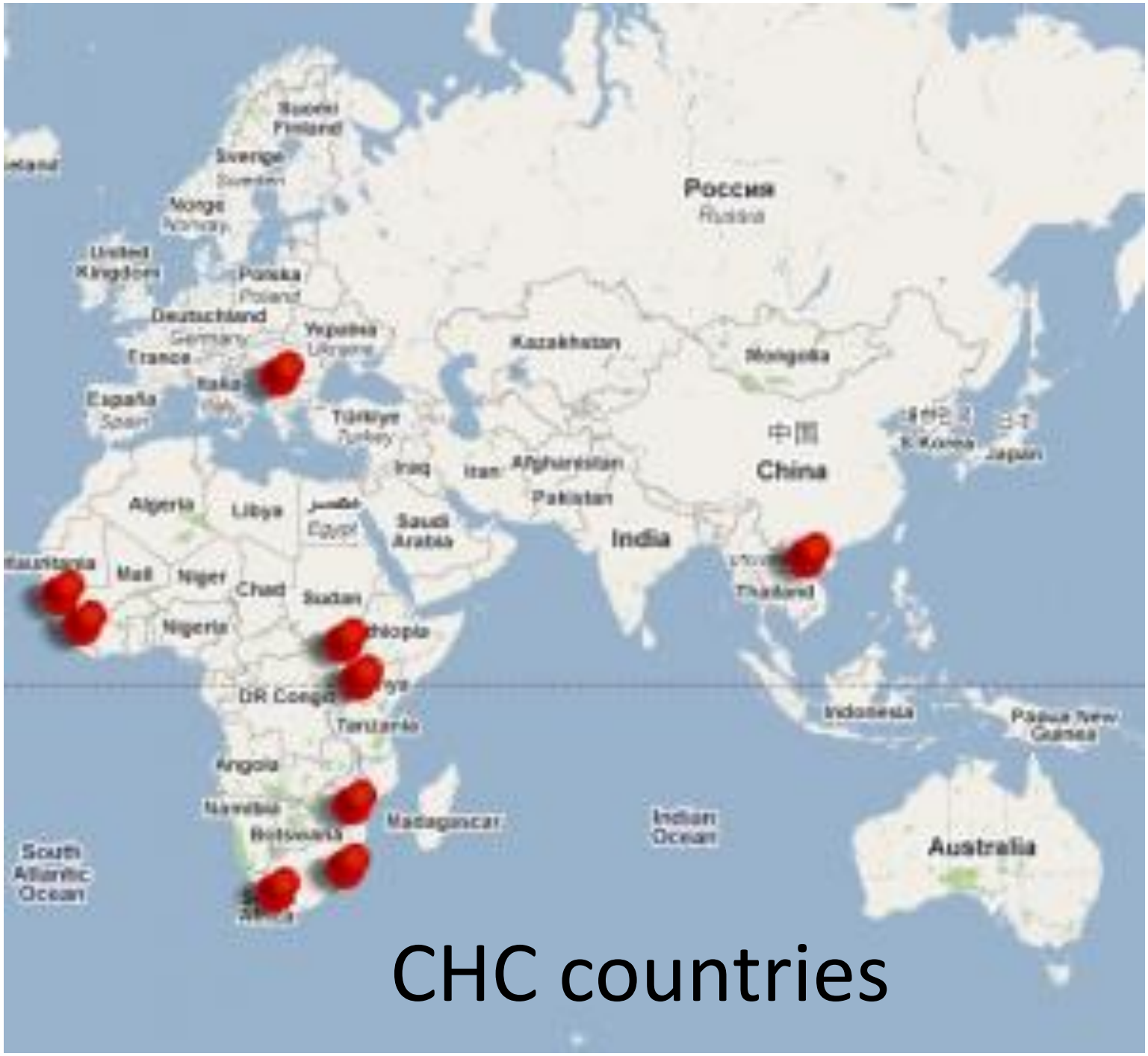
Dissemination and Scaling up of the Community Health Club Approach

Using visual aids in participatory activities, held every week for at least 6 months, health club members discuss how best to have an hygienic home.



CHC countries

Zimbabwe CHC Areas: 1995-2001

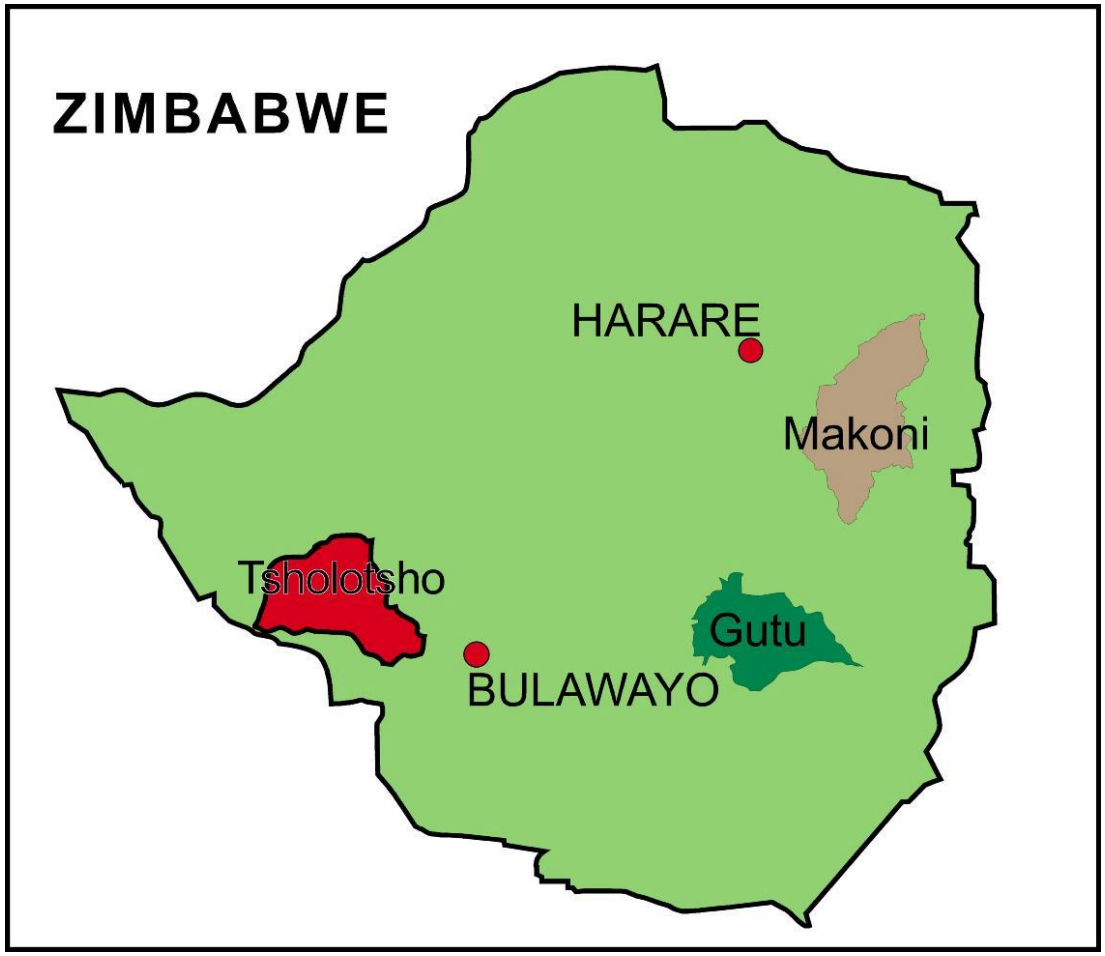


Fig 1. Map of Zimbabwe, showing 3 Zimbabwe A.H.E.A.D Community Health Clubs Districts

