Community Health Clubs: How do they work?

A case study of a programme in Gutu and Mberengwa districts

Conducted by Zim AHEAD 2012
What is Health Promotion?

‘the process of enabling people to exert control over the determinants of health and thereby improve their health.

As defined at the Ottawa Charter for Health Promotion (1986) 1st International Conference on Health Promotion
An Holistic and Sustainable Strategy:

The 4 Stage A.H.E.A.D. Approach

Applied Health Education and Development
The A.H.E.A.D Approach using Community Health Clubs

What is different?

• Uses health education / hygiene promotion as an entry point
• Forms a strong community structure mandated to prevent disease
  • Builds capacity of Ministry of Health Staff
  • Leaves a community with informed facilitators
  • Identifies do-able activities as homework each week
  • Uses a membership card to provide a structure to the training
• Ensures the practical application of knowledge
• Demonstrates behaviour change within the home
• Quantifies achievements
• Quantifies cost-effectiveness of the programme
CLTS within the CHC Structure

- **Community Led:** Every house hold represented in a CHC
- **Total Sanitation:** all households having safe sanitation

Zero Open Defecation (Dodhi) (ZOD) was the slogan. It means the same as ODF (Open Defecation Free)

**ZOD means:**
- No faeces on the ground, or accessible to flies
- Latrine should not allow fecal transmission by flies
  - to be properly covered toilet (Flies cannot enter)
  - or VIP with functional vent pipe (gauze to trap flies exit)
- Self supply of latrines (no external subsidy)
- Wash hand facilities
- Clean kitchen and compound
<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
<th>After 4 months August 2012</th>
<th>%</th>
<th>7 months</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>80,864</td>
<td>80,864</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Districts</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># wards</td>
<td>11</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># villages</td>
<td>429</td>
<td>429</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual households</td>
<td>16,255</td>
<td>15,180 (1,075 closed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># CHC Holds</td>
<td>80%</td>
<td>13,861</td>
<td>91%</td>
<td></td>
<td></td>
</tr>
<tr>
<td># Community Facilitators</td>
<td>154</td>
<td>154</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td># CHCs</td>
<td>450</td>
<td>454</td>
<td>101%</td>
<td>457</td>
<td></td>
</tr>
<tr>
<td># CHC Members</td>
<td>13,620</td>
<td>17,329</td>
<td>127%</td>
<td>17,578</td>
<td></td>
</tr>
<tr>
<td># CHC Committees</td>
<td>454</td>
<td>454</td>
<td>100%</td>
<td>457</td>
<td></td>
</tr>
<tr>
<td>CHC Population</td>
<td>80%</td>
<td>68,160</td>
<td>84%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Stakeholders viewing the map showing village location
Sanitation transparency: CHC Members stand on their village map to show where they live: a rock signifies a latrine, a mudball a temporary
One of the CHC has even constructed this Meeting Place (without any external inputs) to ensure CHC meetings can be held in comfort. A demonstration pot rack is constructed at every CHC Venue.
A typical CHC Household:

All members have at least one Tippy tap at home

All members have a pot rack

All members have a rubbish pit

All members have a wash shelter
Toilets at the CHC venue – resourcefulness use of locally available material-ZOD
Membership cards are a critical component of the CHC and stimulate high attendance at the weekly meetings to complete all 20 sessions.
Most sessions have been completed: ZOD competitions are starting

