AN INVESTIGATION ON THE IMPACT OF THE COMMUNITY HEALTH CLUBS APPROACH ON COMMUNITY HEALTH – CASE OF WARD 19 IN MBERENGWA DISTRICT

Project Submitted in Partial Fulfillment of the Post Graduate Diploma in Water Supplies and Sanitation

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

DEDICATION

I dedicate this project to my children Tatenda, Shingi and Tafara who endured time without me. To Otillia my love, you were instrumental and encouraged me throughout. Thank you.

ACKNOWLEDGEMENTS

ACRONYMS

ACF	Action Contre La Faim
BVIP	Blair Ventilated Improved Pit
CHCs	Community Health Clubs
DEHO	District Environmental Health Officer
EHT	Environmental Health Technician
FGD	Focus Group Discussion
FEWSNET	Famine Early Warning Systems Network
HIV	Human Immuno Deficiency Syndrome
IRWSS	Integrated Rural Water Supplies and Sanitation Programme
KAP	Knowledge Attitude and Practice
MDG	Millennium Development
M & E	Monitoring and Evaluation
MIMS	Multiple Indicator Monitoring Survey
MoHCW	Ministry of Health and Child Welfare
NGO	Non Governmental Organisation
OCHA	Office for the Coordination of Humanitarian Affairs
OD	Open defecation
PHAST	Participatory Hygiene and Sanitation Transformation
PHHE	Participatory Health and Hygiene Education
PROWWESS	Promotion of Women in Water and Environmental and Sanitation Services
RDC	Rural District Council
SARAR	Self –esteem, Associative Strength, resourcefulness, action plan and Responsibility
SPSS	Statistical Package for Social Scientists
UBVIP	Upgradable Blair Ventilated Improved Pit
UNDP	United Nations Development Programme
UNICEF	United Nation's Children Fund

VHW	Village Health Worker
VS&L	Village Savings and Loans
WASH	Water and Sanitation Hygiene
WHO	World Health Organisation
ZimVac	Zimbabwe Vulnerability Assessment Committee

ABSTRACT

This study investigates the impact of the Community Health Club approach on community health in Mberengwa District, Ward 19. The research explores the extent of community participation in CHCs; how social capital and community dynamics sustain health benefits and assess the impact of CHCs on the community's health and quality of life. Research for this report included literature review as well as fieldwork. A total of 6 CHC communities and 2 non CHC communities were visited where research methods including participant observation, focus groups and interviews were used to obtain information from CHC members, non-CHC members, village leadership, ACF staff and MoHCW staff. There was widespread participation in CHCs among all strata of society especially women. Transfer of health related knowledge and evidence of behavior change were evident in all CHC communities. The CHC members, as well as the MoHCW staff indicated that CHCs have greatly improved health outcomes in the community. The researcher found evidence of improved community cohesion, strengthened leadership, and increased undertaking of self-initiated activities such as the VS&L and community gardens. Transition to more participatory and people-centered development, Community Health Clubs (CHCs) approach has been instrumental in bringing about widespread and positive changes in the communities in which it has been implemented. With so many of these benefits occurring at the community level due to community participation, the benefits will be sustainable. For the approach to be successful it is recommended that good relations with the MoHCW and local leaders should be strengthened for sustainability, transparency during club competitions upheld to avoid de-motivating members. The training package for PHHE could also encompass the Village Saving and Lending component to strengthen the communities' ability to meet the economic needs which aid health practices e.g. savings from VS&L could be used to construct a toilet, ensure consumption of more nutritious foods etc. Given these accomplishments, there is great potential for this approach to be adapted and expanded in many rural communities in Zimbabwe as a successful model for health promotion.

CHAPTER 1: BACKGROUND

1.0 Introduction

Sanitation and hygiene promotion are the two most effective interventions for controlling endemic diarrhoea and are the most cost-effective public health interventions. In terms of health impact, experts rank hygiene promotion as the most cost effective followed by sanitation promotion (Hutton, 2007). For international health, the shift toward more participatory, people-centered and community-based development has meant programs addressing the home and the community are now seen as essential complements to efforts for strengthening national health systems (Azurduy et al, 2007). This report investigates the impact of Community Health Clubs (CHCs) on community health.

1.1 Background of the Problem

There is a global crisis of inadequate sanitation leading to high risks of water-borne and water related diseases, in the developing world. According to the World Health Organization, (2012) about 40% of the world's population, 2.6 billion people, lack safe sanitation. Sustainable sanitary practice and infrastructure is lacking in many areas, and this challenge is coupled with increasing population density and poverty (www.webpages.uidaho.edu/sustainability/index.asp). Open defecation (OD) is common in these areas, posing serious health problems. The lack of safe water and hygiene promotion continues to expose vulnerable populations to higher risks of diseases such as diarrhoea, cholera and dysentery.

According to Sidibe and Curtis (2002), diarrhoeal diseases are still a leading cause of mortality and morbidity in children under five. Each child in Africa has an estimated five episodes of diarrhoea per year and approximately 800,000 African children die each year from diarrhoea and dehydration. Hygiene improvement on a huge scale is urgently needed, to reduce this burden of disease and to maximise the health benefits of water and sanitation interventions. Public health professionals have tried various

approaches to reduce diarrhoeal diseases. In the 1980s major investments aimed to improve the coverage of drinking water and sanitation facilities. However, evidence collected over the past decade shows that changes in hygiene behaviour significantly augment the health benefits that arise from drinking water and sanitation projects (Sidibe and Curtis 2002). The principle is therefore well established that hygiene promotion should play a part in water and sanitation programmes.

In the 1990s participatory approaches seemed to provide an ideal way to involve communities in hygiene improvement and hence to ensure the sustainability of projects. However, such approaches are costly in human resources and training, and convincing results are scarce. According to The MDG 2012 Report, the results from the 2009 (MIMS) indicate that the proportion of people in rural areas with access to safe drinking water declined from 70% in 1999 to 61% in 2009. Despite significant efforts to develop rural infrastructure, 98% of those currently without an improved drinking water source live in rural areas (Central Statistics Office Survey, 2009). According to Institute of Water and Sanitation Development (2012) 33% of the population in Zimbabwe is practicing open defecation nationally while 48% of those are the rural population. Lack of rural WASH is a preventable cause of a significant disease burden for rural Zimbabweans. Zimbabwe's health system has faced difficulties in recent years. Currently, the Zimbabwe government, donor agencies, and Zimbabwean and international organizations are committed to implementing health programs and disease prevention activities that aim to bolster Zimbabwe's health system. With only three years to go until 2015, the challenge of the Millennium Development Goals to halve the number without safe sanitation is still to be met in most developing countries, Zimbabwe included.

The problem of lack of safe water and basic sanitation has necessitated the introduction of an innovative way to improve health promotion in rural areas through the introduction of the Community Health Clubs (CHCs) Approach. Action Contre La Faim (ACF) implements a program that aims to sustainably reduce morbidity and

mortality from WASH related diseases, through improvements in access to water, the sanitary environment and hygiene practices, in rural populations in Mberengwa District, Zimbabwe. The program takes an empowering approach; building capacity to attain the WASH MDG targets through the use of the CHCs Approach. The CHCs approach is a highly effective methodology that is able to induce high levels of behaviour change as well as create a demand for sanitation at minimal cost. In rural Zimbabwe, Community Health Clubs (CHCs) have been active since 1995 to change health behaviour and increase demand for better sanitation (Waterkeyn and Cairncross, 2005). These clubs have proven to strengthen social capital and build trust and cohesion within communities creating a culture of health.

1.2 Statement of the Problem

The decade-long economic and political crisis that Zimbabwe as a nation went through brought a lot of complex problems. Among these problems was the stagnation of development in all facets of the economy. Specific to this research are the poor standards of sanitation and lack of safe water experienced country-wide. Epidemiological reports by the MoHCW as well as outbreak response reports by WHO and partners indicate that Zimbabwe continues to be vulnerable to outbreaks of epidemic-prone diarrheal diseases such as cholera, typhoid fever, rotavirus and dysentery (OCHA, 2013). According to the Zimbabwe Humanitarian Gaps Report by OCHA (2013), Zimbabwe continues to be vulnerable to outbreaks of epidemic-prone diarrhoeal diseases such as cholera, typhoid fever and dysentery. The country has reported annual cholera cases since 1998. Rates of diarrheal disease throughout the country have consistently exceeded epidemic thresholds over the past 12 months. A KAP Survey conducted by ACF in 2012 on the challenges facing the community Health Club members found that although 68.8% of the population in Ward 19 (Mberengwa District) sourced water from boreholes and kept the water in safe storage containers, challenges of water contamination remain because of a myriad of reasons. These reasons include the fact that the places of defecation in Mberengwa are bush hence people practise open defecation in the fields/bush. The existence of

Blair or pit latrines (including all temporary and trench latrines) is a cause for concern. To put it in perspective Blair or pit latrines constitute 58.5%, 33.4% and 8.1% in distribution. Furthermore, ownership of sanitary facilities in Mberengwa is 36.6%, which is not only a cause for concern but of serious concern Availability of hand washing facilities on toilets averages 5.0%, indicating a gap on knowledge deficiency on importance of hand washing in the prevention of diseases. Last not least entails the drawing of water done using uncovered cups which consequently poses challenges of water contamination in the home. A host of stake-holders, non-governmental organizations, the government, local communities and the corporate sector came up with strategies and programmes individually and as a group to deal with these problems.