Zimbabwe 1995 - 2001

1997-2001 Zimbabwe AHEAD / Unicef/ Danida, DFID, Oak, NZAID
Founded NGO:
CHCs in 3 districts of Zimbabwe: Makoni, Tsholotsho & Gutu
150,000 beneficiaries (approx 500 clubs).
3,800 latrines built in 2 districts within 2 years
Highly significant hygiene improvement.
Sustainable Livelihoods: income generation, literacy and HIV/AIDS care

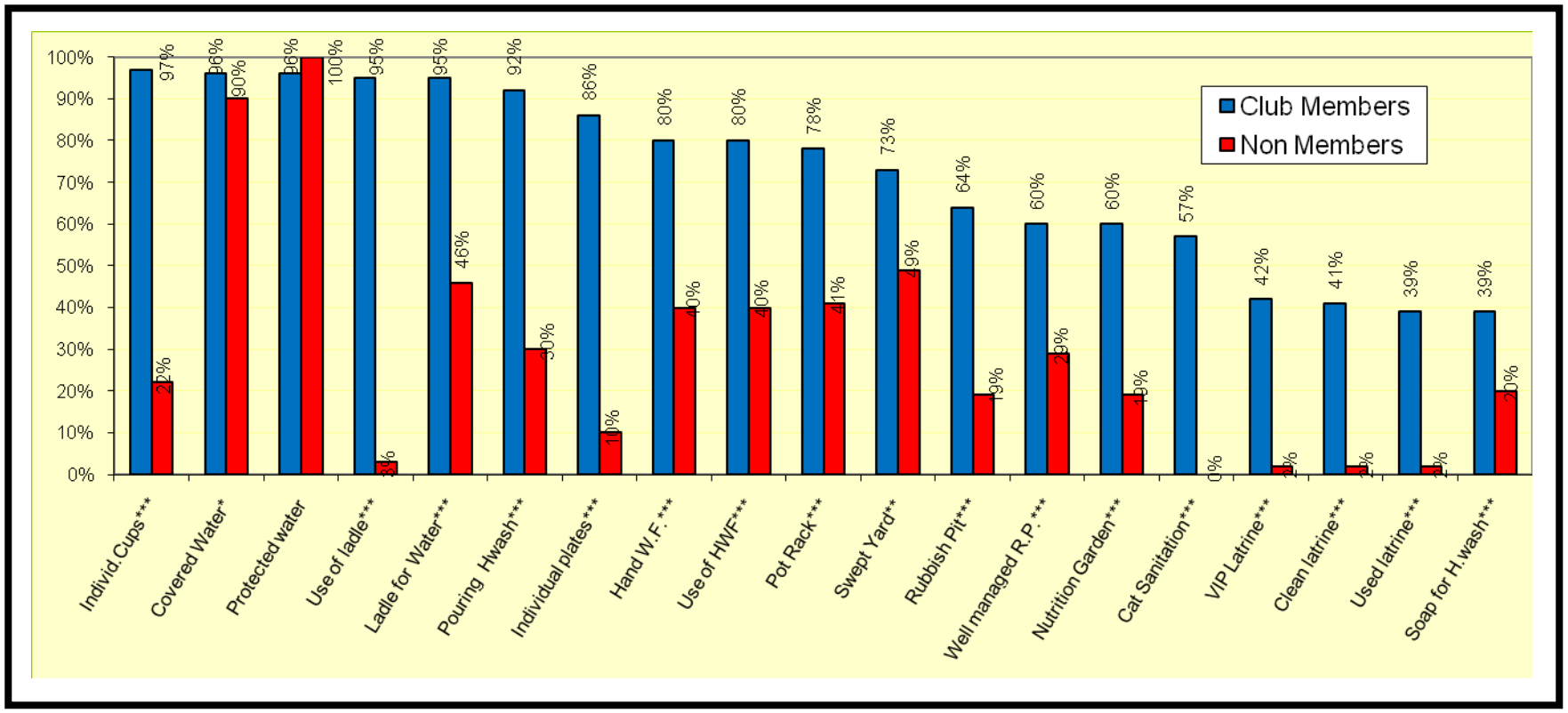
2000 onwards: Zimbabwe political / economic collapse: Donor withdrawal

April 2001- Feb 2002 DFID: Research and Dissemination

- Research of the Community Health Club (CHC) Approach.
- Survey of 75 CHCs and 1,250 households.
- Viability in 3 countries in East Africa

Oct 2001- Nov. 2005. London School of Hygiene and Tropical Medicine
PhD Research on Cost-effectiveness of Community Health Clubs in Zimbabwe

Measuring Behaviour Change



Difference of Prevalence of Observed Hygiene Indicators between Community Health Club Members and non Members in Tsholotsho District, Zimbabwe. 2001

Zimbabwe 2004-2011

2004-2006: LEAD/ NZAID
Rehabilitation of 100 boreholes
HIV/AIDS: Nutrition / herbs for PLWAs and orphan play schools
10,000 nutrition gardens and beekeepers.

May 2007 – April 2010: Zimbabwe AHEAD/ Mercy Corps
Start up of CHC programme in 3 districts: Buhera , Chipinge, Chiredzi.

2008/9 **Emergency Programmes:** Zimbabwe AHEAD / OXFAM
Cholera response: Start up of 50 CHCs and SCHs high density Mutare

2008-2010: Protracted Relief Programme PRP 1 & 2. DFID /IWSD / Zim AHEAD
Training and back stopping 30 NGOs in Zimbabwe to start up CHCs

2009 –2010: Zimbabwe AHEAD / OXFAM: **Cholera Mitigation**
CHC programme in 2 towns: Chiredzi and Masvingo.

