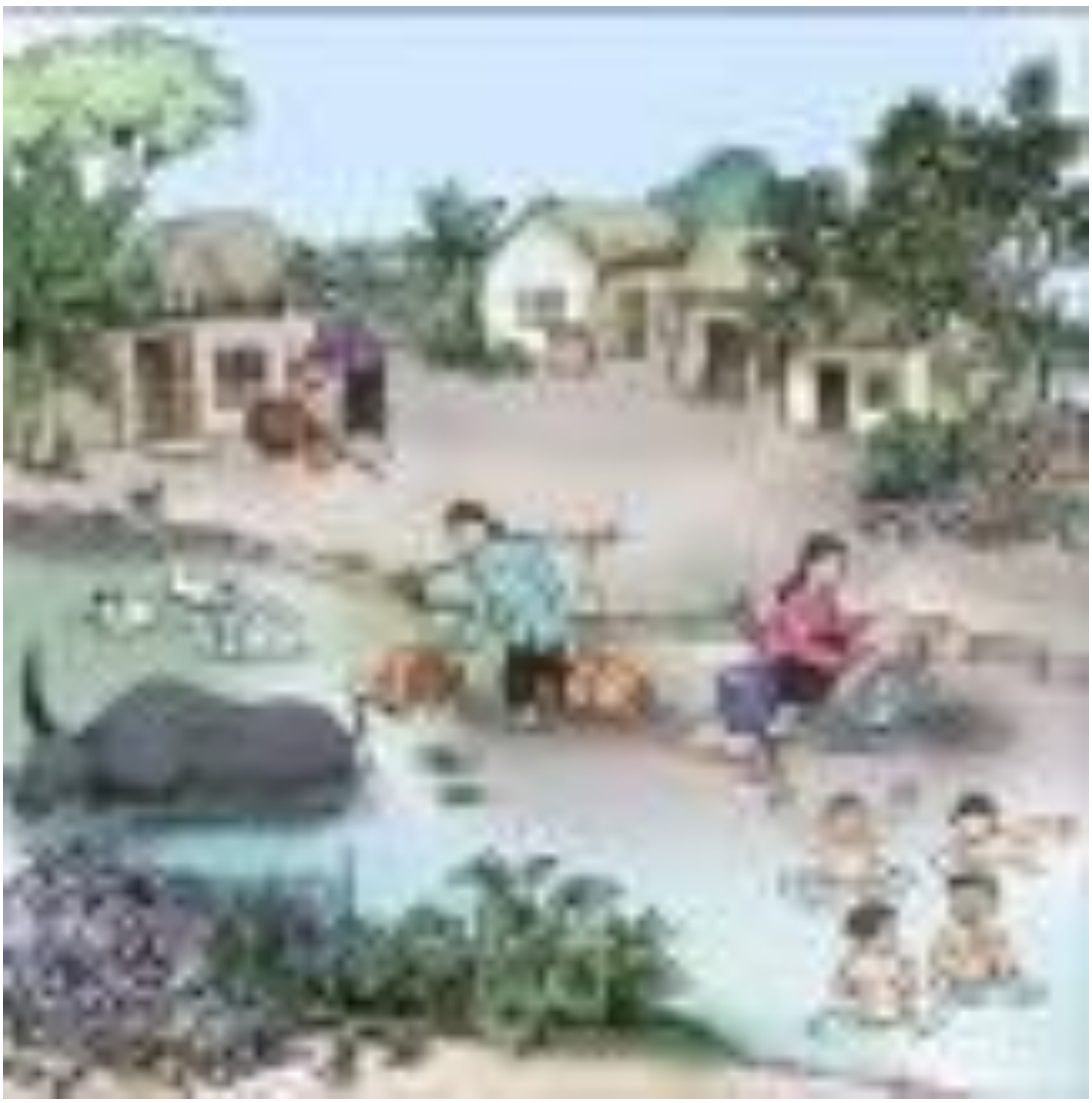
INTRODUCTION TO COMMUNITY HEALTH CLUB APPROACH

WORKBOOK FOR PARTICIPANTS. Module 1.



Submitted to Ministry of Health, Viet Nam

by Dr. J. Waterkeyn (AHEAD)

November, 2009.

CONTENTS

1. INTRODUCTION TO THE CHC APPROACH:

At the turn of the century international focus highlighted the fact that little had been achieved in the past forty years of development and that 2.4 billion people (40% of the people in the world) were still without adequate sanitation. The Millennium Development Goals (MDGs) were set by the United Nations to halve this number by 2015. But how can we suddenly make 1.2 billion people change their ways unless we have new strategies that are more successful than those used in the past to mobilize people's energy?

Responding to the MDG targets since the year 2000, three main 'schools of thought' in the development sector have sought to answer this challenge and provide a way of making people change their behavior.