Hardware interventions such as water and sanitation provision have been carried out in the district by a number of partners since the late 1990s such as Lutheran Development Services, World Vision, CARE International and ACF. Hygiene promotion through PHHE and other education approaches were also introduced but according to evaluation reports, not much improvement was noticed especially at household level. People would change their behavior for a while then go back to their old ways as soon they think that the problems had gone away. This did not only affect their health but also affected the way they operate and maintain water and sanitation facilities. There was a high correlation between poor hygiene practices and non-functionality of facilities.

It was against this background that the CHC approach was introduced in the district in 2011. CHC were introduced as a vehicle to sustain good hygiene practices and to achieve sustainability. CHCs were introduced then to try and maximize the hardware benefits by making sure that the community was responsible for their health through practicing good hygiene practices. This approach has been in existence for 6 years and albeit the merits of CHCs, lack of sustainable participation by the local people is acting as a major hindrance for the achievements of this program to be realized. This

research aims to see whether the CHC approach has brought any positive changes in the lives of people in Mberengwa district.

1.3 Justification of the Study

Improved health is important for economic and social development yet there are so many challenges faced in propelling this in rural communities mainly because of human behaviours. Whilst safe drinking water can reduce diarrhoea by 15% improved personal and domestic hygiene practices can reduce diarrhoea by over 65% for example through hand washing with soap at critical times, diarrhoea can be reduced by 47% (Action Faim M & E Report, 2010). Contemporary public health emphasizes a community-based approach to health promotion and disease prevention. The evidence from the past 20 years indicates, however, that many community-based programs have had only modest impact, with the notable exception of a number of HIV prevention programs. The lack of adequate sanitation facilities and hygiene promotion continues to expose vulnerable populations to higher risks of diseases such as diarrhoea, cholera and dysentery.

Vast literature has concentrated on the successes and failures of community-based programs without exploring the role of individual stakeholders in community-based programs. Unless an investigation on the impact of the community health club approach on health in rural communities within the framework of individuals' role then an analysis of the community health club approach lacks precision of what it is capable of doing to communities. This research also seeks to contribute to existing literature on community based-programs and their effectiveness and efficiencies. Against a background that there is an increase in the number of communities who are facing water and sanitation problems, the need to raise awareness and build community capacity in behavior change ought to be done. These in fact are the major drives for this research. This research focuses on the case of Ward 19 of Mberengwa District in Zimbabwe. Furthermore, the innovative findings and results of this research will essentially guide policymakers, non-governmental organizations and

other interested stakeholders in crafting and implementing policies that are beneficial to the rural communities in mitigating this impeding problem.

1.4 Hypothesis

Failure of all development projects is due to lack of community participation.

1.5 Objectives of the Study

- To explore the extent of community participation in CHCs.
- To determine how social capital and community dynamics sustain health benefits from water and sanitation interventions.
- To assess the impact of CHCs on the community's health and quality of life.
- To proffer recommendations of how the rural community participation can be enhanced in local developmental projects specifically dealing with water and sanitation problems

1.6 Research Questions

1. What is the extent of community participation in CHCs?
2. What social capital and community dynamics sustain health benefits from water and sanitation interventions?
3. What is the impact of CHCs on the community's health and quality of life?
4. What recommendations can be given to improve community participation in local development projects?

1.7 Scope of the study

This study will be based in Mberengwa District Ward 19 where Action Contre La Faim is implementing various WASH projects. The study respondents will be Key informants from various government line ministries, District Administrator, Rural District Council personnel, Chiefs, project participants and non -participants in Ward

1.8 Limitations

The researcher is on full time employment the limiting factor is the short time in which the research will be conducted.

CHAPTER 2: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter will review literature on issues pertaining to community participation, software approaches used water and sanitation projects in Zimbabwe and community socio-dynamics that influence the success of health promotion through the CHC approach. To attain this objective this chapter utilizes published material in the form of text books, journal articles, reports etc. written by other development partners that have scored success stories in using the CHC approach. Reference will also be made to known health promotion theories like diffusion of innovations and theories of interpersonal health behavior to assist in comprehending the hypothesis.

2.2 Background to Software Approaches in Water and Sanitation Programmes

At independence in 1980 the Government of Zimbabwe gave high priority to the improvement of water supplies and sanitation in the rural areas where about 80% of the country's population lived. Initially much was achieved in the provision of new boreholes and latrines for families in the rural areas. While the Integrated Rural Water Supplies and Sanitation Programme (IRWSS) made improvements to community access to water supplies and sanitation, these benefits have not been as high as would have been liked or expected. It is now realized that some of the problems of sustainability and maintenance in the programme are related to management (MoHCW, 2002). The problem as seen today is more multifaceted and not simply based on what people are told, the technology or even the amount of material subsidy. Thus the need for projects that involve people and provide people with a choice in the type of water and sanitation technology they can afford. The importance of hygiene education in the water supply and sanitation programme has long been recognized however, the sector has been battling to find appropriate strategies for promoting hygiene and creating linkages with health and infrastructure

development. According to the MoHCW PHHE Field Guide of 2002, in earlier years of the IRWSS programme, the notion was to teach communities about health (diseases and cleanliness) and that if they did not listen to what they were told, they would probably become ill. This didactic teaching approach used fear of illness and death to convince families to change behaviours. While this approach worked for some people the overall effect did not last and very quickly people went back to their old ways. The shortcomings of this approach were recognized and it was realized there was need to involve people in the development of their own hygiene education promotion that would allow them to make decisions for change – community empowerment.

Participatory approaches were first used in the water sector in the 1980s as a means of community mobilisation (Srinavasan, 1990). The local variant in East and Southern Africa known as Participatory Hygiene and Sanitation Transformation (PHAST) was widely acknowledged as good practice (Lidonde, 2000). In 1993 WHO, UNDP, UNICEF supported the regional workshop held in Uganda and Zimbabwe was among the countries selected to pilot PHAST initiative in Beitbridge, Mutasa and Goromonzi Districts. By 1997 this methodology had became established in Zimbabwe but failed to become translated into well-supported programmes. Although training material had been distributed and district staff were conversant with participatory approaches, they failed to use this in their routine work. (Waterkeyn, 1999) believes the activities were seen as labour-intensive and time-consuming and reliant on trainers with extrovert personalities if they were to be used creatively and with confidence. The lack of dedicated funding was also cited as a constraint. The 5 day training given to field staff was seen as too short, and conventional didactic methods too firmly engrained (United Nations Development Programme/Water and Sanitation Programme—East Africa, 1998). Thus PHAST remained largely an interesting concept rather than an applied programme and by 2001 the regional planners who had launched PHAST were losing interest. After nearly a decade, the PHAST approach had failed to produce empirical evidence of

behaviour change as few practical objectives and indicators of change had been adequately monitored to convince donors to continue support. Aware of the shortcomings of PHAST, but convinced of the ability of participatory approaches to achieve behaviour change through conscientisation (Freire, 1970), a small pilot project was set up in 1995 (Participatory Health and Hygiene Education -PHHE) making health promotion a campaign focused on a dedicated membership promoting inspired leadership rather than using conventional village gatherings controlled by traditional leadership (Waterkeyn, 1999). PHAST was taken a stage further: the exploratory dynamic of participatory activities was linked to achievable objectives with measurable outcomes. PHHE set out to provide indicators and monitoring systems that allowed cost effectiveness to be measured.