2010 (20 days) Unicef / Zimbabwe AHEAD
Design of **School Manual** for National School Health Club Programme

WSP-World Bank: Advocacy / Road map for CBEHPP
National Coordinating Unit: Recently accepted CHC as national approach

Chipinge Rural Project

TARGET	ACHIEVEMENT
12 CHCs, adjusted to 27 CHCs	37 CHCs
75 members per CHC	60 per CHC
Total membership of 2015	4516 registered members
50% expected to attend 20 sessions	2388 graduated (53%)

MONITORING METHOD

Tool:	Household Inventory
Method :	Community Monitoring (Census)
Enumerators:	37 local CHC facilitators
Health Clubs	37 out of 37 CHCs
Total Membership:	4,516
Hard Core membership:	2388 (completed all 20 sessions)

Matimati R & Muringaniza A. (2008) Zimbabwe AHEAD Final Project Report for Mercy Corps / British Lottery Fund

The winner of the best kitchen in Makoni District, proudly displays her health club certificate

Stage 2: CHCs become FAN clubs (Food and Nutrition) **134 FAN Clubs**

Project duration:	**31 months**
Total beneficiaries:	**64,020 people**
	10,670 households

Sierra Leone

Oct **2000**: CARE International
Training of field staff for CHC health promotion project
50 health clubs (3,000 participants)
Used Zimbabwean training Tool Kit

Feb **2001**: Rapid Rural Assessment and Participatory Evaluation of Health Promotion component of Water & Sanitation Programme in **Moyamba & Bo**
Zero open defecation (ZOD) in all 25 villages within 6 months
CHC Approach adopted by the WASH sector in Sierra Leone, lead by Unicef
CARE /UNICEF developed Manual, using CHCs for post conflict resettlement.

2008 Koinadugu District *'…child survival activities through the CHC approach, the CHCs are self replicating and scaling up activities in neighboring villages. 92 CHCs at the onset of the project. CSP organized and strengthened 54. 394 active CHCs strengthened by CHC volunteers, other CARE projects, PHU staff and other NGOs using the CHC package. '*

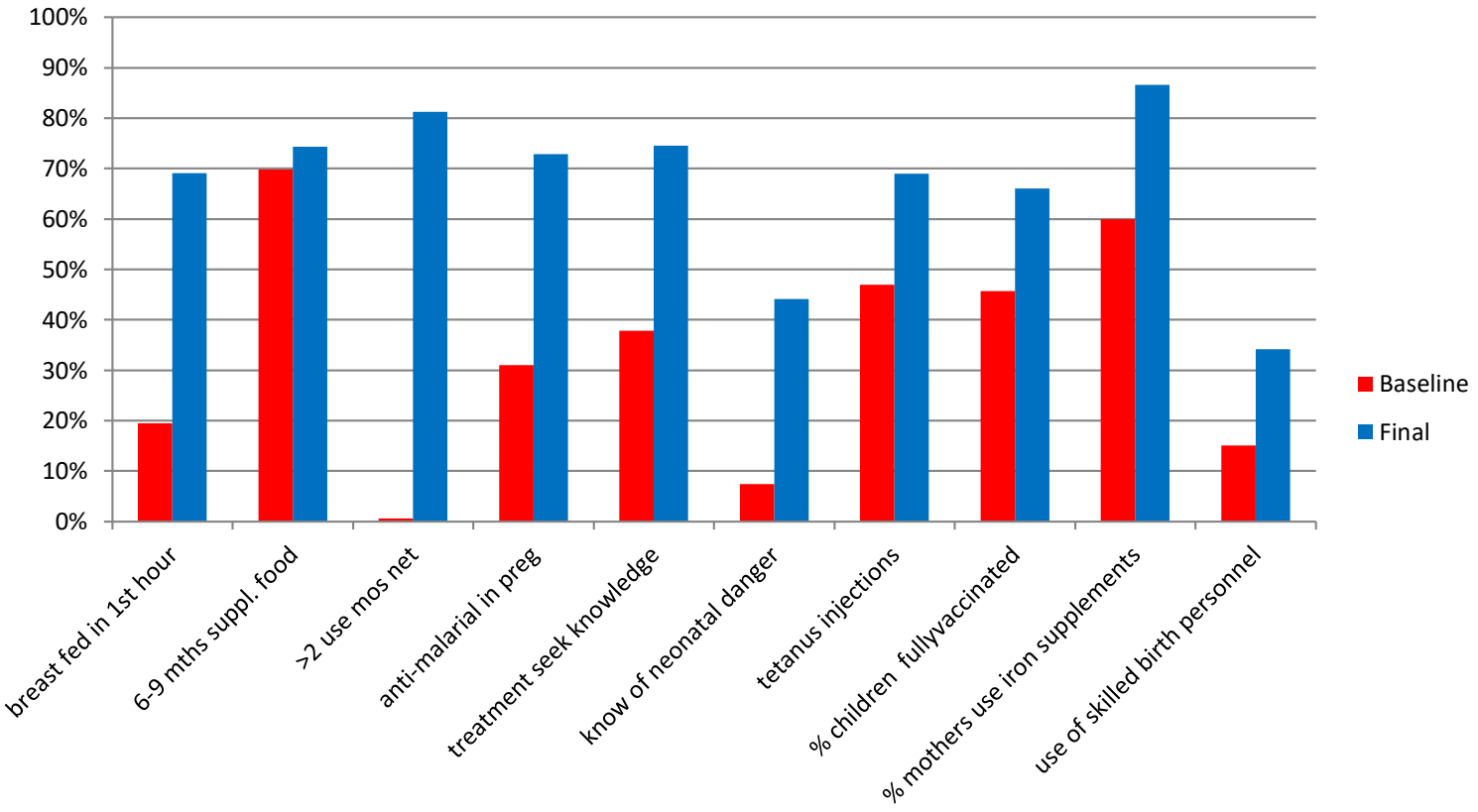
'The DHMT has been an active advocate of this approach and some of the project interventions, described in later sections, are being expanded to adjoining districts as well. It should also be noted that this approach was adopted by other NGOs, thus spread out to other districts as well.'