- Social Marketing : Borghi et al (2002)
- Community Led Total Sanitation: Kar.K. (2003)
- Community Health Club Approach: Waterkeyn, J. and Cairncross, S. (2005)

This manual outlines the Community Health Club (CHC) Approach to provide CHC Trainers with full understanding of the rationale behind this methodology and to enable them to train Village Health Workers to starts up CHC throughout Vietnam.

Community Health Clubs were first started in Africa in 1995 and for the past fifteen years have been tried in many countries and there has never been a disappointing result. Communities, whether they are rural or urban, settled or refugees, Moslem or Christian, Hindu or Buddhist, have responded to the appeal of working in clubs to improve family health. Research has shown that as much as 47% behavior change can be achieved with 19 types of behaviors, when comparing health club to non-health club households (Zimbabwe, 2002) and even if development levels are high it is possible to achieve over 80% compliance with many different recommended practices (South Africa, 2009). This is significantly higher than what has been achieved in most other health promotion methodologies. What are the basic elements of the CHC Approach that account for its success in changing behavior?

The key aspects of the CHC Approach can be summarized as follows:

1. **TARGET GROUP**: A club is a registered group of members that make progress together.
2. **INCLUSIVE:** CHC Members are both men and women of all ages, stages, education and religion.
3. **STRUCTURED:** Members receive a membership card outlining the training.
4. **REINFORCEMENT**: The members meet every week for at least six months to discuss health issues.
5. **PARTICIPATORY:** Members use PHAST activities to promote open discussion and debate.
6. **GROUP CONSENSUS:** Every week members make a group decision on hygiene standards to adopt.
7. **HOMEWORK:** Every member is challenged to adopt a set of recommended practices.
8. **CERTIFICATION:** Members who complete the whole training of 24 topics are awarded a certificate.
9. **QUANTIFYING BEHAVIOUR CHANGE:** Community is monitored with a household inventory.
10. **FAIR**: Only those with a certificate qualify to go to the next stage of the programme.

2. BACKGROUND TO HEALTH PROMOTION STRATEGIES

To understand why we are advocating Community Health Clubs as an effective health promotion strategy for improving home hygiene through behavior change, we should learn from the past and examine different strategies that have been tried to encourage people to improve their lives. Below we summarize 5 different strategies in public health promotion and show how each has contributed to the Community Health Club Approach.

1. SOCIAL PLANNING: Government control

Social Planning means that those officially responsible for public health, identify the problems and provide the solutions and then enforce them by law. In Vietnam the government has an effective system of controlling all public issues through a well organized network that has enabled the Ministry of Health to reach every village in the country by working through lines of communication that spread from the Central to Provincial to District to Commune and finally to each village. There are good policies at central level and by-laws in the districts that lay out standards of hygiene, particularly in public places such as schools, food outlets, and hospitals. People are expected to respect the laws or they will be fined. Although people usually have to comply to government standards, they often do so only superficially, and often their hearts and minds are not behind their actions. For example, if households by law need to have a latrine, they may build one to avoid getting a fine but they would use it for other purposes and continue to defecate in the open because they did not appreciate the risk. It has been realized that forcing people to behave by discipline does not really change people, as they are like children obeying the parents, but the moment they are unsupervised they will drop back to their old ways.

- **Social Planning in the Community Health Club Approach**

  In Vietnam, it is very advantageous in that there are Village Health Workers (VHW) in most villages who will be trained to carry out the health promotion sessions. Because of the VHWs, it will be relatively simple to scale up the programme so that eventually CHCs are run by every one of the 25,000 VHWs in Vietnam. Because the VHWs already have the mandate to enforce standards that are monitored through government systems, this will ensure long term sustainability of the CHC as they will be integrated into the regular MoH system.

2. HEALTH BELIEF MODEL – Understanding why

It has been realised that for people to comply to a law, they should understand the reason behind the laws. It was reasonable to assume that if information was given to people, they would understand and change. However, we have seen how difficult it is to give up smoking, alcohol and drugs, or even to start using a motorcycle helmet correctly, even through we know our bad habits may lead to pre-mature death. Therefore despite much health education in clinics, schools and water and sanitation programmes, many people still continue to have risky habits and have not taken control of their own health in a mature way.

- **Health Belief Model in the Community Health Club Approach :**

  A central belief behind the CHC approach is that people ***do*** want to know why they get ill and that there is a huge ***intellectual starvation*** in low income families who have not have the benefit of much education. The learning that is made available through the CHCs is one of the main attractions to join the club for many mothers who want to learn how to look after their families better. However while the CHC approach endorses the Health Belief model, it is also emphasises that knowledge ***on it's own*** is not enough.

Sometimes being progressive means being different from the group. Whilst this is considered appropriate in upwardly mobile urban societies, being different is is often uncomfortable for more 'traditional' societies. If a person does not have confidence in his/her own judgment, which is often true of people without much education, it is also more comfortable to change with the group rather than trying to take an individual decision. There is also a human tendency to pull people down if they try and be different and this type of jealously often stops people from improving. Although they might want to change, there is peer pressure to conform to traditional ways of behavior for cultural reasons. In addition, people are often idle and cannot be bothered to change unless they are forced to by pressure from their immediate community.

