Number of men and women participating in hygiene promotion forums</td><td>Achievements:
The activities were attended by 7% males (most were at work but some said hygiene promotion was a female domain) and 93% females</td></tr>
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Geographic Area(s):	Mutare	
Sub-Sector: Water		
Beneficiary numbers: 120 000		**Actual numbers reached: 122 340**
Objective: To ensure urban areas affected by severe water shortages have increased access to water for domestic purposes		
Output indicator (G)	**# of clean up campaigns organized and executed**	**Achievements:** Organised one (1) clean-up campaign which was taken up and adopted by the community and has since spread like a veldt fire to other locations we did not work in and is now a culture for the people of Mutare.

Geographic Area(s):	Mutare	
Sub-Sector: Sanitation		
Beneficiary numbers: 120 000		**Actual numbers reached: 122 340**
Objective: To ensure urban areas affected by severe water shortages have increased access to sanitation		
Outcome Indicator (A)	**% of households reporting reduction of visible open defecation**.	**Achievements:** 97% of households now using clean toilets with no open faeces visible in all the surroundings
Output Indicator (B):	**% of households demonstrating knowledge on safe disposal of feacal matter and solid waste.**	**Achievements:** +80% households with refuse pits and sorting refuse to either burn or burry refuse in the suburb. No open faecal matter as toilet use has increased since the toilets are now accessible due to their cleanliness and **lighting/reticulation provided by Mercy Corps**
Output Indicator (D):	**# of beneficiaries benefiting from household/public latrines**	**Achievements:** + 2000 households share public latrines while 118 000 have individual household facilities
Output indicator (E):	**# of clean up campaigns organized and executed**	**Achievements:** One such campaign organised but has evolved into a community culture and now difficult to monitor as its now wholly owned by the community most of whom do not even know of our (ZimAHEAD) existence. Some claim they started it and this is justifiable given some never had contact with project personnel but copied from club members and the situation has been replicated countless times until the originator of the project is no longer known

Geographic Area(s):	Mutare	
Sub-Sector: Non food items		
Beneficiary numbers: 7000		**Actual numbers reached: 7000**
Objective: To ensure vulnerable communities have access to basic hygiene items in target urban areas in order to practice good hygiene, to reduce their vulnerability to WSRD transmission		
Outcome	**% of households**	**Achievements:**

Indicator (A):	**utilizing NFI to practice good hygiene**	**7000**
Output Indicator (B): # of households receiving regular monthly basic hygiene pack.		
Achievements: (7000) 3000 received monthly for 9 months and 4000 received monthly for 3 months		
Output indicator (C)	**# of households receiving NFIs within at least 72 hours of suspected cases reports.**	**Achievements** None were given NFIs this way
Output Indicator (D)	**Quantities and type of contingency stock developed to respond to WSRD outbreak for 5,000 people**	**Achievements**: none

Programme Challenges

- The project had no vehicle and relied on hiring for which they could not pay for three months as the project funds took long in coming.
- ZimAHEAD had no up-to-date computer and relied on assistance from the community nursing department for computer services and this had its challenges.
- Funds took long in being released and for three months the project ran on borrowed stationery and telephone facilities.
- Lack of transport for the Public Health Promoters (PHPs) only one motorbike was later issued to ZimAHEAD to use for both regular and scale –up projects to be used by 8 officers
- Many beneficiaries had no identity documents
- After data cleaning the target was difficult to meet as there was a lot of repetition of names on the JI list
- NFIs came late making harmonisation with food distribution very difficult
- Due to the need to harmonise the distributions ZimAHEAD would end up doing distributions for 2 weeks which would negatively affect health and hygiene promotion sessions in the community health clubs
- Almost everyone encountered during PHP is asking for Aqutabs as they rationalise that even though they do not qualify on our NFI list they are still vulnerable given the scarcity of water in Dangamvura. They say we should aim to avail these since they are not available anywhere else. We however encourage other water purification means like boiling and chlorination as a stop-gap measure.
- There were some incidences of political meddling where one councillor felt he should be involved on the beneficiary selection for NFIs. We have managed to deal with such situations by explaining our position and it has helped reduce tensions.
- Some beneficiaries send representatives who had no identity documents and it was difficult to ascertain that the NFIs reached their intended beneficiaries

- Schools opened late and are closing soon and this impact negatively on delivery of the school health project.