C O N S E N S U S

‘In Africa we sit under a tree, ‘til we agree.’
Julius Nyerere, the first President of Tanzania

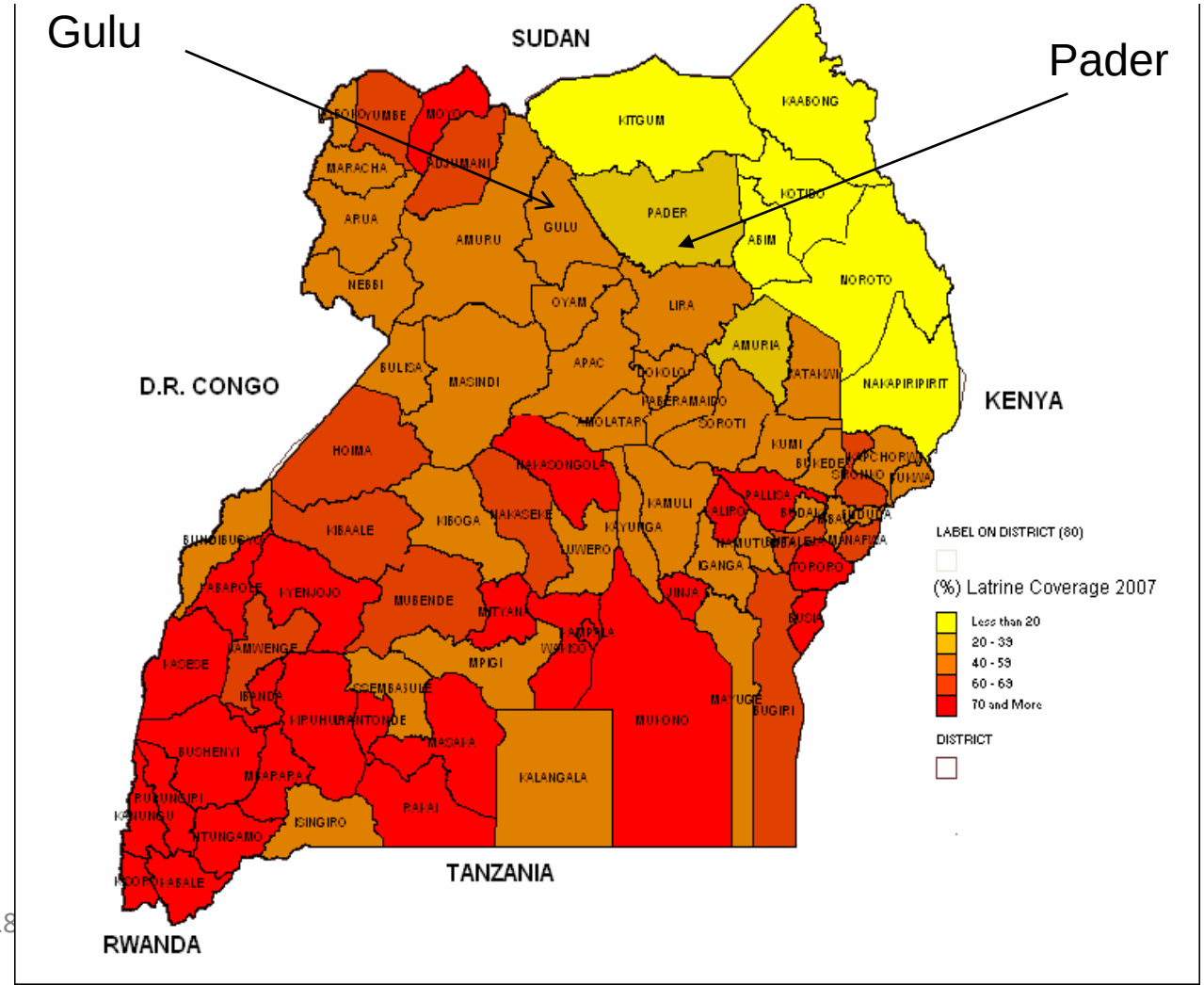
Child Survival Project CARE

Prevalence of indicators of changes in household knowledge and decision-making skills related to health of women and children



Child Survival XIX Project Final Evaluation CARE Sierra Leone, August 1-15, 2008

Northern Uganda IDP camps



Uganda

Oct 2004 - March 2005
(45 days)

CARE International

Emergency Programme in 15 IDP Camps in Gulu District

Objective: Establish 120 Community Health Clubs with 1,250 IDPs, and 10,000 latrines. 50% sanitation coverage

Achievements:

25 facilitators trained and posted in 15 IDP camps
116 CHCs formed by Local NGO (HIDO)
15,522 CHC members in total (40% of IDP households)
6-8 months of weekly training (2,760 sessions in total)
11,800 latrines in 8 months (72% coverage) in 8 months
1,682 Hand washing facilities (Tippy Taps) constructed
8,145 bathing shelters constructed in 6 months

Quantifying Health Promotion

Membership Cards are a key component of the CHC Model:

2007: Guinea Bissau

November 2006 & February 2007

Africa AHEAD for Effective Interventions

Objectives:

- Setting up Community Health Clubs in rural villages as the main intervention in a large clinical trial (50,000 participants)
- to reduce Infant mortality rate by 25% by improved hygiene, health knowledge, and anti natal care.
- Development of Tool kit of Visual Aids.

Research findings to be published soon: No information available at present

South Africa: Cape Town.1.

August 2006 (for University of the Western Cape)
Introductory Training workshop for Khayelitsha Water & Sanitation Forum for Community Health Club programme in informal settlements

March-May 2006: Rickett & Benkeser / Brigham Young University, Utah
Reduction of Disease through Hand washing / soap:
2 year intervention study in Philippi and Dunoon informal settlement

Over 380 Community Health Clubs

started in the 200+ informal settlements in Cape Town

South Africa: Cape Town Informal settlements

March-June 2007 (City Health Department / Danida)

- Design and writing of a 65 page manual ,
- Toolkit of 13 health topics (194 picture codes)

2009: Training Workshop
(30 City Health Department CHC facilitators trained).

2010: Training Workshop
(35 City Health Department CHC facilitators trained)

Institutionalised by City Health Dept: employ casuals only if CHC members

Umbrella Metro CHC with over 380 CHCs started across the Western Cape in over 200 informal settlements: political issues

South Africa: Kwa Zulu Natal

June -Aug 2008: Department for Water Affairs (DWAF) /Danida

- Feasibility Study for starting up CHCs in three Districts in S. Africa
- Pilot project in KZN: Umzhimkhulu District:9 wards
- Starting up, training and training materials for 9 CHCs
- Monitoring and evaluation

2009- 2010: DWAF- eThikweni Municipality (Durban)
Pilot project in Joanna Rd informal settlement in Durban
Providing training and training material
Monitoring and evaluation of 2 CHCs

2008 -2009
(12 months) : DWAF-Danida- Africa AHEAD

Design of pilot CHC project in Kwa Zulu Natal.
Training of trainers and capacity building municipality
Monitoring and evaluation of inpact (Mobile researcher)

South Africa: CHCs take initiative in upgrading water source

Umzimkhulu KZN Household Survey

METHOD

Study Type: Intervention Study

Sampling: Purposeful

Technology: Mobile Research Platform

Enumerators: **7** local CHC facilitators

Health Clubs **7** out of 9 CHCs

Total Membership: 1000

Hard Core membership: 550 (completed all 24 sessions)