3. THE PARTICIPATORY APPROACH – getting people involved

To make people change we need more than a strict authority, we need more than knowledge, people need to participate fully, to get involved right from the beginning, so that they 'own' the ***process*** not only the ***outcome*** of their actions. So the idea of participatory activities became popular: 'community based management' (CBM) gave people the chance to voice their own ideas and make their own decisions. Typical of this were village gatherings where drama and role play, and visual aids were used to stimulate debate and interest. PHAST (Participatory Hygiene and Sanitation Transformation) became the fashion of the 90's. In Vietnam, PHAST was introduced into many districts and many Toolkits were developed, so that there is now a wealth of training material (See References). However, despite so much effort many people still stubbornly refuse to improve their home hygiene and sanitation. Although PHAST was an enlightened idea, it also failed to improve living standards to any degree.

The Participatory Approach (PHAST) in the Community Health Club Approach:

- Like PHAST, our training method uses participatory training methods because it gives everyone a chance to express themselves through fun activities.
- Like PHAST, CHC is based on the belief that people will only change from their hearts if they have had the chance to participate voluntarily rather than being instructed what to do.
- Unlike PHAST, the CHC approaches has let go of the use of paper and pen, and the use of a flip chart, and instead only uses picture cards in a number of different games.
- PHAST programmes in the past have been fun but they have a poor record of achieving change. They give people the chance to interact but do not complete the process by ensuring that ideas are translated into action. By contrast CHCs make sure people so their homework and change their practices.
- PHAST tended to take place at gatherings, in which there would be different people each time: a health club has a membership of people who meet regularly so they can make progress each week.
- Whereas PHAST is open-ended and leaves people to make their own decisions as individuals, the CHCs have set recommended practices, so that CHC ***targets*** that can be reliably ***measured*** by ***community monitoring***.
- PHAST focuses on diarrhea transmitted through poor water and sanitation, whereas the CHC approach is more a holistic training covers all disease that can be prevented (ARIs, Malaria, skin and eye disease etc.).

- CHCs have a more structured programme than PHAST as each topic is outlined in a ***membership card***. This ***small*** difference in project design is the main reason for the ***large*** difference in rates of behaviour change.

4. SOCIAL MARKETING: appealing to people's desire to be smart

We have seen that commercial advertising has been extremely successful in changing people's desires by constant repetition of simple messages on posters, radio and television. The same approach has been used by planners to try to change people behaviors. Social marketing focuses on getting people to change their behaviors by appealing to their desire to be smart and modern. The approach sees it as less important to help people to understand why they have to change. Instead of. 'Health Education', social marketing does 'Health Promotion', and it does so by seeking to reach peole with simple health messages through many communication channels, such as radio, TV, community meetings, peers, and the internet. This methodology usually focuses on a few key behaviors to change - for example promoting the use of soap when handwashing as socially smart. ,

- **Social Marketing in Community Health Clubs**

  The idea of using the media to repeat messages is useful, but it is clear from research that broadcast messages must be reinforced through face-to-face communication to have an impact on behavior. Very few people change their behaviors just as a result of seeing or hearing a TV or radio spot. For this reason, when radio programmes, TV soap operas and health songs are reinforcing a CHC programme there is likely to be an even greater uptake of the recommended activities. At village level social marketing can be used as part of CHC, for example through messages on the community loudspeaker or local radio, dramas and health songs being performed by the CHC for schools and at public gatherings.

5. COMMUNITY LED TOTAL SANITATION (CLTS) : Using embarrassment to change behavior

Many programmes in Asia have been extremely successful in getting people to build latrines through the process known as Community Led Total Sanitation (CLTS). This 'behaviour change' is triggered through a village walk with the people of a village that demonstrates how by their practice of open defecation they are in fact consuming feces. This shocking revelation often galvanizes the villagers to elevate their community to avoid public embarrassment. This has resulted in thousands of villages reforming their sanitation practices and becoming ODF (Open Defecation Free) areas. CLTS does appear to achieve high levels of improved sanitation, but the strategy has also been criticized because it tends to focus only on sanitation and does not tackle some of the real causes of poor hygiene, such as ignorance and poverty, which often are the underlying reasons for poor home hygiene.

Community Led Total Sanitation in Community Health Clubs

- CLTS encourage each member to have an ODF (Open Defecation Free) environment. Health clubs similarly aim for ZOD (Zero Open Defecation).
- CLTS uses local leadership to take charge; the CHC approach encourages local leadership to endorse hygiene behavior change, through enabling a strong CHCs to flourish, rather than take over themselves.