2.1.1 Participatory Health and Hygiene Education

Participatory Health and Hygiene Education (PHHE) is about the process of changing behaviour and has a starting point, the home. The basis for PHHE in Zimbabwe is based on the SARAR/PROWWESS approaches and methods. The approach is learner centered and evolves around the principle and belief that people can take control of their lives and environment by developing their skills in problem solving and resource management. The aim of PHHE is to identify and change behaviours of men, women and children so that when they are added to water and sanitation projects they will maximise the health impact. The PHHE approach broadly seeks to facilitate a change in health and hygiene education approaches from didactic technical model to a participatory social model and specifically seeks to:

- Create a non threatening atmosphere in which people can feel free to ask questions and to challenge each other and outsider on health, hygiene and other developmental issues

- Transform all learning sessions into sharing situations in which everyone can participate equally, learning from each other

- Share and analyse information for collective action

- Facilitate improved community hygiene behaviour and practices

- Prevent and control communicable diseases

Community based facilitators identified from the community will be trained in PHHE so that they can implement the approach in the community. Those selected in each ward to represent a village or group of villages. A whole village can form a community health club (CHC) or several health clubs can be formed in a village. The concept of a club is in line with traditional values of conformity in rural society (Gelfand, 1984) and builds on a long history of women's groups developed throughout the colonial period through the missionaries and philanthropic societies, when an archetype of the smart, club-going woman as a pillar of society developed in Zimbabwe (Burke, 1996).

2.1.2 CHCs in Zimbabwe

The CHC Model works because it provides a structure within which the whole group can endorse decisions, thus removing any individual fears or risks of 'going it alone'. Waterkeyn and Cairncross (2005) believe this strategy is different from the 'trickle down approach' whereby a few 'enlightened' individuals slowly influence others to adapt. Whilst this may 'work' where technology is concerned (like the rapid spread of the use of cell phones) for issues such as sanitation it is not a cost effective method of changing society. Community Health Clubs provide a forum for discussion leading to group consensus and the whole group rises up together. When critical masses of people within the health club decide to do something, the rest will follow even if they do not appreciate all the reasons.

Since community engagement and community cohesion are correlated with improved health (Gallagher, Easterling & Lodwick, 2003), clubs are used not only to provide a forum for participatory learning and action, but also to strengthen community participation that leads to improved health. Clubs are in line with traditional forms of

organization in many communities, and are also seen as a way to develop local leadership (Waterkeyn & Cairncross, 2005).

As health promotion tools, clubs vary in the scope of their membership and the breadth of their mission. CHCs, which are open to all community members and address a wide array of health issues, are among the most comprehensive health promotion clubs. Since in the 1990s participatory approaches seemed to provide an ideal way to involve communities in hygiene improvement and hence to ensure the sustainability of projects. However, such approaches are costly in human resources and training, and convincing results are scarce (Waterkeyn, 2002). In Zimbabwe, however, the ZimAHEAD programme has tried to show that participatory approaches can be cost effective and sustainable. In 1994 ZimAHEAD developed the concept of structured participation via Community Health Clubs, using existing participatory methods but with a structured process and rigorous follow up. Waterkeyn, (2002) indicates that the CHC Approach programme builds capacity within communities through participatory training and also demonstrates effective action on the ground, which can be quantified and costed.

The Community Health Club Approach is a strategy which, over the past 15 years, has been able to change the behaviour of over half a million people in rural and urban communities mainly in Africa, and has succeeded in improving hygiene, sanitation which has reduced diarrhoea and many other preventable diseases. The overall impact of Zimbabwe's decade-long economic decline and cuts in public health expenditure detrimentally affected the health system. This resulted in deterioration of health care facility infrastructure at all levels, resulting in reduced access to basic health care. In addition, key activities such as outreach services, referral of patients, drug distribution, surveillance, and monitoring and evaluation of local health centers were hampered by shortage of transport, poor road network and lack of communication. Moreover, the flight of human resources further compounded the decline in critical public health programmes and quality and coverage of services

such as emergency preparedness and response. The economic downturn also resulted in declines of water and sanitation coverage in both urban and rural areas (OCHA 2013).

2.1.3 CHCs in Mberengwa

In rural Zimbabwe, community health clubs have been active since 1995 to change health behaviour and increase demand for better sanitation.

This Community Health Club project was implemented by ACF in 237 villages, within 6 wards of Mberengwa, Midlands Province, Zimbabwe in 2012. The ambitious aim was to achieve blanket coverage, by getting every household within each village represented in a Community Health Club, in order to achieve complete common understanding and full community participation in the management of safe hygiene and sanitation to achieve Zero Open Defecation.

2.1.4 The CHC Model of Development

According to a Fisher (2013), the CHC approach promotes the culture of health because people meet regularly to learn about and discuss ways to improve hygiene. Divided into four stages (Health Promotion, Water and Sanitation, Sustainable Livelihoods, Social Capital), underlying the CHC approach is the concept that a lack of "common-unity" within communities causes a deficit of development (Figure 1).
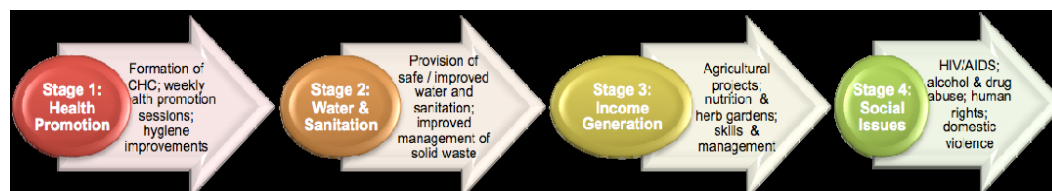

Figure 1: The AHEAD Methodology

Stage 1 consists of CHC meetings which are properly organised sessions with a registered membership which should represent at least 80% of the households in the community. Weekly meetings of CHCs can address up to 30 topics over a six month period. Each session requires members to practice their new learning at home. All

members are issues with membership cards, listing topics covered and recommended practices. Fisher (2013) states this is important as it provides a sense of identity and encourages others to join, setting learning targets, and acting as a monitoring tool preventing gate crushes from reaping unearned benefits. At the end of the six month period, attendance certificates are awarded which confer important social status and are a huge incentive for members. The CHC model of development is:

- **Structured**: A known membership within a Community Health Club: a committed group formed specifically to promote health rather than a loose gathering of people addressed ad hoc.
- **Measurable**: Topics, key messages and targets are set in a syllabus summarised in a membership card.
- **Regular**: club holds weekly health sessions for at least six months.
- **Group Consensus**: appeals to group consensus and peer pressure rather than targeting individuals.
- **Inclusive**: uses health as the 'entry point' because knowledge can be shared infinitely, rather than aid programmes which divide as communities compete for limited hand-outs.
- **Participatory**: members use lively participatory techniques that promote enable self-realisation rather than top-down directives.
- **Holistic**: addresses a myriad of diseases that can be prevented by good hygiene rather than one specific disease (diarrhoea).
- **Horizontal**: A wide focus of all causes of ill health, including poverty, rather than vertically targeting a few issues such as diarrhoea.
- **Long term**: constantly reinforces key messages through focus on 24 different issues in stage one and continues to apply information in subsequent stages.

Once one has completed the health promotion modules, one graduates to the second stage, where club members act to fill the greater demand for water and sanitation resources and hygiene practices created by the sessions, by doing activities such as latrine creation, maintaining a safe water source, and ensuring safe solid waste

disposal. Non-club members are encouraged to participate in these activities and trainings, thus causing the WASH knowledge to spread throughout the community. Stages 1 and 2 lay the foundations for poverty alleviation projects.

Stage 3 involves establishing income generating projects and or skills/financial training. After the community has generated some income and reached this level of organisation, they can begin to explore how to solve deeper social issues (alcoholism, HIV/AIDS orphans, and domestic violence).

2.2 Community Participation in Health Initiatives

Members of a community are assumed to have a sense of community, which means that they have a sense of belonging to and of sharing common aspirations with the other members of the community. Israel *et al*, (1998) suggested that most people yearn to be part of a larger network of relationships that give expression to their needs for intimacy, usefulness, and belonging and that people tend to self-segregate—that is, interact with others like them because of shared interests, similar cultural norms, and greater empathy toward individuals who remind them of themselves.

A key element of the community based approach is the principle of participation— that is, the involvement of community members in defining the health/safety problem and finding the solutions. Community member participation refers to "the social process of taking part (voluntarily) in formal or informal activities, programs, and/or discussions to bring about a planned change or improvement in community life, services and/or resources" (Bracht *et al*, 1990). In particular, greater representation from the different sectors of the community led to broader and more holistic understandings of health and also to greater overall success in project objectives. Additionally, in regard to long-term success, it has proven important that different social groups, particularly those that may have been historically marginalized, feel equally empowered to participate and lead community groups (Edwards, 2004; Campbell, 2003; Healy, 2001). Community member participation represents a bottom-up (or

grassroots) approach to program planning and decision making. The 1978 World Health Organisation (WHO) Declaration of Alma Ata recognized that people must be actively involved in the process of promoting and protecting their health (Laverick, 1990). Not fostering this type of inclusive environment limits benefits by denying voice to potential contributors, and can also cause the program to fail since those who feel underrepresented or denied access to leadership positions may impede the project as they lobby for broader social change (Guggenheim, 2006; Uquillas & Nieuwkoop, 2006).