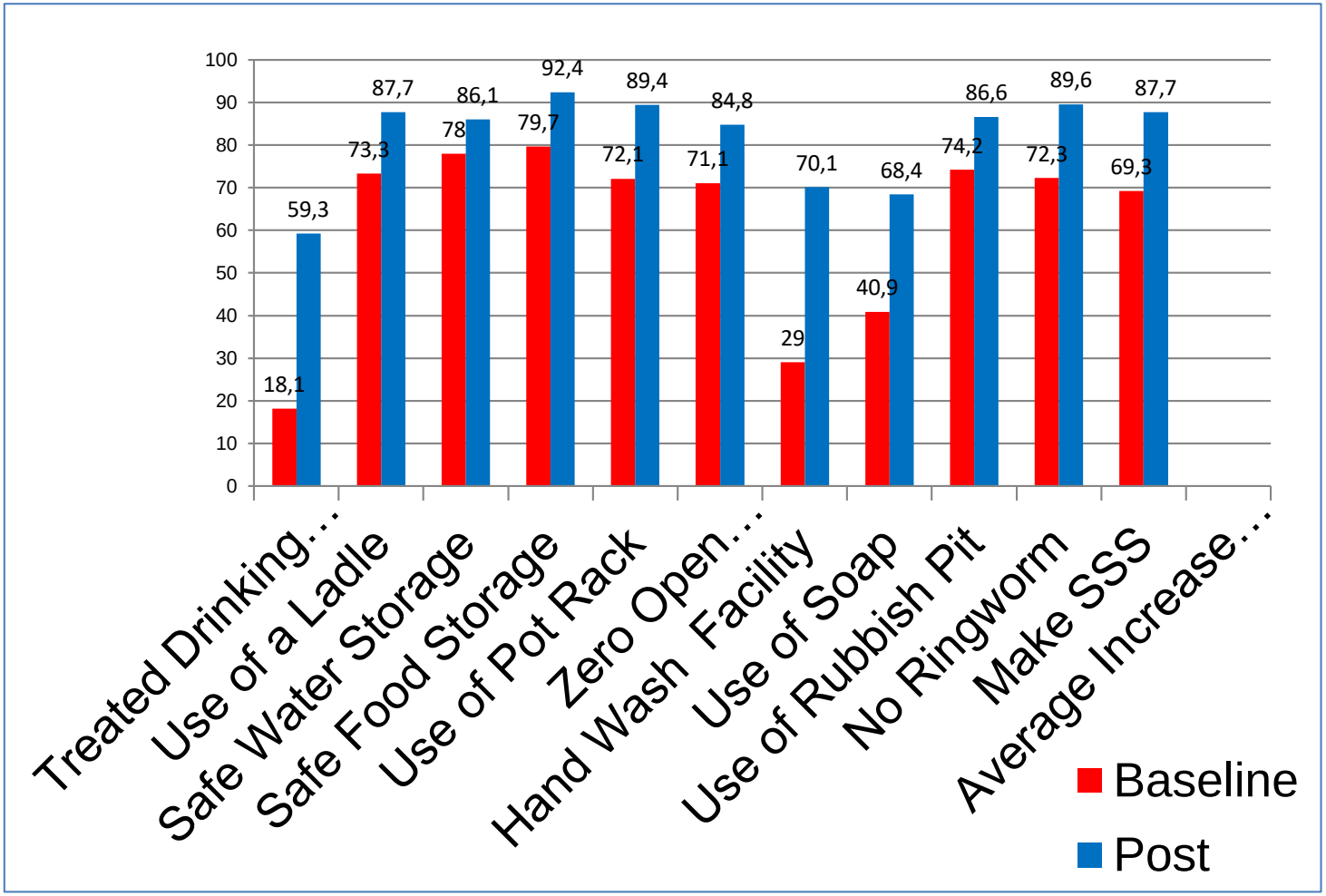
Sample Size Baseline: 469

Sample Size Post Int.: 538

Waterkeyn, J & Rosenfeld J (2009) Africa AHEAD Monitoring Hygiene Behaviour Change Through Community Health Clubs. Poster. PHASA

Kwa Zulu Natal: Rural

20% change in hygiene behaviour in 8 months



Joanna Road Household Survey

Study Type: Intervention Study

Sampling: Purposeful

Technology: Mobile Research Platform

Enumerators: One

Health Clubs Two

Total Membership: 54

Hard Core membership: 31

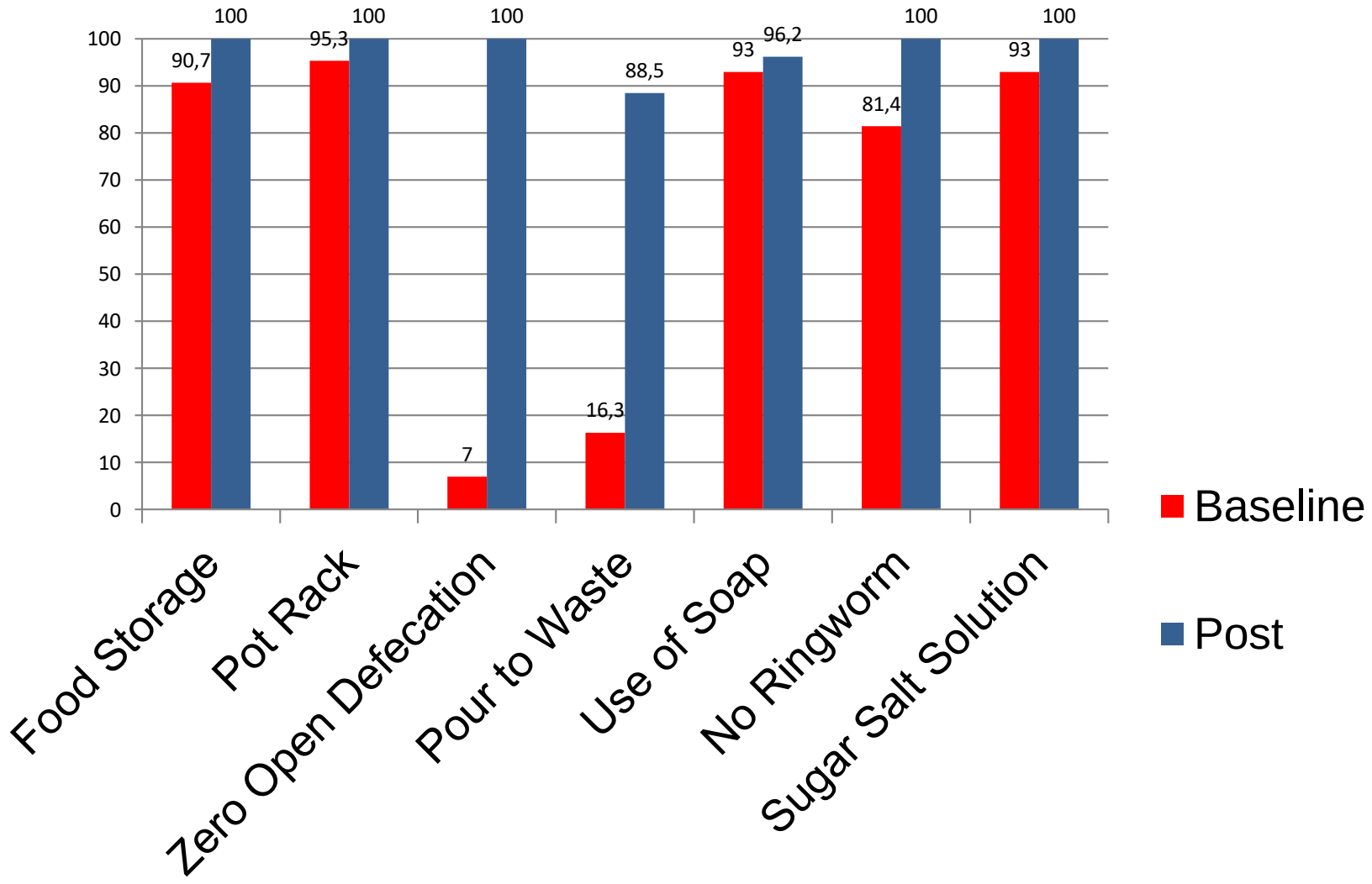
Sample Size Baseline: 104 (sample of all households)

