Presentation for the SuSanA Webinar
26th January, 2016

Making 'community led total sanitation' work with Community Health Clubs

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Title page: Introduction:
In the past decade the 'Community Led Total Sanitation' has become synonymous with most sanitation programmes, but recently some doubt has been cast on the *efficacy* of this approach. I would like to present a more holistic development model which I think does *indeed* deliver 'clts' (lower caps) – a behavior change model that really can achieve high levels of sanitation and much *much* more, through the use of a community mobilization strategy known as a Community Health Club.

With the end of the massive effort to achieve Millennium Development Goals in 2015 and the start of a new era for development with the SDGs, I think it is a very relevant time to present a more holistic methodology that can indeed achieve hygiene and sanitation behavior change, but a model in which WASH is just a part of the whole process of development.

Please bear with me as I try and introduce this model in the next ten minutes.

Slide 2: A Community Health Club
What are Community Health Clubs? A club is more than a group of people who meet loosely. A club attracts people with the same interest, the same vision or dreams, in this case the vision of having children that survive and prosper through the avoidance of common and preventable diseases.

A Community Health Club consists of representatives from as many households as possible within a village or area. Clubs can be anything from 50 -150 members, who have all signed up for a course in hygiene. They are not *exactly* 'women's groups' as men are encouraged to attend, but it is also true that 80% or more will usually be women. So, a club is a voluntary organisation of all ages, education levels and income brackets with a common vision.

Slide 3: CHC Countries
The concept of a CHC was first pioneered by the team which is now Africa AHEAD in Zimbabwe in 1995, and as consultants we have improved the hygiene of over 1.54 million people mainly in Africa. This is excluding the massive national programme in Rwanda where there are CHCs registered in most of the 14,000 villages in the country. Elsewhere it remains at an NGO level and our organisation Africa AHEAD is the key proponent of the approach and we have trained over 30 leading International and local NGOs in the CHC Model. So what is so special about the Approach?

Slide 4: Membership card
The key to the CHC Model is the membership card, which is given to every member. This card lists the sessions that will take place once a week for a couple of hours in a six month training. When a member attends their card is signed, and when all sessions are complete they qualify for a certificate. This may sound simple but it is the only input of the programme: there are no subsidies for any water or sanitation initiative. The card is immensely popular and helps to convince the community that this is a serious project and they can count on the sessions to be arranged.

There are 20 sessions, which range through all the WASH subjects of water, sanitation and hand washing but go much further into the prevention of common diseases, not only diarrhoea but also worms which are easily controlled through good hygiene, skin disease, bilharzia, malaria and we also include nutrition, child card, and HIV/AIDs. These are introductory sessions to stir up debate and group analysis of the challenges of living below the poverty line. However as interesting as these sessions are using participatory activities and over 300 illustrated visual aids, it is the *homework* which is all important. Each week, the club decides on small changes that they can make themselves in their homes to better organize their facilities to be clean and hygienic.

Slide 5: Zim programme
As a case study, I would like to present to you the achievements of one of the most ambitious CHC programmes we have ever done, in two districts of Zimbabwe, Gutu and Mberengwa, in partnership with Action Contre la Faim, funded by the EU.

Our objectives was to achieve not just a *high* membership but *blanket coverage* of CHC households so that every *single* household belongs to a CHC.

We also aimed for ZOD- Zero Open Defecation –the same as Open Defecation Free (ODF) but easier to remember! ZOD has become a great rallying cry for change and everyone understands the meaning: no unburied faeces, latrine which block out flies. An unsealed latrine is worse health hazard than open defecation as at least surface crap dries in the sun! So all CHC latrine have to be either sealed with a well-fitting cover or be a ventilated pit latrine.

Slide 6: After 4 Months
The programme was massively popular and we have no difficulty reaching and even surpassing the targets. As you can see above there was a total of 16,255 households in the catchment area of the two districts, and we had 17,329 members. We had 429 villages and 454 CHCs, meaning more than one CHC per village, and more than one person per household attending the sessions. In total there were 68,160 people directly benefitting from this training. The training was done by 154 community based facilitators. – these were village men and women, mainly women nominated by the village to lead the sessions. Africa AHEAD provided the training and we had 12 field officers, one in each ward to monitor and support the CBFs.

Slide 7: Meeting place
When I did a tour of the project I was excited to find that in many places the CHC venue had not only been cleared but some had constructed meeting houses. This effort clearly underlined the long term commitment that CHC members had to their club. They also used the shelter for a play school for their children. At each CHC venue there was a demonstration like this of the facilities recommended for each household. Here we see the pot rack for draining utensils after being washed up.

Slide 8: ZOD Latrine
There was also a latrine at every venue, with a vent pipe demonstrating how these latrines can be built with little support. This is a break through in Zimbabwe where the well know cement brick VI was the standard and there had been subsidy for years. When donor funding dried up there was a steep decline in latrine building and coverage of sanitation dropped to comparable levels with other countries in Africa, an average of 32% with improved latrines…. with no external inputs more sustainable.

Slide 9: Tippy Tap
The well known hand washing facility called the Tippy Tap is also a feature of the CHC venues and all the CHC homes, where there is often more than one tippy tap in use, one by the toilet and one by each entrance to the compound. All members must have a pot rack, a wash shelter and to be able to manage their rubbish, recycling and reusing it.