According to Collins, (1993) multifaceted interventions of community based health and safety programs are aimed at achieving communitywide health and safety effects; a population outcome is the goal. Hence, the approach directs many interventions towards the general population in the community rather than to high risk individuals. The population based strategy is an attempt to control the determinants of morbidity and mortality and to lessen risk across the population. While this strategy may be of little use to a given individual, with a resultant prevention paradox, even smaller effects can be meaningful at the community level, where a modest reduction in the level of risk can have a significant public health impact. According to Merzel and D'Afflitti, (2003) in practice, many programs combine elements of population based and high risk strategies in order to more effectively reach community subgroups.

2.3 Social Capital and Health interventions

Health can be improved by addressing the underlying causes of poor health such as limited information, poverty, and lack of social capital, including organisational capacity within the community to effect sustainable change (Waterkeyn and Cairncross, 2005). A growing body of research has found that the presence of social capital through social networks and communities has a protective quality on health. Social capital affects health risk behaviour in the sense that individuals who are embedded in a network or community rich in support, social trust, information and norms have resources that help achieve health goals (Lin, 2007). Social capital, conceptualised as characterising whole communities, provides a useful framework for

what constitutes health supporting environments and guidance on how to achieve them (Erikson, 2011). Social capital is the social glue that helps people, organisations and communities to work together towards shared goals. It comes from everyday contact between people, as a result of their forming social connections and networks based on trust, shared values, and 'give and take'. Building social capital develops community cohesion, and there are a number of reasons why this is important. Some of those reasons include:

- developing neighborhood and social networks enable communities to collaborate and trust each other
- people who are active in their community or belong to groups and clubs tend to enjoy better health

Community cohesion is about a sense of belonging, valuing diversity, tackling inequalities and promoting interaction to develop positive relationships within a community. Norms and solidarity can also affect health by social influence between members of a network. Bourdieu (1972) believes trusted peers may influence health behaviour in others by functioning as role models. This influence can either be health enhancing or health damaging depending on the existing norms in the network. Strong norms and solidarity may also lead to high social control which enables the network to control the norm compliance. Furthermore in an environment where people trust each other, healthy norms are more easily spread since social interaction is high (Bourdieu, 1972).

2.4 Theoretical Framework

2.4.1 Diffusion of Innovations Theory

According to Rogers (1962), Diffusion of Innovations is a theory that seeks to explain how, why, and at what rate new ideas and technology spread through cultures. Rogers (1996) refers to diffusion as the "process by which an innovation is communicated through certain channels over a period of time among the members of a social

system". Orr, (2003) indicates that the most striking feature in the diffusion theory is that, for most members of the social system, the innovation-decision depends heavily on the innovation-decision of the other members of the system. In fact the successful spread of the innovation follows an S-shaped curve. Diffusion scholars divide the bell shaped curve to characterize five categories of system member innovativeness, where Rogers (1995) goes on to define innovativeness as the degree to which an individual is relatively earlier in adopting new ideas than other members of a system. These groups are innovators, early adopters, early majority, late majority and laggards.

Rogers (1995) acknowledges that decisions are not authoritative or collective and that each member of the social system faces his or her own innovation-decision that follows a 5 step process shown on Figure 2. This process is a type of decision-making. It occurs through a series of communication channels over a period of time among the members of a similar social system. An individual might reject an innovation at any time during or after the adoption process.

Figure 2: Five stages in the Decision Innovation Process

1. Knowledge – person becomes aware of an innovation and has some idea of how it functions

2. Persuasion – person forms a favourable or unfavourable attitude toward the innovation

3. Decision – person engages in activities that lead to a choice to adopt or reject the innovation

4. Implementation – person puts an innovation into use

5. Confirmation – person evaluates the results of an innovation-decision already made

It used to be assumed that the media has direct, immediate and powerful effects on the mass audience but the diffusion theory argues that, since opinion leaders directly affects the tipping of an innovation, a powerful way for change agents to affect the diffusion of an innovation is to affect opinion leader attitudes (Orr, 2003). Diffusion of Innovations Theory is helpful for understanding these concerns and the dissemination of new health promotion tools and strategies, including prevention and health education curricula in the case of Mberengwa District. The theory addresses how new ideas, products, and social practices spread within a society or from one society to another.

Communication channels are another important component of Diffusion of Innovations Theory. "Communication is a process in which participants create and share information with one another to reach a mutual understanding" (Rogers, 1995). Diffusion theories view communication as a two-way process, rather than one of merely "persuading" an audience to take action. The two-step flow of communication, in which opinion leaders mediate the impact of mass media, emphasizes the value of social networks, or interpersonal channels, over and above mass media, for adoption decisions. Community leaders are important allies in communicating about new practices or ideas to improve health. When they reiterate information that is provided through mass media channels, the chances that consumers will decide to act increase (Rogers, 2003).

2.1.2 Theories of Interpersonal Health Behaviour

Theories of health behavior at the interpersonal level assume that individuals exist within environments where other people's thoughts, advice, examples, assistance, and emotional support affect their own feelings, behaviors, and health. The significant individuals and groups include family members, co-workers, peers, health professionals, and other social entities who are similar to or influential for them. People are both influenced by, and influential in, their social environments.

Theories of interpersonal health behavior are not limited to developing an understanding of interactions, though the dynamics of relationships are often at the core of these theoretical frameworks. The theories at this level include factors related to individuals' experience and perceptions of their environments in combination with their personal characteristics (http://rex.nci.nih.gov/NCI_Pub_Interface/Theory_at_glance/HOME.html).

3.0 CHAPTER 3: RESEARCH METHODOLOGY

The methodology that was adopted in this study was based on the interpretivist approach. The field research was conducted in Mberengwa over a period of 15 days. Since it was not possible in this short time frame to visit and assess each of the 39 CHCs, in-depth analysis was done on a small sub-set of the CHCs (6 CHCs) and contextualize these findings through discussions with ACF project staff, government line ministries, local leaders, ACF projects intended beneficiaries and project documentation addressing CHCs. In addition, 2 communities (villages) without CHCs were sampled to serve as "control groups" and provide valuable insight into the role of CHCs in health promotion and draw comparisons. The team used a variety of qualitative research methods to address the research questions, including participant observation, key informant interviews and focus groups, discussions. Since it is not a vast population this research will not utilize questionnaires as this method works better in expansive areas as units of analysis. There was both triangulation methods and findings from the various research instruments used.

3.1 Description of the Study Area

Mberengwa district is in Midlands Province of Zimbabwe (Figure 3). The area lies south of the Province area (below 900 meters above mean sea level). There are 37 Wards in Mberengwa District. The total population is about 186,164(as of the National Census of 2012). Mberengwa District is in Region 4 and 5 and is prone to droughts and high temperatures. The main livelihood activities are subsistence farming as well as mining of minerals like gold, iron ore, emeralds. Annual rainfall is generally low, around 350-550mm, and the soils are poor and prone to erosion (MHCW, 2008). The district has a rainfall season that begins in November and lasts until March. The major crops grown are millet sorghum, maize, round nuts, groundnuts and cowpeas (Bush, 2010, ZimVac and FEWSNET, 2005).It also has a water coverage of 30% and sanitation coverage of 40%.

The ward in which the study was carried out is Ward 19 (Figure 3), where ACF has been working since 2011. With a Ward population of 9254 and 1481 households there is only 1(one) Rural Health Centre. There are 45 villages and to date 39 Community Health Clubs have been formed.
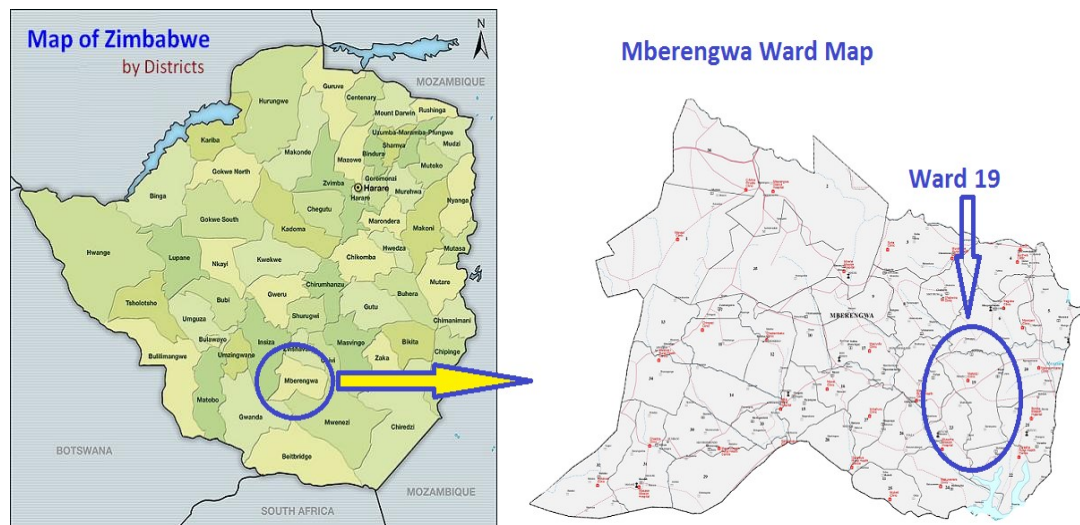
Figure 3: The map of Zimbabwe showing the location of Mberengwa District and Mberengwa map showing ward 19