- CLTS use group conformity to put pressure on people sharing a village so that a critical mass of people change, which makes the slow adapters follow out of need to conform.
- CHCs ***encourage*** members to change through **positive peer pressure** out of the belief that this contributes to their dignity and sense of worth**.**
- CLTS puts up a placard to distinguish compliant villages; CHCs reward those who meet the standard with a certificate after six months of regular attendance.
- CLTS tends to focus only on sanitation to reduce diarrhea: CHCs require over 50 practices to be changed in the home.
- CLTS in its classic form seeks to only ensure that a latrine is built: CHCs address all preventable diseases.

ACTIVITY. 1 : UNDERSTANDING DIFFERENT DEVELOPMENT STRATEGIES

METHOD: GROUP DISCUSSION

Once you have listened to the presentation which outlines the rationale for the CHC approach, divide into groups.

Discuss what experience you have had in the past of different ways to make people change.

Have you used any of the methodologies mentioned in the section above?

In what way and to what extent have you used these methodologies?

Social Planning	Yes / No	How?	……
Health Belief Model	Yes / No	How?	……
PHAST / Participatory	Yes / No	How?	……
Social Marketing	Yes / No	How?	……
Sanitation Marketing	Yes / No	How?	……
CLTS	Yes / No	How?	……
CHC Approach	Yes / No	How?	……

- Have you had success with above methods and if so, why did it work?

  ……

  ……..

  ……..

- If there were problems what do you think were some of the reasons?

  1. ……

  2. ……

  3. ……

- Do you think that the Community Health Club Approach may be appropriate in your area? If so, why?

  ……

  ……..

  ……

3. GUIDELINES FOR STARTING UP A COMMUNITY HEALTH CLUB

What happens in a Community Health Club?

CHC ACTIVITIES MAY INCLUDE:

- Weekly meetings to learn about hygiene in 24 topics
- Singing, quiz, debates and drama competitions
- Visits to members homes to advise/assist
- Assistance to local schools, health posts
- Voluntary counseling, support networks
- Training in domestic skills and crafts
- Training in literacy and management
- Home based care for the vulnerable
- Revolving funds and savings groups
- Income generating groups and trading
- Nutrition and cooking classes
- Sewing, knitting, other home industries
- Village clean ups and recycling
- Sanitation improvements, latrine construction
- Water supply projects
- Catering for funerals and weddings

Creating an identity: a Constitution

- The club identifies itself publicly by a specific name representing its objective.
- Often members identify themselves by uniforms.
- A banner is made showing a map of the catchment area of the club.
- Each Health Club has its own health songs and slogans which unite members
- Every member has a membership card.

Creating an institution: an executive committee

Sometimes groups fail because they disagree on who can join, or who should benefit and in what way. A standard way to prevent conflict is to create a set of guidelines that can be used to resolve conflict in an objective way. A constitution which outlines the main rules of a Club is important for long term sustainability.

DEMOCRATIC REPRESENTATION

Once the member know each other, a committee should be elected from the club members as their representatives. This should consist of a Chairperson and Vice Chairperson, a Secretary and Vice Secretary and a Treasurer and Vice Treasurer. To prevent people abusing the power that always can be misused within a group, all members in the health club should vote annually for a new committee. This ensures that if the leadership is ineffectual or corrupt it can be changed before it does too much damage to the group.

ACTIVITY 2: UNDERSTAND THE VOCABULARY OF THE CHC APPROACH

METHOD: GROUP DISCUSSION

How is a Community Health Club different from the Woman's Union?

……

……

Make up a definition of a **Community Health Club**?

……

……

What is a Culture? .....

Think of some things which define the Vietnamese culture?

Vietnamese Food .....

Type of family .....

Vietnamese Proverb .....

These habits, preferences, and ideas are what make a Culture

CULTURE means shared **KNOWLEDGE, ATTITUDES AND BELIEF.**

Shared **Knowledge** creates a common understanding
Common Understanding makes similar **attitudes**
Similar attitudes ensures there is a **Group Consensus**
Group consensus means a shared set of **beliefs**
This ensures accepted ways of **hygiene behaviour**

What do we mean by a **CULTURE OF HEALTH**?

- If every one shares the same **norms** and **values**
- Health Club Members develop their own **Culture of Health**
- All they do is based on **principles of good hygiene** and care of their own health.
- Members will be recognised by others as a **Health Conscious** person.
- They are enlightened and their family will prosper because they are healthy.
- A family with a **Culture of Health** will be a **Cultural Family**

See Annex 1 : for standard definitions of the CHC Methodology

4. FREQUENTLY ASKED QUESTIONS

WHY DO WE NEED COMMUNITY HEALTH CLUBS?

- The problem is that most communities are not very organised.
- Public Health is an issue that must involve everyone in the neighbourhood.
- A woman on her own is powerless, but women together are a real force for change.
- A club is the forum for decision making.
- Clean ups are possible if most homes in each area are within the club.
- Members support each other to make positive improvements for the good of all.
- This is a way to spread the benefits as widely as possible whilst maintaining standards.
- It helps organise people effectively and makes a functional community.