- NFI delivery was erratic half the time

Financial Narrative on spend:

- Total approved budget was $144, 324.00
- Amount spent was $ 120, 427.00 (83%)
- The Balance of $23, 897.00 was never claimed (17%)

Overspending on the individual budget lines

- Salaries- there was an overspend on the personnel budget due to the extended time of operation for the Cholera Response (Scale up) programme.
- In country travel- the overspend was caused by the fact that there was no budget for perdiems on the Cholera response scale up programme
- Bank Charges- generally the costs of transfers, withdrawals and service charges were more than had been projected

Under spending on the individual budget lines

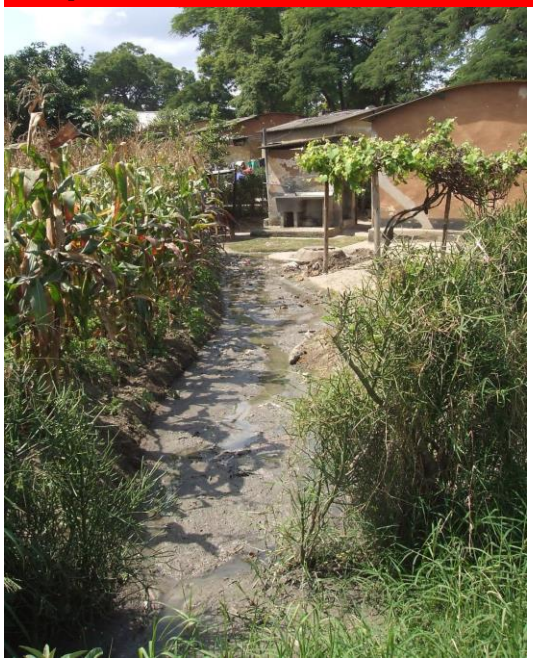
- We had budgeted for three motorbike of which only one came and it also came when the project was half way through
- Riding suits were not bought since we only got one bike. We used what we already had.
- Office Utilities budget was under spent due to the fact that we were given free spare in Mutare
- Facilitators allowances were not exhausted because the school based programme was not run effectively because of disruptions in the education sector
- On programme activities, the disbursement of the Cholera response programme came almost towards the end of the project, so not much had been spent on this line.

CASE STUDY 1

High Cholera Risk: Aged and broken down water and sanitation infrastructure

Sakubva: Considered the worst high density Area in Mutare:

Expected to become the hot spot for Cholera



Blocked sewer system

Overflowing raw sewerage

Cracked water pipes

Cholera suspected in Sakubva

Emergency Response to Cholera – in Dangamvura & Sakubva

Non Food Items distribution

- monthly distribution of soap, cotton wool and aquatablets to 7000 vulnerable beneficiaries

Vulnerability criteria

- households led by people aged under 16 or over 65 years
- Chronic medical condition
- Disability
- OVC

- 26 School Health Masters trained
- 26 School Health Clubs formed
- + 2600 school pupils in clubs

- 10 Community Based Facilitators trained in CHC Approach
- Each facilitator has 3-4 clubs
- 37 Community Health Clubs (CHC) in Sakubva

Ability to Scale Up:

One public health promoter for approx 500 people

- Each club with about 130 members
- Total number of members = approx. 5,000

Street and Market Clean up

Clubs divided into groups of 20

STREET PRIDE

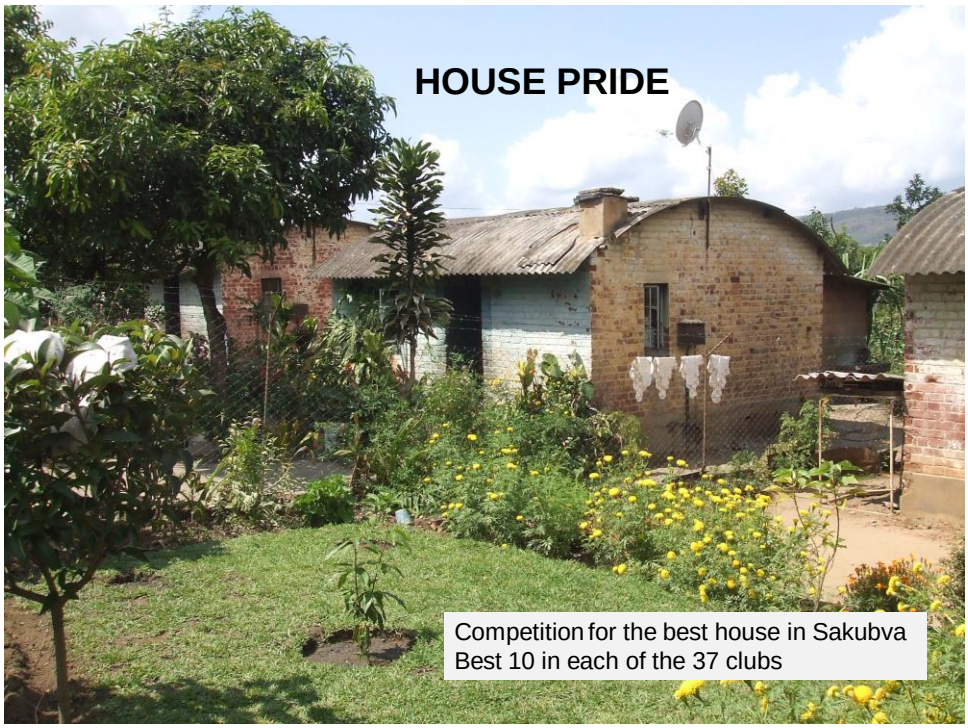
Each household is responsible for

Keeping drains unblocked

Removing garbage

Filling pot holes

People are now fighting over garbage as they see it as a resource for making compost


HOUSE PRIDE
Competition for the best house in Sakubva
Best 10 in each of the 37 clubs


Community Efforts have impressed the Director of City Health Department
You have done a wonderful job. The councillors from Sakubva are saying, 'there is no more refuse in Sakubva.' The main problem which remains is unblocking the sewers and that is our job as the community cannot do it

Thanks to the communities of Sakubva and Dangamvura

Council promises to attend to sewers

Achievement: CHOLERA CONTAINED

The community with ZimAHEAD managed to keep the cholera prevalence rate this low in the face of the potential to burst by doing the following:

- Improved understanding of faecal-oral transmission of Cholera and diarrhoea
- Improved Community home hygiene
- Improved Hand washing with soap
- Improved Environment due to clean ups

Lessons learnt :

- **Community participation in CHCs bring about community ownership of the sanitation program**
- Community responds positively for health when they see it as their **responsibility**

CASE STUDY 2 Knowledge Attitudes and Practices Change: an Impact of CHC

Below is a presentation of the knowledge, attitude and practices change for health that transpired during the 5 months community health club activities. At the onset of club activities 2629 members o rganised themselves into smaller groups and visited each other's homes and assessed their health and hygiene enabling facilities and statuses. Just before graduation they repeated the assessment and recorded impressive changes that they noted at their homes. This clearly showed that the club theory session were applied at home and brought about the desired change for better. This is the argument for the strength and effectiveness of a protracted series of deliberately planned once weekly sessions with the same group of participants over a 6 -8 months period as opposed to the fly past health promotion talk shows that cannot bring about the same impact. More change would have been noted had the project run full cycle for the 6-8 months period

Recommended Practice	Households visited	Members with recommended practice	% Feb 2009	project evaluation June2009(%)
1.Rubbish pit	2629	392	15	2629(100)

