

BACKGROUND

The Johanna Road informal settlement 10 kilometres north of Durban, KZN was selected by the Water and Sanitation Department in eThikweni Municipality to pilot the use of community health clubs as a means for cleaning up informal settlements and improving the quality of life for their residents. Despite being well supplied by the municipality in terms of services (two communal ablution blocks, standpipes, and solid waste pick-up), the area is very problematic in terms of health, hygiene, and sanitation. In a baseline survey of 104 households, 88.5% believed that solid waste was a problem in the community. Although Johanna Road is relatively small (200-250 households), lack of community cohesion was identified as one of the major obstacles for maintaining facilities. The community health club approach (Waterkeyn & Cairncross, 2006) was identified as a possible means of creating social capital and improving community relations, as well as improving home hygiene.

COMMUNITY HEALTH CLUBS IN JOHANNA ROAD

In July and August 2009, working with eThikweni Water & Sanitation, two Community Health Clubs were started in Johanna Road. Africa AHEAD's facilitator, with the help of two local community members, mobilised the community and conducted health promotion sessions using PHAST participatory activities to promote hygiene behaviour change. Despite political gatekeeping, a majority of single parents, and a household employment rate of 57%, almost a quarter of homes were represented in health clubs. During the 6 months of sessions, CHC members conducted community wide cleanups, renovated communal walkways, started a recycling project, and created communal vegetable gardens. The municipality chose the CHCs to pilot agri-tubes for the recycling of grey water. In response to the community efforts, the municipality renovated the problematic ablution block. The 57% of members attended all sessions received certificates at a graduation ceremony in April 2010.

RESULTS

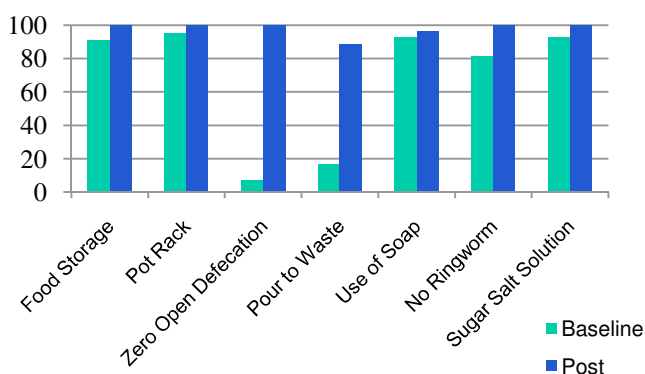
The levels of behaviour change as a result of this project are exciting, with an overall average of 30%, which is considered high comparing similar programmes (WSP-World Bank, 2002). In the post intervention survey (February 2010), it was found that 89% of all registered members are now following the key recommended practices promoted during the weekly health promotion sessions. As is shown in the chart below, whereas before the project only had 7% zero open defecation before, there is a 93% change for 100% of CHC households having zero open defecation within five paces of their homestead. Marked improvements in pour-to-waste methods (72.2%) and no visible ringworm (18.6%) were also observed. CHC members measured 100% for 7 of the recommended practices (safe water storage, use of ladle, safe food storage, use of pot rack, zero open defecation, knowledge of sugar-salt-solution, no visible ringworm).



Demography of Respondents

Number of Respondents	Total
Female Respondents	65%
Male Respondents	35%
Median Age	30
Marital status & h/hold size	
Married	8%
Single	90%
Widowed/Divorced	2%
Median Household size	3
Religion	
Christian Denomination	20%
Christian Apostolic	56%
Traditional Religion	13%
Not Religious	11%
Education & employment	
No schooling	3%
Primary only	19%
Secondary	49%
Matric + passed	26%
No formal income	43%

30% change in hygiene behaviour in 6 months



ZERO OPEN DEFECTION

RESEARCH METHODOLOGY

METHOD

Study Type:	Intervention Study
Sampling:	Purposeful
Technology:	Mobile Research Platform
Enumerators:	One
Health Clubs:	Two
Total Membership:	54
Hard Core membership:	31
Sample Size Baseline:	104 (sample of all households)
Sample Size Post Int.:	54 (CHC members only)

Prior to the training a base line survey was conducted in Johanna Road. After 3 and 6 months, this 'household inventory' was redone, and hygiene changes as represented by the 10 observations in household inventory were tracked by the community facilitator. There were fewer respondents in the post intervention, as only health club members were surveyed. Hand washing facilities were determined inappropriate as each community member was located less than 200 metres from a tap. At baseline, all CHC members safely stored their water and used ladles, therefore there was no significant difference at 6-months.

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.

p>0.001



Observed Home Hygiene after 6 months of weekly health promotion training sessions in Community Health Clubs



96%

Use of soap to wash hands



89%

Use pour-to-waste method for handwashing



100%

Zero Open Defecation



100%

Use of ladle to take drinking water



100%

No children with Ringworm



100%

Know how to treat dehydration (SSS)



100%

Pot Rack use



100%

Safe water storage



100%

Safe food storage