Slide 10: Model Kitchen
The kitchens of the CHC members in Zimbabwe really have to be seen to be believed. This is a typical kitchen, in Zimbabwe, where unlike many other places in Africa they are used to a dedicated room, where water and food is stored and where cooking takes place. Inside, the mud walls have been moulded in clay into shelving. Everything has its place: the water , properly sealed with cups for each member of the family, so as to prevent sharing cups and spreading germs. The cheap tin places are transformed into a work of art. This kitchen is not a unique, but one of thousands which are throughout Zimbabwe thanks to the fashion we have started through Community Health Clubs. This is how positive peer pressure (i.e. fashion, wanting to be smart like others) helps to influence hygiene behaviour.

Slide 11: Fuel Efficient Stove
The CHCs are not just concerned with food hygiene but also can help to reduce the deforestation through pushing the used of ‘fuel efficient designs for stoves. We recently partnered with International Lifeline Fund in Uganda, and trained 70 CHCs in villages where they were providing boreholes. Not only were we able to mobilise the community as they had never seen before but we are were able to create a ready market for the fuel efficient stoves which they were producing. CHCs can be useful in practically any programme where an idea or a product needs marketing. The ‘group decision’ making that takes places can endorse an idea which then all members tend to follow. With a low margin for error, the poorest of the poor are often resistant to new ideas if they are not sure they will work. The use of a latrine is one of those new ideas, and for it to be sustainable the whole village has to endorse the idea.

Slide 12: PLAN Study
The past ten years has seen a massive uptake of what is popularly known as CLTS – Community Led Total Sanitation – an inspired name which caught the imagination of many but which has been a let down in terms of sustainable sanitation.

In 2013 `PLAN International conducted a five country study to ascertain the sustainability of latrine coverage as a result of their CLTS programmes.

Only 8% of survey respondents had a clean, functioning latrine with a lid over the hole and a hand-washing facility with soap or ash and evidence of their use.

Slide 13: Sanitation Resiliency
In 2015 another study was done to measure the sustainability of sanitation in CHC. It used the same criteria as the PLAN study to measure if latrines had been maintained since the end of the formal CHC programme.

Plan International CLTS study: 21% slippage rate on latrine use in 2-3 years.
Toberte surveyed 6 CHC villages **5 years** since last contact with Africa AHEAD **FAN phase (completed in 2010) and in fact 7 years post-PHHE portion (completed in 2007/08)**
105 He compared CHC graduates who completed all 20 PHHE lessons to 32 non-graduates who completed 0 to 8 lessons
The percentage of houses improving their sanitation since the end of the CHC (2010) was significantly higher amongst CHC graduates (23% vs 10%, $p<0.05$)

Slide 14: San & Hygiene uptake
A study was done in 2011 by Whaley and Webster in Zimbabwe comparing a CHC area and a CLTS area using only two indictors, Sanitation and hand washing, and also tested for sustainability. This is one of the comparative graphs that they produced.

CHC villages were almost 20% higher on open defecation free indicator, meaning no faeces found lying around the home. Superficially it looked like the CLTS areas produced more latrines, until it was discovered virtually none of the latrines were built since the CLTS intervention. Meanwhile of the 20% of households which had their own latrines, virtually *all* were built since the CHC had started. More persuasive still, 60% of CHC households had tippy taps whilst CLTS areas showed only 8%.
Conclusion: The CHC Model is able to get a high level of buy in from most households in a community and therefore there is more coordination between household to block ALL transmission pathways that cause diarrhoea, (the 5 F's) not just sanitation coverage, but food hygiene, safe drinking water and good hand washing.

Slide 15: CHC & CLTS
Given these results there needs to be some analysis as to why the CLTS approach is so unsustainable. Let us just compare the implementation of CLTS and CHC in terms of methodology: ie number of interfaces with the community, the triggers for change that are used, the means of adoption, and the outputs.

Being inspired to change rather than ***shamed*** into action is much more sustainable, because we are changing the core values that underlie every behaviour. I know this through our own work… we have been starting CHCs throughout Africa for the past 20 years and never have we had a damp match box. I can safely claim that every village where we have started a CHC the people have flocked to join it, women enjoy learning and they enjoy working together.

However, we don't have to throw the baby out with the bath water. Let us build on CLTS which had many strong supporters to make a 'quick and dirty' intervention more 'sustainable'. There is no need to do a U term on CLTS but simply to convert this narrowly focused 'sanitation' programme into much more *holistic* package through a CHC. It was ambitious to think that communities can sustain change so easily after just a one day triggering event. Conclusion:

Whilst CLTS provides a kick start to the community it fails to sustain the impetus. Much more community mobilisation is needed to sustain sanitation and hygiene and this can be achieved through a strategy that builds the self efficacy of the community through group cohesion. We believe CHC is such a strategy and could be used to reinforce the sanitation initiative started by CLTS.

Slide 15: CHCs in the SDGs

However, expanding the vision of good development. I would just like to end with a broader brush strove. Whilst in SuSanA network we are focused particularly on WASH issues, the potential for the use use of a CHC is more appropriate as ever when we move into the Era of the Sustainable Development Goals, a much more integrated approach.
A Community Health Club is an engine driven by 'people power' which can deliver a whole range of projects, I like to think of a CHC as the engine of a train, which is able to pull all the SDGs along in an on-going process of development, from WASH to Nutrition, Energy and Environment.
But that is another topic. Time does not permit me to elaborate. Thank you very much for your interest.

Please do explore our website. www.africaahead.com for more information

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