2.Pot rack	2629	1415	54	2147(82)
3.H/ wash facility with soap	2629	2042	78	2386(91)
4.Clean bedroom	2629	2128	81`	2629(100)
5.Protected water	2629	2259	86	2629(100)
6.Safe water containers	2629	1074	41	2629(100)
7.Use of ladle	2629	411	16	867(32)
8.Clean cooking area/kitchen	2629	1355	52	2629(100)
9.Preparation of SSS	2629	1271	48	2459(94)
10.clean Toilet	2629	2348	89	2543(97)
11. Clean Bathroom	2629	2381	91	2558(97)
12.Mosquito nets for children	2629	523	20	631(24)
13.Household garden	2629	1688	64	1983(75)
14.Houses with windows	2629	1976	75	1988(76)
15.Child immunisation	2629	1830	70	2384(91)
16.Children without worm infestation(swollen bellies)	2629	1926	73	2191(83)
17.Children with a healthy skin	2629	1931	73	2489(95)
18.Individual cups	2629	1743	66	1986(76)

Please reflect any human interest stories and photographs from the communities with whom we are working – what has been the impact of the programme for them?

The graduation in pictures 3526 (71%) community health club members graduated and its planned that the remainder will graduate when they finish their sessions with guidance from Mutare City Council.

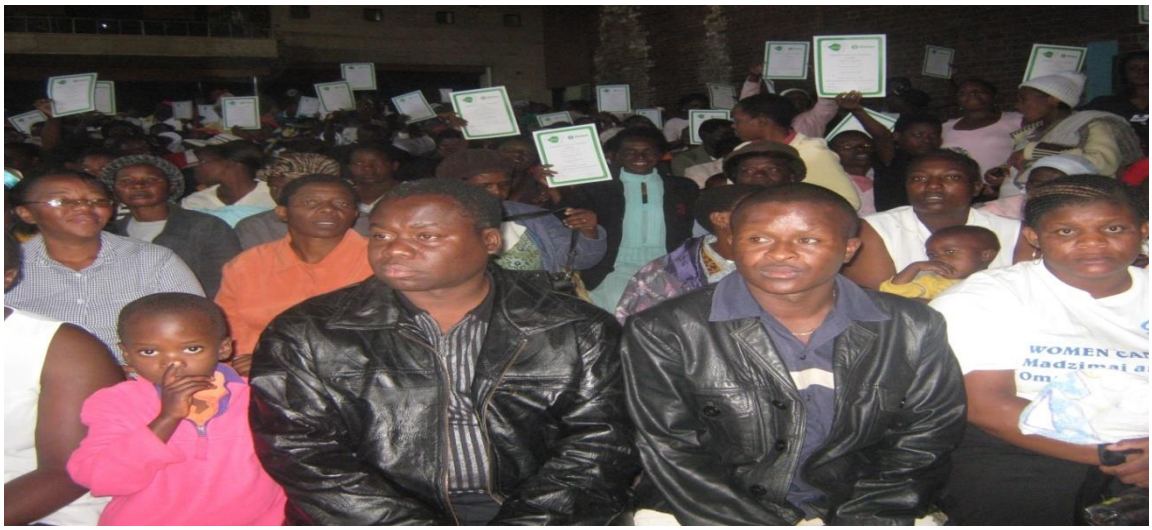
(left to right) a local councillor, Deputy Mayor of Mutare, Project Manager and 2 PHPs, behind them are some of the participants at Sakubva Stadium on the CHC graduation day 25 June 2009

The jubilant graduates pause for a photo with their Facilitators

They admire their OGB ZimAHEAD certificates

The Project Manager addresses participants at one of the club graduations before the grand-finale

The project manager and Deputy mayor hand over +1000 certificates to on of the Facilitators



The Councillor and Deputy Mayor pause for a photo with part of the graduating participants

Part of the graduating crowd watching as names are called out to receive the certificates

One of the 7 % graduating male participants