WHY WOULD PEOPLE WANT TO JOIN A COMMUNITY HEALTH CLUB?

- Members join a club because they want to be with like-minded progressive people.
- All members share a common interest to learn and improve family health.
- Members enjoy being together because they share a common vision.
- The club provides a safety net and reliable friends in time of need.
- The meeting each week is a time of fun and socialising as well as learning.

WHAT ABOUT NON CLUB MEMBERS?

- There are no qualifications to becoming a member so there is no reason they cannot join
- Anyone can join at any time, so it does not prevent people joining late
- The health club is free of charge, so it does not exclude the poor
- It is open to men and women of all ages, as everyone is part of the community
- People of all levels of education can join as none of the activities involve reading and writing
- People of all religions can join, because religious issues are not discussed
- If people do not join it is because they do not want to join and that is their choice
- There are always non adaptors but they may get ideas from their neighbours

HOW DO YOU GET SO MANY PEOPLE TO JOIN THESE CLUBS?

The membership card a gives a guarantee that the programme is serious and people have more trust in the implementing agency will fulfill its their promises. In addition the reward of a certificate encourages people to keep on coming to the sessions, because they have to complete all of them to get a certificate. It is also clear that people are often eager to learn and they have a sense of self achievement when they learn. People get more self confidence as they become more knowledgeable. Also they see how interesting the sessions are using pictures and they continue come to the health sessions, because it is fun and sociable.

ACTIVITY 3: BECOME A COMMUNITY HEALTH CLUB

Experience being a Community Health Club member! Pretend that you are a member of your community.
Right at the beginning of the workshop, divide all the participants up into Community Health Clubs.
It is best to divide them by Province/District, so that they get to know each other well during the training and this will build a strong team for the future.

Each group should become a health club for the duration of the workshop, working in the same groups for all activities**.**

METHOD

- **NAME:** Select a name for the Community Health Club
- **SLOGAN:** Come up with a powerful slogan that can be used to rally the members
- **SONG:** Make up a good health song for the club which includes health messages and actions
- **DRAMA:** Make up a health drama (15-20 minutes) which will show some of the key health issues

OBJECTIVE:

1. Pretending to be a CHC will enable the trainers to form closer bonds with other participants
2. It should also be more fun and create a sense of competition between the two groups.
3. It enables participants to have a ready made song and drama to take back to the community in case they are not able to compose their own.
4. It enables participants to have practice in performing because a good facilitator has to be extrovert and lead the others
5. Being a CHC will demonstrate
    - the value of the group dynamics when people are set a practical activity.
    - the power of POSITIVE PEER PRESURE
    - the sense of COMMON UNITY and CONSENSUS

5. OBJECTIVES AND TARGETS OF A COMMUNITY HEALTH CLUB PROGRAMME

1. To build capacity of local community to sustain their own health clubs.

2. To empower families to effectively prevent disease through good hygiene.

3. To increase social capital by enabling a strong social network through CHCs

4. To enable existing Government Village Health Workers to manage their workload better through CHCs.

5. To measure behavior change so that the Government has information on results of the programme.

6. KEY FACTORS FOR A SUCCESSFUL CHC PROGRAMME

Before starting a CHC Programme, it is important that the following four issues are discussed by the management team to ensure that the best design is put in place and that it is properly supported with a suitable budget. Although the CHC methodology can be cost-effective in terms of value for money, this does not mean it is a cheap programme. It is inexpensive compared to the funds needed for the hardware aspect of water and sanitation programmes but that does not mean there are no costs. Broadly, the following main aspects have to be considered and cost will vary according to the degree of support available. In order to optimize the results, there must be adequate support to ensure that the CHC facilitators can do their job properly.

A well supported programme must ensure an adequate budget for the following main expenses:

- **Trainers**
- **Training Material**
- **Training**
- **Transport**

1. TRAINERS: ***Who are the best people to facilitate this programme?***

- **Government field workers:** For long term sustainability, the most effective option is, of course, an existing cadre of government health workers who have already been trained in public health, and who are currently in the field, such as Village Health Workers. However, some may not be available or may have too many duties to be able to be available as a facilitator for a number of CHCs.

- **Mass organization representatives:** Another effective option is to train representatives of the mass organizations at village level, such as the Women's Union or the Farmers Union. These cadres have often already received training in IEC approaches and community facilitation. For example, with some extra training in public health village level Women's Union representatives could take on the role of CHC facilitator.

- **Community Facilitators:** If neither of the options above are feasible, community members should be trained. Although this is a cost-effective and fairly sustainable strategy, with lack of background in health and faciliation community members may be less competent facilitators. In addition there are often real problems of credibility from their neighbours who may not have faith in one of their own. Therefore they need more training and more supervision than more qualified trainers, and this is often an additional expense.