3. 2 Research Design

Fraenkel and Wallen (1996) define a research design as a systematic and orderly approach taken towards the collection of data so that information can be obtained from those data. Zikmund (1997) defines research as seeking through methodical processes to add to one's own body of knowledge and hopefully to that of others, by the discovery of nontrivial facts and insights. As earlier mentioned this research takes an interpretivist approach. Proponents of the interpretivist approach hold the view that the social world cannot be described without investigating how people use language and symbols to construct social practices, that is, understand their experience (Robinson, 2002). It therefore believes that the world is interpreted through the mind and it uses qualitative data in its research. It describes the procedure taken by the research findings.

McPhail (2001) argues that qualitative approach in research focuses on the social process and how individuals shape and give meaning to the social world. Understanding and interpreting these meanings underpins qualitative methodology. He further alludes to the fact that the qualitative method is a research approach where social reality is multiple, divergent and interrelated. Qualitative indicators measure perceptions and quality of participation and health outcomes due to effectiveness of CHCs. Qualitative methods used in this research were focus group discussions, semi structured interviews with key informants and field visits and observations.

3.3 Population of the Study

Polit and Hungler (1999) refer to population as an aggregate or totality of all the objects, subjects or members that conform to a set of specifications. Fraenkel and Wallen, (1996) explain that it is upon this group that the researcher would generalize the results of the study. The population includes all individuals whom the researcher is interested in obtaining information and making inferences on. Defining the population is important because it helps the researcher in selecting a sample for study (Saunders et al, 1997). The target population for this study is 39 CHCs communities of Ward 19 in Mberengwa District, local leaders, VHW, EHTs, Nurses and DEHO. It was however not feasible to obtain information from every club member hence a representative sample of the total population was used as outlined below. 20 Households that did not participate in the CHCs selected from 2 villages will be used as a control group in order to assess the impact of the CHCs.

3.4 Sampling Procedure

Ferber (1974) defined a sample as a small part of anything designed to show the style, quality and nature of the whole. The purpose of a sample is to approximate the measurement of the whole population well enough, within acceptable limits. There are two methods of coming up with a sample. Saunders et al (1997), report that random (probability) sampling ensures that the probability of each case being

selected from the population is known and is usually equal for all cases. On the other hand, non-random (non-probability) sampling is such that the probability of each case being selected from the total population is unknown and cannot answer questions that require statistical inferences about the population's characteristics.

This research will utilize purposive/judgmental sampling method to select the staff and management at ACF, local government representatives and the government line ministries. Purposive/Judgmental Sampling is a method whereby a researcher uses a wide range of methods to locate all possible cases of a highly specific and difficult-to-reach population. It uses the judgment or expertise of experts in selecting cases also with a specific purpose in mind. These unique and specific cases are especially informative. This research will also utilize the simple random sampling method. This method will be used to select project participants who are locals for both interviews and focus group discussions. Simple random sampling method is a basic sampling method in statistical methods and computations. When collecting a simple random sample each unit of the target population is assigned a number a set of random numbers is then generated and the units having those numbers are included in the sample

3.5 Primary and Secondary Data

Information was obtained from both secondary and primary sources of data. Text books from the library, electronic journals, newspaper articles, magazines and other journals were made use of.

Primary data is collected specifically for a project. It is expensive to collect, but it is important, as it is possible to formulate structured and unstructured questions that focus on the study topic. In this study, primary data was obtained from focus group discussions, observation and key informant interviews. The researcher has an excellent knowledge of SPSS so analysis of results was easy.

Secondary data is data gathered and recorded by someone else prior to (and for purposes other than) the current project. The secondary data includes the use of information from the internet, ACF documents, the UNDP Library and other Development activities journals. Secondary data has the following advantages: data is already available; data is highly accessible and less expensive to obtain. However, secondary data has the following disadvantages: data may not be relevant to the current study, data may be outdated for the current purpose, one may not be able to correct errors in the data, and also, bias and collation errors may arise.

3.6 Research Instruments

In this research, the researcher relied heavily on in-depth interviews to capture the views of staff and management at ACF, local government representatives, government line ministries, local leaders and ACF projects intended beneficiaries and the local people. Full anonymity will be granted to those who will be interviewed.

3.6.1 Participant Observation and Focus Group Discussions (FGDs)

Assessing the quality of participation can be done through participant observation and the recording of selected qualitative information on e.g. who speaks at meetings, does one person or group dominate the discussion, how decisions made and conflicts are managed, McAllister (1999). In addition to field observation, local people (community members) were asked to provide feedback through participatory methods like the focus group discussion. The FGDs were guided by the following themes:

- scale of participation and representation: dealing with behaviour, knowledge and adoption of improved health behaviour
- social capital and how that promotes sustainability and effectiveness of CHCs and health outcomes.
- practices emanating from knowledge gained through participation in CHCs
- health issues before and after participation in CHCs

The researcher also asked the Community Services Officer (RDC) to be an observer who did the evaluation. This was done since observation must be conducted by a neutral qualified observer as it allows for considerable participation by different stakeholders, Rudqvist and Woodford-Berger (1996).

A CHC effectiveness tool (Annex 4) was also administered by the researcher where he observed and interviewed 10 participants in each of the 6 CHC communities. The tool was administered at the homestead to allow the researcher to observe hygiene practices and knowledge application. The researcher interviewed 10 members from 2 non CHC participating communities for purposes of comparison, to assess practices emanating from knowledge gained through participation in hygiene promotional activities (CHC) as to come up with a model homestead. Tables, graphs and pie-charts will be used to present the research findings and results. Data analysis will be done using a Statistical Package for Social Scientists (SPSS). Since the data for model homes (annex 4) will be collected from a representative sample, statistical methods such as the mean, median, mode etc. shall be applied to determine common hygiene practices.

4.0 CHAPTER 4: RESEARCH FINDINGS AND DISCUSSION

4.1 To explore the extent of community participation in CHCs

Statistical information collected from ACF, an NGO spearheading the use of the CHC approach in promoting community health shows that community participation in CHCs is significantly high in ward 19 of Mberengwa district where 74% of the households participate. Attendance at FGDs indicated widespread participation in CHCs among all strata of society from general community members to local leaders, males and females, young and old and this has propelled the CHCs to success. Table 1 below shows participation levels in the 6 groups in ward 19 that were interviewed for this research.

Table 1: Community Participation in CHCs

Name of CHC	Village population (HH)	No HH participating in CHC	Male	Female	% Female
Utsanana	45	31	13	18	58.1
Hupenyu Hutsva	101	73	35	38	52.1
Kunzwa Nekuita	78	65	26	39	60.0
Chiedza	23	19	7	12	63.2
Tamuka	61	45	19	26	57.8
Murambatsvina	42	29	12	17	58.6
Total	**350**	**262**	**112**	**150**	**57.25**

The ratio between male and female members varied from village to village, often with a slight female majority (see table 1). Participation, especially by women has

been strongly encouraged resulting in 57.25% of the participants in the interviewed CHCs being women. The atmosphere for training was free and all members felt comfortable to participate and seek out causes of health problems and holistically create solutions. Observations of participation during two CHC meetings proved that women are vocal as much as the men, a contrast to an earlier belief where women never contributed in the presence of men. Women also asked questions, participated and took initiative in model homes. One participant said *" in the olden days women were not allowed to speak or make suggestions as it was believed that all good things come out of men, but now women are free to participate. In our club we have twelve women and seven men"*. There is evidence of improved gender relations in Ward 19 as 66.7% of the interviewed CHCs have women leaders. Selection of the women was deliberate as participants believe that women have a passion for health and are more likely to lead the group to success ensuring closer follow up. Women also have reduced mobility in search of jobs in the towns thus are likely to see the clubs to graduation. Many CHCs benefit women directly and participation has resulted in women's issues being addressed. Improved gender relations have made it easier for the community to work together to solve community problems, health included.