<table>
<thead>
<tr>
<th>Theory Session</th>
<th>Zuva</th>
<th>Facilitator’s Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Zvakatikomberedza</td>
<td>31/05/12</td>
<td>E. C.</td>
</tr>
<tr>
<td>2. Kuona rudzi rwezvirwere</td>
<td>14/05/12</td>
<td>E. C.</td>
</tr>
<tr>
<td>3. Utsanana/Kugeza maoko</td>
<td>21/05/12</td>
<td>E. Clams</td>
</tr>
<tr>
<td>4. Kuchengetedza Misha zvineutsanana</td>
<td>08/05/12</td>
<td>E. Clams</td>
</tr>
<tr>
<td>5. Panobva mvura yekunwa</td>
<td>31/05/12</td>
<td>E. Clams</td>
</tr>
<tr>
<td>6. Kuchengetedza mvura mumba</td>
<td>13/06/12</td>
<td>m. chisanga</td>
</tr>
<tr>
<td>7. Kushandisa mvura mumba</td>
<td>20/06/12</td>
<td>m. chisanga</td>
</tr>
<tr>
<td>8. Mvura yekunwa</td>
<td>27/06/12</td>
<td>m. chisanga</td>
</tr>
<tr>
<td>9. Kufamba Kunoita utachiona</td>
<td>14/07/12</td>
<td>E. Clams</td>
</tr>
<tr>
<td>10. Manyoka</td>
<td>14/07/12</td>
<td>m. chisanga</td>
</tr>
<tr>
<td>11. Mvura yemunyu neshuga</td>
<td>18/07/12</td>
<td>E. Clams</td>
</tr>
<tr>
<td>12. Zvimbudzi</td>
<td>25/07/12</td>
<td>m. chisanga</td>
</tr>
<tr>
<td>13. Chipfunga</td>
<td>01/08/12</td>
<td>A. Chindego</td>
</tr>
<tr>
<td>14. Chimhungwe</td>
<td>29/08/12</td>
<td>m. chisanga</td>
</tr>
<tr>
<td>15. Kudya kunodiwa nemuviri</td>
<td>31/08/12</td>
<td>m. chisanga</td>
</tr>
<tr>
<td>16. Makonye</td>
<td>02/08/12</td>
<td>m. chisanga</td>
</tr>
<tr>
<td>17. Zvirwere zveganda nemaziso</td>
<td>29/08/12</td>
<td>E. Clams</td>
</tr>
<tr>
<td>18. Rurindu nezvirwere zvechipfuwa</td>
<td>05/09/12</td>
<td>m. anikiva</td>
</tr>
<tr>
<td>19. Mukondombera</td>
<td>02/09/12</td>
<td></td>
</tr>
<tr>
<td>20. Kuronga zvekuita</td>
<td>20/09/12</td>
<td>J. Tamba</td>
</tr>
</tbody>
</table>
Who said you can't write if you have no paper? Theory sessions on tree trunk
Visual aids enable CHC members to problem solve around health issues.
‘Teach the women and you teach the nation’
Julius Nyerere
Community Based Facilitator is selected from each village, is trained with toolkit and then conducts weekly health sessions but is behind not in charge of the CHC.

It is important that the Head man of village is fully involved and gives his full support to CHC.
The CHC is run by an annually elected Committee: Chairwoman, vice, secretary, treasurer etc. who keep all records of members and their household facilities, they conduct the base line survey and monitor monthly.
One of the HHs visited during the ZOD competitions
Model Home Competitions stimulate high standards

Swept yards

ZOD

The Kitchen seen from the outside
Inside the kitchen

Safe Water Storage

Safe storage of kitchen utensils

Good food hygiene

Good personal hygiene

Fuel efficient stove

Hygienic latrine
The ZOD Latrine

- Community designed
- Community built
- Community used
- No external inputs

Monitoring: Household Inventory was collected as baseline and end line is being finalised at present. Therefore % hygiene change in this project but following slide is from a similar project, from 2011 in nearby Masvingo (OXFAM as partner to ZImAHEAD)
MONITORING: OXFAM - ZIMAHEAD Project
% hygiene behaviour change in 5,502 CHC Members, in 121 CHCs in Masvingo Rural, Zimbabwe, 2011

23% improved hygiene in 16 indicators within 6 months
Fuel efficient stoves are encouraged to protect the environment

NB: THIS ASPECTS NEEDS MORE FOCUS AND COULD BE EMPHASIZED MORE IN FUTURE PROJECTS
Good nutrition is as important as good hygiene.

As a demonstration at the CHC meeting place, each member learnt to grow their own green vegetables in a sack.

In the next stage each CHC will have a large communal garden.
Sustainability: the next stage
The CHC plans to start a play school in their meeting place and mothers show the toddlers who stand to benefit from this community initiative
CURRENT DEBATE BETWEEN TWO MAIN APPROACHES

CHC Approach: Implementation strategy
- 6 months Hygiene sessions 20 sessions (each week)
- Learning through fun participatory activities reinforce good practice (song, drama)
- Informed group decision making and weekly homework
- Voluntary household improvements
- Zero Open Defecation (ZOD) & 20+ other hygiene improvements

CLTS Approach (ZimCATS) Implementation strategy
- One ‘Triggering’ day + a few follow-up visits
- Village walk to shock community that they are eating their own faeces
- Community shamed into action
- Leaders enforce change with fines
- Open Defecation Free (ODF) Village free ODF zone
Comparing effectiveness: Survey results
CHCs were significantly more effective than CLTS:
1. 92% CHC disposed of their faeces by some method other than OD as opposed to 77% in CLTS
2. 64% in CHCs had and used a Hand Wash Facility versus 10% in CLTS (p<0.0001)
3. 26% of CHC respondents owned a latrine, but all of them had been built since start of project. 66% practiced cat sanitation (88% ODF)
4. 44% of CLTS respondents owned a latrine, whilst 57% without latrines claimed to share (101%) !?

2011. Whaley & Webster. See www.africaahead.com
Observed Indicators of Sanitation and Hygiene between CLTS and CHC villages in Zimbabwe

2011. Whaley & Webster. See www.africaahead.com
Acknowledgements:
Zim AHEAD Team on the ground in Mberengwa and Gutu (2012)
ACF partner in the programme