Sample Size Post Int.: 54 (CHC members only)

Gounden.T, Sibiya, L, Waterkeyn, J & Maksimoski, N. (2010) Grey Water reuse through Community Health Clubs in eThikweni informal settlement. Poster PHASA conference. South Africa

eThekwini: Informal settlement

30% change in hygiene behaviour in 6 months



Vietnam

2008: Evaluation of Watsan. Pemconsult / Danida.
Advocacy for CHC Approach to Ministry of Health

October, 2009 (20 days) :
Africa AHEAD for Danida/ Ministry of Health

- Design of training for pilot project of CHC programme
- Training of national trainers

July, 2010: (20 days)

- Finalisation of visual aids and manual for CHC Programme,
- Workshop for training of five district teams

March 2011: (10 days)
Evaluation of the CHC Programme in 3 districts

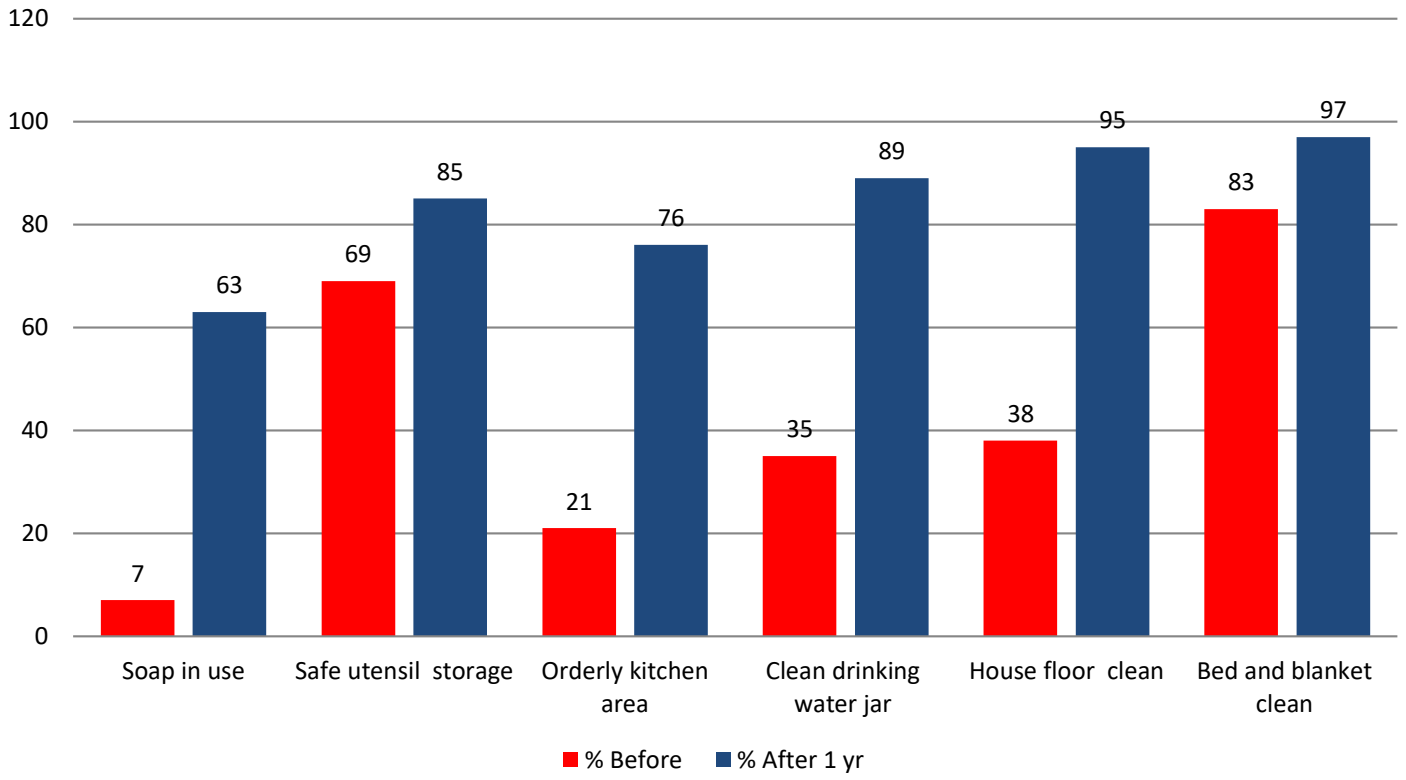
Waterkeyn, J. (2011) Africa AHEAD. Evaluation of pilot project in Son La, Phu Tho and Ha Tingh for Danida/ Ministry of Health

A CHC in an ethnic Thai community of Vietnam

Prevalence of Indicators of Changed Hygiene behaviour in Ha Tinh after one year of CHC

Average 42%

Change in hygiene behaviour in 6 indicators average 42% after one year



Cost Effectiveness of CHC Programme

Cost effectiveness is measured by cost per beneficiary, taking the overal cost of the project and dividing by number of beneficiaries.
NB: Beneficiaries are the number of members x estimated average household size per Province