In addition, there was a diverse representation of ages among CHC members (starting from the late teens), though the oldest members of the community often did not participate due to limited mobility. CHC membership also included people with a wide variety of educational backgrounds, from those who had no formal schooling to the local teachers.

Additionally noted was compelling evidence that the CHC Approach stressed on achieving health goals through economic and social incentives, and by incorporating the traditional knowledge and wisdom of local peoples accumulated over generations of intimate participation in health promotion. An example given is the use of ash for hand washing as a substitute to soap in Murambatsvina and Kunzwa Nekuita clubs. CHC Approach using PHHE was viewed as a modern attempt to revive established

and traditional local and indigenous cultural and institutional mechanisms for promoting and managing community health systems for example participants constructed pit latrines out of pole and dagga and after trainings have adopted UBVIP and BVIP latrines.

CHCs occasionally resulted in more decision making responsibility among local people. The shift from state to more community-based management of health assisted marginalized and neglected groups in obtaining a greater role and stake in making informed decisions on their health and surroundings. Despite this occasional success, encountered at Murambatsvina, Hupenyu Hutsva, Kunzwa Nekuita, Tamuka and Chiedza clubs some challenges were noted at Utsanana CHC where members failed to meet regularly after graduation. This was a clear sign that sustainability structures were weak. FGDs revealed a conscious attempt at devolving authority from national and state to more local peoples and institutions, empowering them. Local communities were frequently only marginally more empowered than prior to the implementation of CHC, with considerable control still residing in national and state authorities. Moreover, devolution often resulted in power being concentrated in particular groups and sectors in the local communities. This situation was especially evident in empowered participating for women, where there was a significant shift in power to women. Devolution of authority typically resulted in power being concentrated in particular community groups and members, with others routinely excluded.

CHCs show significant evidence of success and likelihood for sustainability. The project is largely community driven; while initially project staff managed the project, responsibility has been transferred to stakeholders. CHCs now implement health related activities, organize monthly action plans, rollout trainings to neighboring communities, and participate in self-initiated activities, such as building infrastructure.

In order to understand why 26% of the households do not participate in CHCs the researcher interviewed non-CHC members in Ward 20. When asked why they did not participate, 42% said they had moved to the rural area after the CHCs had begun trainings and as a result found it difficult to join in. 32% cited not having enough time to participate as they spent most of their time working or looking for food. Qualitative information from CHC participants also echoed these findings as respondents said those who did not participate were absent during registration due to travel or work commitments. However CHC members were confident that health messages still reached the non participants through routine outreach and sharing of health messages.

4.2 To determine how social capital and community dynamics sustain health benefits from water and sanitation interventions

Social capital and community cohesion helps communities build capacities and solve self-identified problems. In the area of community cohesion, the researcher found that CHCs had helped to bring communities together. Community members indicated that CHCs had helped to create unity, stimulate a collective spirit, increase women's participation in decision-making, and enable an environment where everyone's ideas were valued. Community members indicated that by illuminating the benefits of working together, CHCs had inspired the formation of other groups within the community. CHC success also led to the formation or revitalization of many other community groups, including village savings and loan (VS&L) clubs and community gardens. Increased community cohesion is also seen in the CHC's efforts to incorporate everyone in CHC activities and benefits. Non-CHC members are aware of CHC activities and benefit from their impacts, which spread across the ward. CHC activities, such as village cleanings or growth promotion activities are seen as collective endeavours not limited to CHC.

This peer monitoring reveals an increased level of community cohesion, where community members are more likely and willing to work together, and in fact expect this type of cooperation. Leadership is a second vital aspect of socio dynamics. When asked about the elements for successful CHC implementation, key informants emphasized commitment and leadership as the essential components driving long-term success. ACF field staff gave a compelling picture of the importance of leadership where they highlighted failure to meet occasionally after graduation due to lack of leadership at Utsanana CHC where the facilitator left the village for Zvishavane in search of greener pastures. The village also has in house squabbles on who is the standing village head after the village head passed on just after the club members graduated.

At the cognitive level, the project improved organizational skills and health knowledge which enabled beneficiaries to self identify problems, organise, and come up with solutions. When asked what motivates people, the Nurse at Matedzi clinic summed it up in three elements: knowledge transfer, awareness raising, and leadership. Improved health outcomes were predominantly a result of information diffusion and organizational skills training that provided people with the tools necessary to undertake self-initiated activities. Participatory trainings, open election of leaders, and gender inclusion made possible changes in attitudes related to good governance.

In most CHC communities, leadership is emerging both at the CHC and Village levels. Particularly enthusiastic CHC members who have gained the respect of their communities have been selected to take the lead in CHC activities. These leaders are very dedicated to the CHCs. In addition, they have many of the skills necessary to maintain CHCs, such as the ability to organize and run meetings, as well as oversee and undertake activities such as outreaches. One area that was not directly noticeable was the ability of CHC members to maintain the motivation. Motivation seemed to

come principally from individuals' commitment to CHCs, or from external sources such as ACF staff visits or other special events. However a few individuals seemed to require motivation in terms of t-shirts to continue participation. In one village Utsanana club) participants highlighted that competitions (club or model home) demoralised members as competitions were marred with cheating and favouritism though the idea is noble.

Village heads and EHTs have become more effective leaders in the process of CHC creation. VHWs in all the CHC communities visited were active participants in leading the community's development. VHWs met regularly, organized action plans to benefit the community and provided valuable oversight to CHCs. Community leadership has been strengthened from within as well as from without. From without, ACF has been actively involved in working with community leaders to strengthen their leadership skills. For example, ACF has worked with Village heads, Government line ministry representatives and CHC leaders (VHWs) to recognize their roles and responsibilities as well as to provide them with the training necessary to uphold these duties. Community leaders indicate that this training has enabled them to improve their leadership. Leadership strengthening has also occurred as a result of internal pressure. As CHC members gained insight into their rights, they came to expect more from their leaders. Participants revealed that in addition, the CHC approach promotes peer monitoring, which has allowed village members to supervise the performance of their leaders and other club members thus exercising social oversight. The high levels of community commitment have generated demand for leaders to perform well.

While leadership is beginning to emerge, much leadership is still in the early stages of development. Many leaders' experience was limited only to their involvement in calling for community meetings called for by NGOs. As a result, leadership remains an area where additional efforts could be beneficial. Recognizing the extreme

importance of leadership in maintaining and sustaining CHC benefits, ACF is focusing on expanding leadership training as the project approaches its end date. For the remaining 18 months of the project, and as part of its exit strategy, ACF will continue to provide refresher leadership training skill workshops on sustainability, transparency, governance and accountability.

Currently CHCs are able to decide upon and implement a variety of self initiated activities without field staff supervision. On occasion, CHC monthly planning sessions take place without ACF presence and group leaders report to ACF field staff on the progress of the activities and the agreed upon tasks for the following month. This has capacitated the leaders and members to run the clubs, a move seen to enhance sustainability. However, as CHC members learned to plan and execute monthly activities, they began to increasingly incorporate their own ideas. Communities now identify their own needs and potential solutions. This process has led to a more holistic understanding of the factors affecting their health. Chiedza club members expressed their interest in establishing a community nutrition garden and start a vegetable drying project where they would promote growing of nutritional horticulture produce and in the event of excess production, drying using a solar drier and improved methods would be done. This would ensure reduced malnutrition, increase incomes and overall development in their community. In the spirit of togetherness, club members also joined VS&L projects implemented by CARE another NGO operating in Mberengwa district. Participants echoed, the savings are intended to address health needs eg construction on BVIP latrines among others and as a vital source of capital for productive needs. The VS&Ls provide for these 'emergency funds' for pregnant women when they need transport money to the nearest health center for delivery and antenatal services. As Lucas (1988) shows, there is a strong positive correlation between per capita income and social indicators, such as health outcomes. As income per capita increases, social indicators improve.

Given this correlation, it makes sense for CHCs to reinforce economic activities, which also lead to better health.

Though the main objective of CHCs is to spearhead health related efforts, participants also took part in other development-related activities. CHCs in ward 19 clearly promoted health through direct trainings and created a forum for raising economic and educational standards indirectly. Indeed, these examples show that there is no shortage of self-initiated activities in CHC communities. On the other hand, communities have a host of ideas and community meetings like CHCs aid mobilisation and sharing of ideas. This is in stark contrast to the non-CHC community of Mberengwa where community members were not actively involved in collectively addressing any community needs

The CHCs also increased coordination between communities and the health sector. A MoHCW staff at Matedzi clinic highlighted that CHC members in Ward 19 are also actively involved in a variety of health promotion activities including, promoting mothers to attend antenatal clinics, vaccination outreaches for measles and cholera alert campaigns. For these activities CHC members help to notify community members about these important events, ensure attendance, facilitate activities and use these opportunities to share heath messages. This improved health outcomes and created an atmosphere of enthusiasm, empowerment and motivation to continue with positive health behaviour. Local leaders, community members and MoHCW staff are confident that these benefits are long lasting as the community fully participated and sustainability structures are in place and functional.