2. TOOLKIT: ***Can you use the Toolkit provided in this training?***

The illustrations used in the visual aids (the Toolkit) that accompanies this training have been developed for low income families living in Northern Vietnam. Your area may have a different material culture to the people depicted in this toolkit.

Many PHAST toolkits have already been developed in Vietnam and therefore there is no shortage of visual aids. It does however taken time to modify these Toolkits, and this should be done before the training starts, and time is also needed to check that the pictures are suitable by pretesting them with some of the target population. The kits should be printed or photocopied and laminated so that the facilitators are well equipped to carry out the training. With the wrong tools a workman cannot do his job effectively. A good container to store the toolkit is also needed so that the kits are kept carefully and protected from damp or rain, and will last longer.

3. TRAINING: ***How will you organize the training of the CHC Facilitators?***

There are 24 sessions in the CHC training and each session usually takes between one to two hours in the community. For the CHC Facilitators to learn how to conduct these sessions they must have a chance to do the sessions themselves (as if they were community members). Therefore the training of the sessions alone takes a minimum of 48 hours. A six day workshop of 8 hour per day is a very demanding workload for semi-educated trainers. Unless they are already qualified in Environmental Health and are used to the subject matter and conversant with the participatory approach, a six day workshop will be an overload of information. Village Health Workers as CHC facilitators will need to have more time and practice so that they have confidence in the new activities. Therefore it is recommended that the training be broken down into three training workshops (3 days every two months) which will enable them to learn the sessions only for the next two months. They then return to their areas and use the information before it is forgotten. The other advantage of breaking up the training is that the workshop will also provide a forum for an exchange of experiences and will enable them to learn from each other. Once they have the training they become able to start up other clubs and their costs are negligible after the initial outlay.

4. TRANSPORT: ***What transport can be provided in your programme?***

Whether it is by bicycle, motor bike, bus or car, a field worker has to be mobile in order to carry out this demanding programme. If a facilitator has several CHCs under their care, they may have to visit different communities every day. The more mobile a trainer, the more can be expected of him/her. It is in the interest of the programme to ensure that transport is never allowed to become an excuse for non-performance. If there is no budget for transport the facilitator can only be expected to work within walking distance, within his/her own village. This is less cost effective, as each facilitator will then only be able to do one CHC. Trainers are costly to train, and therefore once trained, they should be used to their full potential. With transport a facilitator can be asked to visit one or two health clubs every day, thus they can run between 5 and 10 CHCs simultaneously. This enables a rapid scaling up, and makes the facilitator more cost effective, given that their expenses are divided by the number of people benefitting from their training.

ACTIVITY 4 : PLANNING TO START A CHC PROGRAMME

OBJECTIVES :

- Be clear about why you are starting Community Health Clubs
- To analyze which are the best areas for a CHC
- To gain experience in mapping so as to teach the VHW

Divide into groups made up of everyone from your operational area and discuss the following:

WHAT ARE THE MAIN OBJECTIVES OF THE CHC PROGRAMME?

1. ……

2. ……..

3. ……..

WHICH AREA WILL BE THE BEST FOR A COMMUNITY HEALTH CLUB?

It is obviously best to target the least developed areas of the Commune, where there is poor sanitation coverage and where hygiene standards are lowest, and levels of diarrhea are particularly bad. If you cannot decide, make a list of the villages and then award the a number (from 0 to 10, with 10 being the most developed) for development of water, sanitation, health, wealth, etc as shown in the example below:

Village	Sanitation level	Water Supply	Health status	Wealth	Schools
A	8	7	9	8	6
B	5	7	5	8	4
C	2	4	3	4	3

Clearly Village C, has the lest amenities and would benefit most from the CHC programme.

MAPPING

It is important for the participants to work together and think about all the resources in their area.

As drawing a map usually takes a long time this activity is best done in the afternoon rather than in the morning, to be completed by the next day. It does not have to be geographically exact, but it must provide information to enable planning to be discussed.

Each CHC should have a map which shows all their homes and those who have latrines, roads, schools, clinics, pagoda, and any other important facilities such as boreholes, dam, river, etc.

Although this is usually drawn on a flip chart in the Training, when it is done in the community it should be transferred to a large piece (1 metre) cotton cloth. If it is embroidered onto the cloth this is more durable and it will become a good planning tool for the health club and assists in the planning of future programmes.

It is also becomes a banner when the Graduation Ceremony takes place, enabling visitors to understand the area. Prizes should be awarded to the CHC with the best banner/map.

The banner becomes a flag for the village, a symbol of their health club and planning tool for future programs.

7. MONITORING: THE MEMBERSHIP CARD

The membership cards must be printed in readiness for this training. Look at the Membership Card and see what the topics are for the training. You will see there are 24 separate topics and 24 recommended practices. Each time a members attends a session the membership card is signed by the facilitator of that session. Every month the VHW or CHC Chairperson/Secretary must visit all CHC members and check which of the recommended practices are being adopted in each household. When those practices are observed the membership card can be signed against the practice observed. When the membership card is completely signed, the member qualifies to receive a certificate.