HA TINH PROVINCE

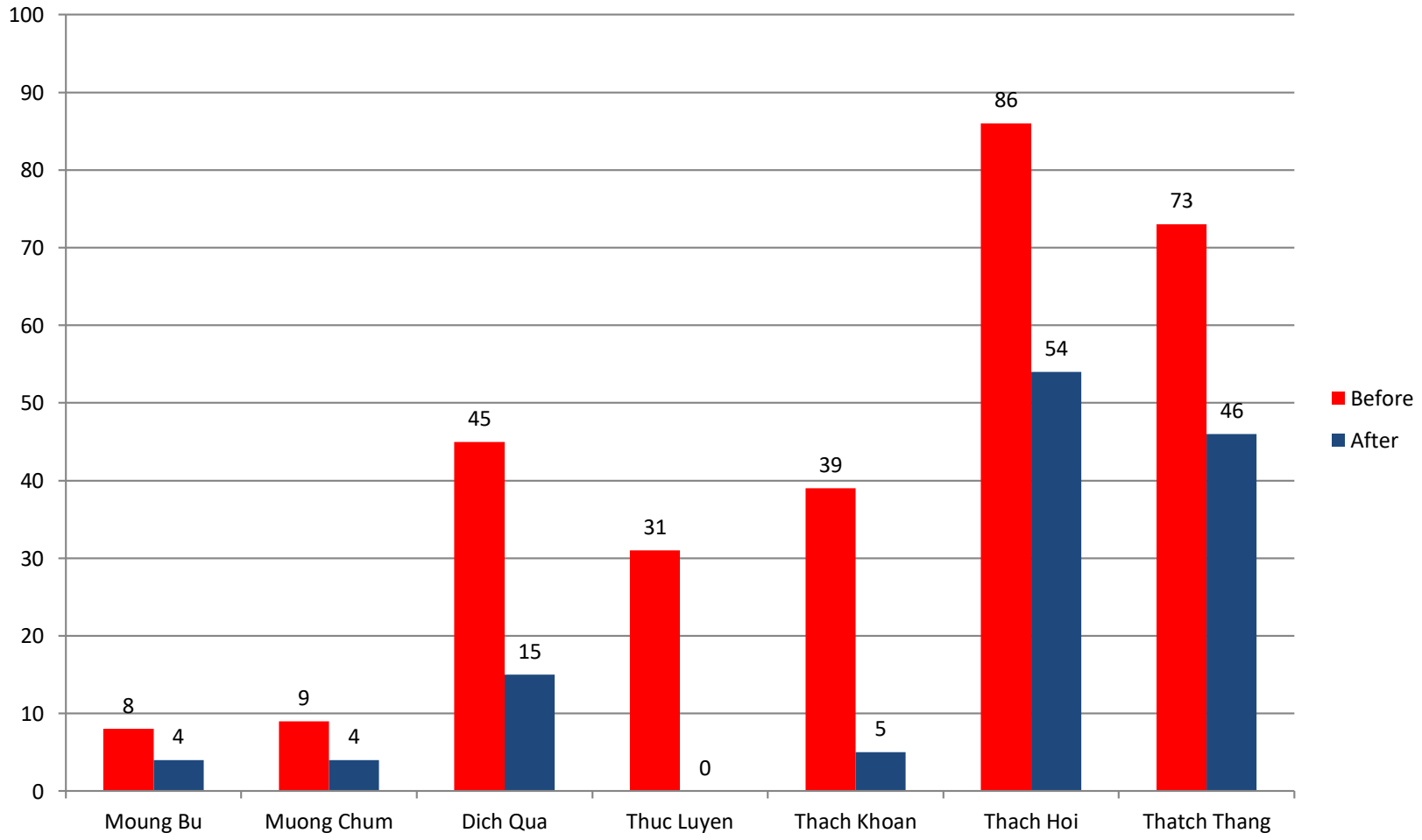
- **Average number per household**: 4.58
- **Number of CHC members:** 828
- **Number of beneficiaries** estimated at 10,808
- **Cost per beneficiary (one year, 2010):** US$0.87 per beneficiary
- **Cost per beneficiary:** including local costs: US$1.40

•District Head of Environmental Health said:

CHC project is low-cost – high result'.

NB. Costs not included were often borne by the facilitator and district staff. This included fuel to get to the sessions and no per diem in some districts. ***This may need more support.***

Reduction of Dysentery in 7 communes: 2008/9 – 2010 after one year CHC



Rwanda

2008: WSP-World Bank capacity building MoH - WASH
Advocacy for CHC Approach to Ministry of Health

Nov 2009: WSP-World Bank: Road Map for Community Based launched Environmental Health Promotion Programme (CBEHPP)

May, 2010 (10 days) : Unicef/ Ministry of Health
Design and first draft of manual for Public Health training through for community based Environmental Health Promotion Programme through Community Health Clubs

September, 2010 (10 days): Unicef/ Ministry of Health
2nd draft of 2 manuals for village health workers and Environmental Health Officers, supervision of visual aids development (400 illustrations).