4.3 To assess the impacts of CHCs on community's health and quality of life

Success in health related interventions relies predominantly on generating behaviour change by transmitting information and raising awareness. During FGDs community as members reflected on the impact of CHCs on their lives, the increases in health knowledge was evident. In addition positive changes in health behaviour which other community health programs found difficult to achieve were apparent. CHC members were excited to speak of the many issues they learnt and are practicing through the CHC trainings. CHC members were articulate about the topics they covered, a clear indication that training was effective and well understood. The topics mentioned include disease management, nutrition, personal hygiene and environmental sanitation among others.

Health education did not only increase knowledge but translated into behaviour change. For example in Utsanana CHC knowledge that drinking water from unsafe sources like the rivers, unprotected well and dams may result in diseases, bathing such water can result in skin diseases shown by increased use of borehole water from 68.7% to 84%. In Chiedza CHC knowledge about the fecal oral routes of contamination and how to block the routes improved ownership of latrines from 36.6% before training to 53%, hand washing facilities from 5% to 27.1% at the time of the interviews

CHC feature a mixture of organizational, environmental, social and economic benefits in rural communities of ward 19 in Mberengwa. Participants of FDGs suggested that mothers did not only desire hygiene for the sake of avoiding diarrhoea, but also for aesthetic and social reasons. The CHC approach was also able to increase coordination between communities and the formal health sector. Increased knowledge, behaviour change, and improved coordination with the formal health sector have improved health outcomes and created an atmosphere of enthusiasm, empowerment and motivation to continue with positive health behaviour. Consequently, there is significant likelihood that these benefits will be lasting.

CHC members interviewed spoke of learning about malaria prevention, causes, and when to seek help at the clinic. Both men and women spoke of the importance of monthly child weighing to monitor development and identify children with illnesses. Others recounted the importance of vaccinations and how they had seen a dramatic decrease in disease and deaths of their young children after being vaccinated. The Sister in Charge at Matedzi also echoed an increase in the number of mothers brining their children for vaccination.   Nutrition for children and pregnant women was also frequently mentioned, specifically the importance of exclusive breastfeeding for the first six months. In Hupenyu Hutsva, a CHC member told the story of a child that at five years of age was unable to walk due to poor nutrition, but now the children were healthier as they knew what types of food to give them

Table 2: CHCS training effectiveness shown at model homes

	Utsanana	Hupenyu Hutsva	Kunzwa Nekuita	Chiedza	Tamuka	Murambatsvina
Household sanitation	3	4	5	4	3	4
Kitchen Hygiene	3	4	4	4	4	4
Sanitation (Latrine)	2	3	4	4	3	3
Hand washing facility	2	3	4	4	3	4

Table 2 shows mean scores after assessing model homes where the score key is as follows**: 5 –** Excellent, **4 -** Very good, **3-**Good,   **2-** Fair ,**1-** Poor. Generally the members mastered the concepts taught and have put them into practice. Utsanana Club seems to lag behind in terms of sanitation and hand washing facilities mainly because the club rarely meets and follow up is nonexistent. One example where behaviour has change across all clubs is the use of clotheslines and plate racks, rather than drying these items on the ground as this can lead to contamination from the soil, resulting in skin rashes, while drying dishes on the ground can facilitate the spread of intestinal illnesses such as Typhoid. In this case, behaviour change was obvious: the

majority had clotheslines and plate racks, which were in use. Not only are these tangible objects visible in CHC communities, but secondary and tertiary beneficiaries in the surrounding communities have also put up clotheslines and plate racks. Here, not only was the behaviour change evident, but community members also recognized the positive health impacts: they noticed fewer skin rashes and intestinal diseases. Having experienced these benefits, CHC communities encouraged others to adopt clotheslines and plate racks. In the end months of the mobilization phase, most monthly activities were ACF-initiated.

One village head said women in the past used to use a string tied around the child's wrist and waist to monitor growth but now the women are seen taking their children for baby clinic where they are weighed to monitor growth. As a result, they are now more able to identify when children are ill and need health care leading to noticeable improvements in overall child health. Increased environmental sanitation was another element of behaviour change that community members often cited. Mberengwa CHC members described the newly clean environment within their homes. Community members reflected on their sense of pride and accomplishment in the clean environment that was now the norm and expectation within their community.

Most community members no longer drink water from the stream and follow the regulations that when constructing a latrine, it should be more than 30m from a well in order to protect their drinking water supply. Additionally, most boreholes and wells in CHC villages had fences to keep the livestock out and protect the hardware. These positive behaviour changes have become the norm and as such create potential for successful sustainability.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The overall implementation of CHC varied greatly, with most clubs marked by relative effectiveness and success, and a few burdened by mismanagement and failure. Based on these analyses, efficiency and effectiveness of CHC were more evident than problems and deficiencies that affect health outcomes. Moreover, most of the success encountered involved socio-economic objectives, while the failures were mainly due to poor selection of the Community Based Facilitator, poor leadership and failure to sustainably manage the clubs. Success in health related interventions relies predominantly on participatory participation by community members to instil a sense of ownership, empowerment and strengthen social capital which resultantly ensured sustainability. As community members' reflected on the impact of CHCs on their lives, the increases in their health knowledge was evident and pparticipatory practices were prevalent across the CHCs. CHCs are currently bringing about a multitude of positive change, as the activities initiated by their members are practiced at the community level. Not only have health indicators changed, but more importantly, village member's perceptions of their capacity have increased; they feel more able to control disease and improve their lives. More importantly, they are taking action to prevent disease and sharing what they have learned with other communities.

The project concludes the CHC approach has been instrumental in bringing about widespread and positive health changes in the communities in which it has been implemented. With so many of these benefits occurring at the community level and by the community members themselves, there is strong indication that these benefits will be lasting. Given these accomplishments, there is great potential for this approach to be adapted and expanded in all wards of Mberengwa District and in Zimbabwe as a successful model for health promotion.

5.2 Recommendations

- As the project implements its exit strategy, certain design elements that were implemented from the start, such as forging good relations with the MoHCW and local leaders should be strengthened for sustainability, continued monitoring and evaluation and integrate CHCs with formal institutions.

- Club competitions are a good motivation strategy but are also a source of conflict resulting in disintegration of clubs. To reduce conflict, competition guidelines must be set in a participatory manner and all clubs should be made aware of the guidelines and given time to prepare. Judging must be done by external personnel for transparency.

- Communities recognise all types of needs (health, social and economic). The training package for PHHE could also encompass the Village Saving and Lending component to strengthen the communities' ability to meet the economic needs which aid health practices e.g. savings from VS&L could be used to construct a toilet, ensure consumption of more nutritious foods etc.

- Consult and coordinate with existing structures in identification of Community Based Facilitators. The MoHCW trained Village Health Workers who are more competent to handle health and hygiene trainings, are more dedicated to work on voluntary basis and can lead the club embers to graduation.

REFERENCES

-Action Faim M & E Report, 2010 (unpublished)

-Ajzen, I. (1991). <u>The Theory of Planned Behaviour. Organizational Behavior and Human Decision Processes</u>

-Bracht N, Tsouros A. (1990). <u>Principles and Strategies of Effective Community Participation.</u> Health PromotInt.5199–208.208.

-Central Statistical Office/UNICEF Multiple Indicator Monitoring Survey. 2009. MIMS

-Davis, F, Bangozzi, R and Warshaw, R. (1989). <u>User Acceptance of Computer Technology: A Comparison of Two Theoretical Models</u>. Management Science.

-Fishbein M, Ajzen I. (1975). <u>Belief, Attitude Intention and Behaviour: An Introduction to Theory and Research.</u> Menlo Park: Addison-Wesley

-Fisher, J. (2013).WELL Briefing Note 38 <u>The Consensus Approach- Health Promotion through Community Health Clubs</u>. , [Online], Available: http://www.lboro.ac.uk/well/resources/Publications/Briefing Notes/BN 38 Consensus.htm [18 February 2013].

-Gielen A C, Collins B. (1993).<u>Community-Based Interventions for Injury Prevention.</u> Fam Community Health.

-Israel B A, Schulz A J, Parker E A. *et al.* (1998).Review of Community-Based Research: Assessing Partnership Approaches to Improve Public Health. Annual Rev Public Health.19173–202.202

-Laverack G. (2004). <u>Health Promotion in Context. In: Health Promotion Practice: Power & Empowerment.</u> London: Sage Publications.