Why do you need a membership card?

The membership card provides a structure to a programme so that all stakeholders are clear about what is expected. It is the key to the whole programme as it not only outlines the topics, but also establishes the key recommended practices which are the indicators used for monitoring in the household inventory. If the Membership Card is not appropriate for the area it can be adapted as required by the programme. The content may be varied according to area, depending on the health issues that relate to each context. For example, the topic of 'malaria' may not be as important in some areas as in others. Topics can be done in any order also depending on the seasonal priorities. e.g. if there is an outbreak of Avian flu the topic should be done immediately, rather than wait until the end of the programme when it may be too late to prevent an epidemic. The membership card is the hallmark of a CHC programme and its importance can be summarized as follows:

1. **Sense of Identity**: It provides a sense of identity and belonging and makes people feel they are important.

2. **Mobilises:** The cards should be given out at the first meeting or when the household is visited because it encourages other to join when they see the cards that their friends have been given.

3. **A contract:** When people see the printed card they realize that this is a serious programme and are convinced that the programme is going to be done properly and it is not all promises and no action.

4. **A Structure:** The membership card gives the members a list of topics so that they know what they are going to be doing and this is a common politeness in most meetings - we tend to want to know our agenda before starting a meeting.

5. **Targets:** There is also a list of the recommended practices that should be undertaken by all serious members, and so this sets targets and gives a set of behaviours which is standardized.

6. **Monitoring:** Because the card is signed every time a member attends a session, it enables the attendance of the community to be properly monitored, both by the facilitator and the managers.

7. **Accountability:** The cards makes the CHC facilitator accountable as there is no chance that they claim they have been training when in fact they have been skipping sessions.

8. **Achievement:** Once the membership card has been completed the member is entitled to a certificate of full attendance. The number of members who have earned this can be verified so that there is no unfair advantages though favoritism or corruption.

9. **Fairness:** Those who have completed the training of the first module are entitled to continue to the next grade. If there are any material benefits to be gained, the first to be rewarded will be those who have completed the training. This is a just system which prevents those who have not given their time to gain unfairly when they do not deserve to benefit.

8. SETTING REALISTIC TARGETS

WHAT ARE YOUR MAIN TARGETS?

It is important to know when you start the programme exactly what you are trying to achieve in terms of targets.

1. How many Health Clubs do you expect to be able to achieve in one year?
The number of CHCs that you can do in an area depends entirely on the amount of time the Village Health Worker can give to the programme. At a minimum she should be able to run one health club, meeting once a week for two hours. However if she can meet on health club every day and can manage 5 per week, then the program becomes much more cost-effective. As the training takes six months, she may be able to do 10 CHCs in one year. This is the extreme and few manage to coordinate this many CHCs at once.

2. How many members do you expect per health club?
In most countries CHC members number between 50 and 100 members. The amount depends on the density of the population, the season when the training takes place, and the charisma and competence of the facilitator. Even if the clubs are small (less than 30 members) it is worth persevering as they often expand later once people have seen what they are about. When a club becomes bigger than 100 it may be worth splitting it into 2 clubs to enable easier communication at the sessions.

3. What percentage of households in the area should be represented in the health club?
You should aim for all households to have a representative in the CHC. However, this is seldom possible practically so aim for at least 50% the first year and 80% in the second year.

4. How many months will the health promotion training continue?
The training is designed to last for 24 sessions of about two hours each, to be held every week for six months. However it usually takes about a month to mobilize the community to join, as well as to conduct a base line survey (household inventory). In addition sometimes sessions are delayed because of rain, holidays, funerals and other reasonable priorities, so usually it takes 8 months to complete the 24 sessions. Sometimes the community asks for repeats to enable them all to catch up on missed sessions so they can get their certificate. So to be able to be unstressed it is usually wise to plan one intake of members each year rather than try and squeeze in two intakes in a year.

5. How many of the sessions do you expect each member to complete?
Of course we would want every member to complete all 24 sessions, but this is setting a very exacting standard which will not be realistic. Past experience has shown that 50-60% of all members are able to complete all the sessions.

6. What do you expect in terms of the average attendance at each meeting?
Attendance means the number of people at each session compared to the total membership. Adding the attendance of each session and taking an average of all sessions, is a simple way to monitor the relative success of each VHW, and will also enable managers to see which facilitators are the most cost effective, by dividing their costs by the average attendance. Past experience has shown average attendance is between 30 - 50% of the membership. In CHCs where attendance is compulsory, average attendance can be 80-100%.