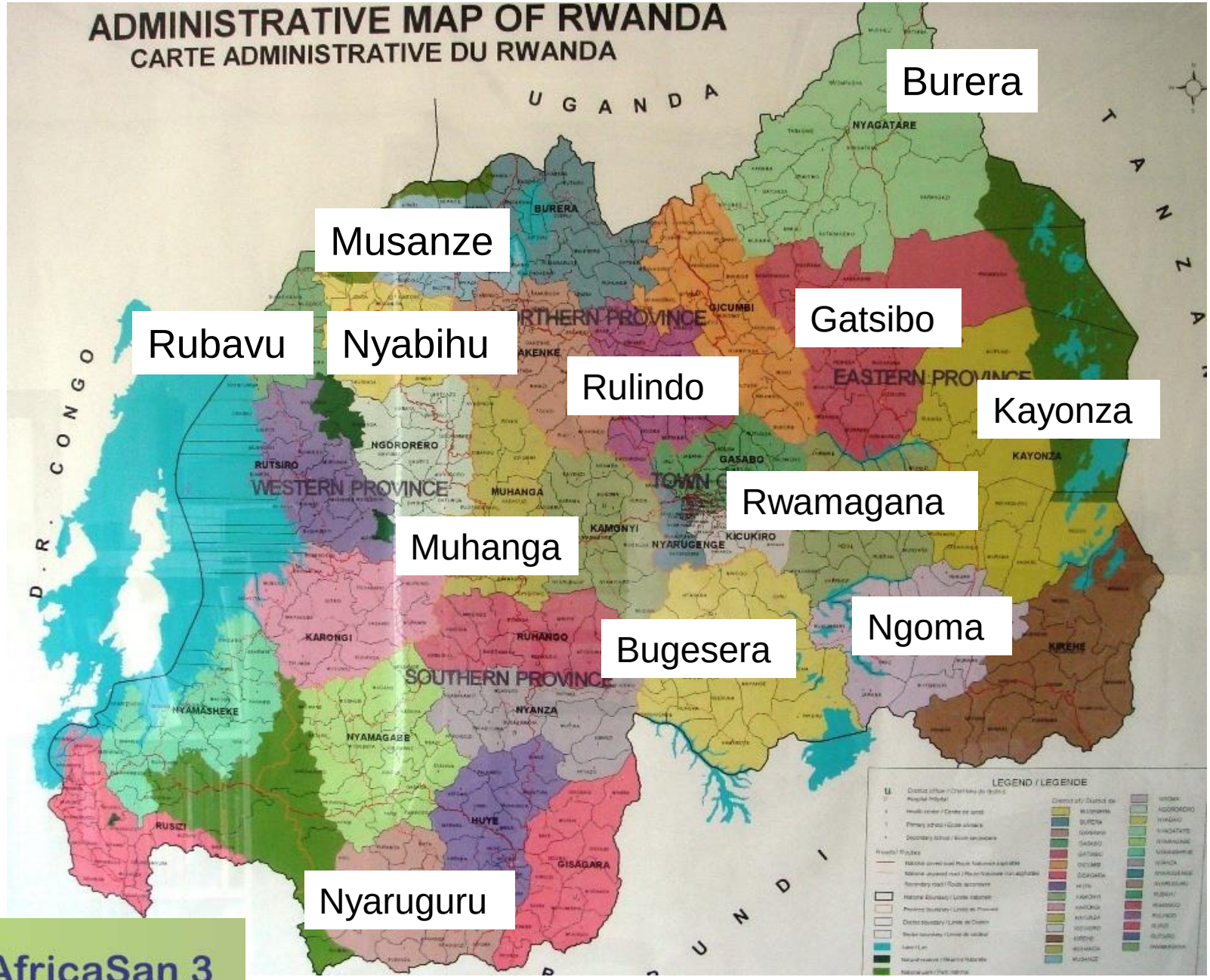
November, 2010 (10 days): Finalisation of training manuals and Toolkit of visual aids, pretesting and training of MoH staff

Pretesting materials

Launched **Road Map** for Community Based Environmental Health Promotion Programme in Nov 2010

Start up in 5 districts: President scaled it up in his water and sanitation initiative

Target: to start CHCs in all 15,000 villages of Rwanda


ADMINISTRATIVE MAP OF RWANDA
CARTE ADMINISTRATIVE DU RWANDA
UGANDA
TANZANIA
D.R. CONGO
BURUNDI
Burera
Musanze
Gatsibo
Rubavu
Nyabihu
Rulindo
Kayonza
Rwamagana
Muhanga
Ngoma
Bugesera
Nyaruguru
NYAGATARE
BURERA
GICUMBI
RUTSIRO
NGORORERO
WESTERN PROVINCE
MUHANGA
GASABO
KAYONZA
KAMONYI
NYARUGENGE
KICUKIRO
KIREHE
KARONGI
RUHANGO
SOUTHERN PROVINCE
NYAMASHEKE
NYANZA
NYAMAGABE
RUSIZI
HUYE
GISAGARA
LEGEND / LEGENDE

CBEHPP

Rwanda: Measuring Behaviour Change: The 10 Golden Indicators

1. Increased use of hygienic latrines in schools and homes from 28% to 80%
2. Increased handwashing with soap at critical times from 34% to 80%
3. Improved safe drinking water access and handling in schools and homes to 80%
4. Establishment of CHCs in every village from 0% to 100%
5. Achieve Zero Open Defecation ZOD in every household from 28% to 100%
6. Safe disposal of children's faeces in every household from 28% to 100%
7. Households with bath shelters increase to 80%
8. Households with well managed rubbish pits increase to 80%
9. Use of pot racks for drying dishes increase to 80%
10. Households with clean yards increase to 80%

Summary

Between 2001 – 2011: The CHC Model has been replicated in:

Africa: Zimbabwe, Sierra Leone, Uganda, Guinea Bissau, South Africa
Asia: Vietnam

Rural and **Urban** areas: informal settlements & high density

Muslim and **Christian** societies

Never encountered any resistance:

High response: 50-150 members per club

6-8 months weekly sessions (20-24 sessions)

High attendance rates 50-90% completion of full training

High behaviour change rates depending on base line level
10-20 indicators: between 20% - 47% change

CHALLENGES

1. CHC training is dependent on culturally appropriate Visual Aids: Time needed to get the Tool Kit designed for each country (one year), but once this have been done it is easy to scale up

2. Dedicated long term funding for Donors, usually short 6mth – 1 year emergency projects

3. Lack of support from **Big** donors: Need a dedicated Agency

4. Need for more advocacy, larger team to promote approach.

5. Resistance to change (slow to grasp new ideas) from the top (planners) , but never from communities

For more information:

Waterkeyn . J. 2010. Improving Community Hygiene in Africa through Health Clubs: Cost-effective Behaviour Change through Group Consensus.

Waterkeyn,J, R. Matimati, and A. Muringaniza (2009) ZOD for all - Scaling up the Community Health Club Model to meet the MDGs for Sanitation in Rural and Urban areas : Case Studies from Zimbabwe and Uganda. IWA Conference. Mexico.

Waterkeyn & Rosenfeld (2009) Monitoring Hygiene Behaviour through Community Health Clubs (under review)
Rosenfeld .J & Waterkeyn.J.(2009) Using Cell Phones to Monitor and Evaluate Behaviour Change Through Community Health Clubs in South Africa.Addis Ababa. 30th WEDC Conference. www. wedc.lboro.ac.uk/conferences/2009

Waterkeyn J. (2006) District Health Promotion using the Consensus Approach. WELL/DFID/ London School of Hygiene and Tropical Medicine

Waterkeyn, J & Cairncross, S. (2005). Creating demand for sanitation and hygiene through Community Health Clubs: a cost-effective intervention in two districts of Zimbabwe. **61**. Social Science & Medicine. p.1958-1970

Waterkeyn, J. (2005). Decreasing communicable diseases through improved hygiene in Community Health Clubs. Kampala. 31st WEDC Conference.

Okot, P., Kwame, V., and Waterkeyn, J. (2005). Rapid Sanitation Uptake in the Internally Displaced People Camps of Northern Uganda through Community Health Clubs. Kampala. 31st WEDC Conference.

Waterkeyn J. (2003). Cost Effective Health Promotion: Community Health Clubs.
Abuja. 29th WEDC .www. wedc.lboro.ac.uk/conferences/2003

Waterkeyn J. (2001) Quantifying the Cost-Effectiveness of the Community Health Club Strategy in Rural Areas of Zimbabwe. Royal Society of Tropical Medicine and Hygiene.

All publications found on www.africaahead.com