-Merzel C, D'Afflitti J. (2003). <u>Reconsidering Community-Based Health Promotion: Promise, Performance, and Potential</u>. Am J Public Health.

-Principles of Sustainability and exploration of sustainability. Chapter 7: Sustainable Solutions for Water Resources. www.webpages.uidaho.edu/sustainability/index.asp [16 February 2013]

-Rogers, E.M. (1995). Diffusion of Innovations (4th edition). The Free Press. New York

-Rogers Everett M. (2003). Diffusion of Innovations, Fifth Edition. Free Press, New York.

-Sheppard, B.H, Hartwick, J and Warshaw, P.R. (1988). The Theory of Reasoned Action: A Meta-Analysis of Past Research with Recommendations for Modifications and Future Research. Journal of Consumer Research.

-Sidibe, M and Curtis, V. (2002). Hygiene Promotion in Burkina Faso and Zimbabwe: New Approaches to Behaviour Change. PS Press Services Pvt, Ltd. Kenya.

-St Claire L. (2003). Rival Truths: Common Sense and Social Psychological Explanations in Health and Illness. Hove: Psychology Press.

-The ZimCATS Pilot Project: Creating Open Defecation Free Villages.2012. Institute of Water and Sanitation Development.

-Theory at a Glance: A guide for Health Promotion Practice: National Institutes of Health National Cancer Institute (http://rex.nci.nih.gov/NCI_Pub_Interface/Theory_at_glance/HOME.html). [16 February 2013]

-Waterkeyn, J. (2002). ZimAHEAD Report. Zimbabwe.

-Waterkeyn, J. and Cairncross, S. (2005). Creating Demand for Sanitation and Hygiene through Community Health Clubs: A Cost-effective Intervention in Two Districts in Zimbabwe. Social Science and Medicine; vol. 61, no. 9; p. 1958-1970.

-Zimbabwe Humanitarian Gaps Report. (2013). OCHA- United Nations. New York. USA.

https://docs.unocha.org/sites/dms/CAP/2013_Zimbabwe_Humanitarian_Gaps.pdf

[12 March 2013]

ANNEXES

Annex 1: Key informant interview Guide

Name of District: …………………… Ward: ……………………

Name of key informant: ……………………………………………

Position of key informant: ……………………………………………

PURPOSE: The objective of this tool is to capture opinions, attitudes, expectations and recommendations from stakeholders on factors influencing the success or failure of the CHC Approach

QUESTIONS	RESPONSES
1. Gender of respondent	
2. Is there a CHC in your community?	
3. Is anyone in your household a member?	
4. What role do you play in the CHCs?	
5. How did you learn about the CHC approach?	
6. How were the CHC Facilitators selected?	
7. How are CHC participants selected?	
8. How frequent do the CHC participants hold meetings?	
9. Which other stakeholders are involved in training or monitoring outcomes of the CHCs?	
10. Is the CHC training well structured? (Does it cover all relevant topics)?	
11. Does the CHC have a constitution?	
12. Where are the sessions conducted in the area and who selected the venue?	
13. Are there any incentives for CHC Facilitators?	
14. What is the proportion of men to women in CHC sessions?	

15. In your own opinion do you think the CHC approach has been successful or failed in your community?	
16. What percentage of participants in your CHC managed to graduate (question only relevant to the CHC facilitators)	
17. What do you think is the main attribute to the success or failure to the CHC approach?	
18. What changes have you observed in the community due to participation in CHCs?	
19. What recommendations would you suggest in improving the CHC Approach?	

Annex 2: FGD guide with CHC members

QUESTIONS	RESPONSES

1. Why did you decide to participate?
2. How did the CHC come to be established in your village?
      i. How was the idea broached with local leadership? With the community?
      ii. Did the leadership / community make suggestions?
      iii. If so, how were the suggestions received
3. What kind of activities does the CHC do?
      i. Who participates?
      ii. Who manages on a day to day basis?
4. What have you learned from the CHCs
      i. health lessons, organisational	

skills, leadership

5. Has participating in the CHC changed the ways you take care of yourself, your children? How?

6. Do you think the CHC has benefited your family? The village? How?

      i.   health, access to health services, gender relations, organisational skills, leadership

7. What happens when someone completes CHC training?

      i.   Tell me about some of the graduates and what they are doing

      ii.   Are there any examples of graduates organizing other activities?

8. Are you happy with the CHC activities?

9. Do you have any health concerns or notice any health problems in your family or the community that the CHC has not addressed

10. Have you ever made a suggestion to improve the CHC? What about other CHC members?

11. Tell me about the facilitator /leader of the CHC

      i.   What is your relationship like?

      ii.   Tell me more about them

12. Do you think you can continue with the CHCs with less help from ACF staff?

13. Does the CHC ever work with the Ministry of Health and Child Welfare (clinic, hospitals?

    a. If so, what types of things have they done recently?

    b. Does the CHC ever work with a CHC in another village?

    j. What kinds of activities do you do together?

16. What types of people are leaders in the community?

    a. Men/Women

    b. Elders/Youth

    c. Specific ethnicities, etc

17. Have the types of people that take on leadership roles changed recently? If so, do you think this is because of CHCs?

    a. Are more women participating in the decisions of the village since the CHCs were established?

    b. Are more youth participating in the decisions of the village since the CHCs were established?

18. Do you participate in more in community activities since the CHC began? If so, do you think this is because of your CHC participation?

19. Since participating in the CHC, do you feel more confident to (play an active role) be active in

community decision-making?	
20. Is there anything else you would like to share about the CHC or health in your community?	

Annex 3: FGD Guide with non CHC communities

QUESTIONS	RESPONSES
1. Have you noticed any changes in the community since the CHCs began working?	
2. Have you noticed any changes at the peripheral health unit?	
3. Do you think the CHC has benefited the community?	
4. Have you ever gotten together with other community members to give a solution to a local problem? If not, do you feel able to do something like that?	
5. Do you think CHCs are taking care of community health needs? -What kinds of activities do they do?	
6. Have you noticed any changes in health in the community recently? -What about gender roles? -Other areas?	
7. Tell me a little bit about your family's health -How did you learn about caring for	

yourself/children? -Do you feel like you know a lot about keeping your family healthy? -In your family, who makes health decisions? 6. Do you know about the CHC in Ward…? Tell me a little about what you know about it. -Do you know anyone who participates in the CHC? Have they ever told you anything about it? If so, what? 7. Would you be interested in joining a CHC if one was formed in this community? Why or why not? 8. Is there anything else you would like to share about your community or family's health?	

Annex 4: CHC Effectiveness Assessment Tool

District: …………………………… **Ward:** ……………………………

VIDCO: …………………………… **Village:** …………………………..

HH Name………………………………………………………………….

Time Spent in the Club…………………………………………………..

 Assessment Date: ……………………**Club Name**: ………………………

Purpose: To assess practices emanating from knowledge gained through participation in hygiene promotional activities (CHC) as to come up with a model homestead.

Score key: 5 - Excellent   **4 -** Very good   **3-**Good   **2-** Fair   **1-** Poor

No.	Question	5	4	3	2	1
1	**HOUSEHOLD SANITATION**					
a.	Is litter scattered around the yard					
b.	Is refuse pit available and being used					
c.	High housefly population at the refuse pit					
d.	Pot rack available					
e.	Pot rack area messed up with waste water and matter scattered underneath					
f.	House fly population at the pot rack area high					
2	**KITCHEN HYGIENE**					
a.	Kitchen floor swept					

b.	Kitchen shelves available						
c.	Kitchen utensils well arranged						
d.	Container for drinking water has a wide opening						
e.	Container for drinking water covered						
f.	Container for drinking water has a tap						
g.	Is a clean ladle or scooping cup available						
h.	Cup rack provided						
i.	High housefly population in the kitchen						
j.	Is foodstuffs in the house covered						
3	**SANITARY FACILITY (LATRINE)**						
a.	Is there a latrine at the homestead						
b.	Is latrine10m from the household						
c.	Roof provided and still intact						
d.	Dark interior of the superstructure						
e.	Is the Squat hole clean (no fecal matter visible on the floor sides)						
f.	Pooling of urine on the floor						
g.	Presence of flies in the latrine						
h.	Strong odour in superstructure (latrine smelling)						
i.	Vent pipe is provided and still intact						
j.	Is there a fly screen on the vent pipe						
4	**HAND WASHING FACILITY**						
a.	Is hand washing facility provided at the household						
b.	Is the hand washing facility a Tippy Tap						
c.	Presence of water in the hand washing facility						
d.	Is there evidence of usage of the hand washing						

	facility spill of used water underneath the hand washing facility					
e.	Is there any hand washing detergent provided within 2m radius					
f.	Is there any growing vegetation underneath drainage area					