Monitoring Hygiene Behaviour Change Through Community Health Clubs

Juliet Waterkeyn & Jason Rosenfeld (2009)
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BACKGROUND

Umzimkhulu Municipality in Kwa Zulu Natal Province has one of the lowest levels of development in South Africa. The base-line survey highlights that only 15% of households have access to a safe water source whilst the remaining households have to use open ground water, usually in the form of unprotected springs. Sanitation usually consists of a household pit latrine. Although the coverage is high at 90%, around 50% were unhygienic and attracted flies. A health promotion campaign was introduced to build the capacity of the community, with the objective of developing a community-led demand for improved water and sanitation. As the Community Health Club Approach is known to be capable of achieving high levels of behaviour change (Waterkeyn & Cairncross, 2006) it was chosen as the strategy for a health promotion campaign in nine wards of Umzimkhulu. Although Africa AHEAD has initiated Community Health Clubs in informal settlements in Cape Town, this is the first pilot project in South Africa to be implemented in a rural community.

THE COMMUNITY HEALTH CLUB APPROACH

In February 2009, working with the Umzimkhulu Municipality and local councillors, a Community Health Club was started in each ward. Africa AHEAD trained facilitators from the community in how to conduct health promotion sessions using PHAST participatory activities to promote hygiene behaviour change. Almost 1,000 members were registered and weekly sessions were held in all nine wards. Attendance rates varied according to the proficiency of the facilitator, but although most members attended some sessions, there were 550 hard-core members who completed all 24 health topics within six months. Certificates were awarded at a Graduation Ceremony in September 2009, attended by district and provincial representatives which marked the end of the pilot project. In the next phase, relevant government departments are planning to use these well mobilised communities to improve water, sanitation and quality of life through agricultural and income generating activities.

RESULTS

In the post intervention survey (September 2009), it was found that 76% of all registered members were following the recommended practices promoted during the 6 month health promotion project. As is shown in the chart below, whereas before the project only 18.1% had safe water, there is a 41% change. Although the water source is still not safe, 51% now treat their water, 86.1% store it safely and 87% take water for drinking using a ladle, so minimizing contamination. Sanitation has improved by 14%, from 71.1% with no open defecation to 87.8% of members having ZOD (Zero Open Defecation) defined as clean covered latrines with no faeces. In addition, whereas only 29% of member households had a dedicated hand washing facility near their latrine at the beginning of the project, 70.1% have now constructed a simple facility that allows them to wash their hands immediately upon exiting their latrine. Even more impressive is the use of soap for hand washing that has risen from 40.1% in February to 68.4% six months later. An observable indicator is an 18% drop in ringworm seen in CHC households; 87.7% mother can now prepare SSS correctly.

SELF SUPPLY

There is little doubt that family health has been improved where health clubs have been established in Umzimkhulu, and demand to scale up this programme to all other wards is high. Meanwhile the self-motivated improvements that

some Health Clubs have already made contingency measures to protect their water sources, without any external financial or technical assistance. Each CHC now has a trained building group, constructing safe latrines on demand for members. This display of self reliance validates the CHC Approach, which aims to empower communities so that they manage their own health and utilize existing resources more effectively, at least until government can provide the required services.

RESEARCH METHOD

Study Type: Intervention Study
Sampling: Purposeful
Technology: Mobile Research Platform
Enumerators: 7 local CHC facilitators
Health Clubs Seven
Total Membership: 1000
Hard Core membership: 550
Sample Size Baseline: 469
Sample Size Post Int.: 538

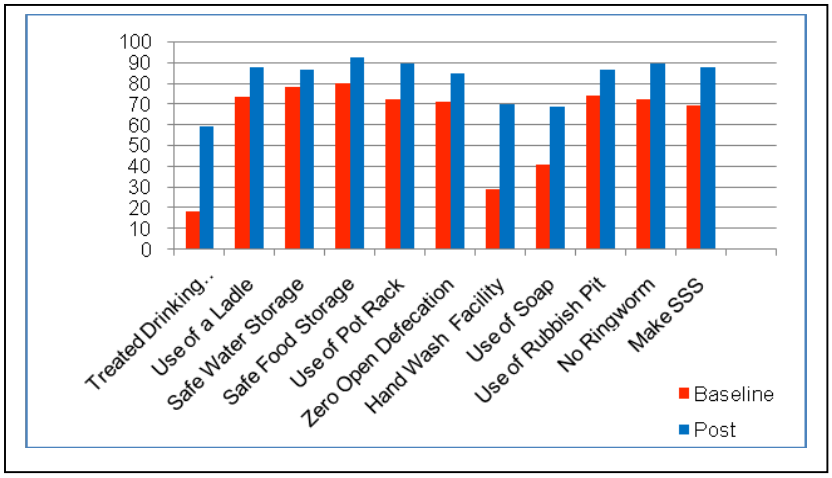

Fig. 1. Hygiene Behaviour Change in Umzimkhulu, as measured by mobile researcher, in CHCs before and after 6 months of health promotion

RESEARCH METHOD

Prior to the training a base line survey was conducted in all nine wards, with most Community Health Club members being interviewed. Each month, this 'household inventory' was redone, and hygiene changes as represented by the 12 observations in household inventory were tracked by the community facilitators. There are more respondents in the post intervention as members increased. Two of the facilitators failed to complete the surveys correctly and the data was rejected. Although preliminary finding in were higher in Round 5, (August 2009) the data in this poster shows the final round 6 data using only 7 out of 9 CHCs to ensure correct claims (September 2009). One observation 'pour to waste' handwashing method was ignored as it was obsolete when members adopted the hand washing facility which was a more reliable indicator , being more observable.

TECHNOLOGY

Most household surveys are conducted on paper, and this leads to much human error and spoilt forms. To speed up data collection and collation and minimize human error, an innovative tool has been used in this research. A standard mobile phone was issued to each facilitator with the Household Inventory installed. Responses could be keyed eliminating human error, and data sent like an sms to a central website where results were updated automatically and instantaneously. This eliminated manual computer entry, and thus much time and error was saved. The monthly monitoring with cell phones gave facilitators a more glamorous role, and the members responded to this monitoring (Hawthorne Effect) by making changes that were recommended. Thus the monitoring has contributed as much as the methodology to the high rates of behaviour change.