7. What do you expect in terms of % members following all recommended practices?
This depends on the level of hygiene at the start of the project. If the levels are low (-20%) of the indicators chosen, then % change can be high after six months (20-50%). Alternatively if the levels are quite high already (+50%) then aim for high % ***levels of compliance*** (over 80%) rather than ***levels of behavior change.*** CHC projects in the past have achieved up to 47% change in 19 different proxy indicators (Waterkeyn & Cairncross, 2005). Most studies show between 5% to 20% for a few indicators. The objective is to have a high % compliance with many indicators, as this will provide strong evidence of change. At least 30% of the households should be surveyed.

ACTIVITY 5: TARGETS AND CHALLENGES

DISCUSSION:

SETTING TARGETS: Based on the information above, discuss the targets that are appropriate for your area.

POSSIBLE CHALLENGES

Think of some of the issues that may be a problem and how this could be worked into the planning

What will you do if there is a demand for latrines to be built?

What will you do if there is a demand for safe water infrastructure to be built?

Remember:

The training in CHC usually results in a strong demand for sanitation, so management must have something to offer in terms of assistance for sanitation.

- Train a latrine builder in each CHC so there is local skill available for hire by CHC members themselves
- Link the CHC up with the local Women's Union which could assist in starting a revolving fund for latrine construction
- Link the CHC up with the local promoters for the Vietnam Bank of Social Policy water and sanitation loans
- Provide latrine subsidies only to the poorest of the poor

Do not create the expectation that all household latrines will be subsidized. If not expectations can be raised and then unmet, which will make the population cynical and unlikely to join future initiatives.

TIMING OF THE PROJECT

- **Are you conducting training sessions during the monsoon rains or in the agricultural season?**

Discuss when is the best time to start a Community Health Club, bearing in mind that it takes six months of weekly sessions to complete the training. It is important that the timing of the programme is in tune with the demands of the season. In farming areas the rainy season is very demanding on women in particular and they may not have the time for health club activities. If health clubs meet outside, the rain may affect attendance, so for best results it is important to start the sessions at the beginning of the dry season.

If you are obliged to start health clubs at an inconvenient season, make plans as to how this can be achieved, for example, by using a school or the village cultural house for a meeting place.

STAKEHOLDERS AND PERSONNEL

- **Who needs to be involved to ensure that it is a success? (political, religious leaders, mass organizations)**
- **In each area, who in particular, should be notified or briefed?**
- **What is the criteria for selecting facilitators?**

9. SUSTAINABILITY

After six months, the first 24 sessions should be completed. So what happens to the Health club when the sessions have finished? The effects of the project on the beneficiaries can be sustained in two ways:

1. SUSTAINABLE BEHAVIOUR CHANGE:

The lessons that are learnt have been completely taken into the daily lives of the health club members so that they have changed their hygiene behaviour and continue to practice good hygiene. This is the most important objective of the whole programme. If this is achieved the programme will have met its objective to improve family health and prevent diseases like diarrhoea, cholera, malaria, skin diseases and worms. Transfer of knowledge can be done within six months and experience shows that some behaviour change does take place immediately. However but to ensure this is **sustained**, it must be **continually reinforced.** It takes at least 2 years to ensure a new behaviour becomes a habit. Once a Culture of Health has been developed people have fully taken on many beneficial hygiene practices that will improve family health in the long term. Although the CHC may cease to meet the benefit of the information will remain as long as good habits have been adopted permanently.

2. SUSTAINABLE STRUCTURE:

It is a bonus if the health club continues to meet and actively work together into the future, without any external support. Many CHCs do survive without external support for many years but they need a good leadership from the community and also something concrete to do. Good facilitators will encourage the CHC to monitor and manage all activities through a functional Executive Committee, with minimal outside interference to build the capacity of the leadership and confidence to take control and make decisions.

THE AHEAD APPROACH

Applied Health Education and Development (AHEAD) is the full Module (see: www.africaahead.com) which uses CHCs as a vehicle for a whole process of development. To use a Community Health Club to its fullest potential, the health promotion is only the first stage, an entry point into a water and sanitation project, as a strong demand for improved facilities is the natural outcome of this methodology. After this, CHCs will want to continue to improve their standard of living and the next stage may involve an agricultural project and nutrition gardens, bee-keeping, re-forestation, income generating projects such as bee keeping, paper making, and soap making, and many other skills can be developed.

A Community Health Club that is properly set up should be able to continue after the direct health promotion phase of the project has stopped. CHCs can be active without the assistance of outside support, and find activities that are initiated by their own efforts. This may include social support for vulnerable families, widows, orphans, those suffering from HIV/AIDs or other disabilities. Some CHCs have started play schools and soup kitchens and there is no limit to the usefulness of such an empowered group of people. Other organizations readily support these initiatives as it is clear that they are an organized organization, and they are able to raise loans, grants and micro credit is more available. Health Promotion is the first step on the ladder of holistic development.

WOMEN'S UNION

In Viet Nam, where the women's union has grass root activities in many villages, it would be expected that CHCs will link into this existing network and provide another forum for improving living standards.

EMERGENCY PROJECTS

CHCs can be used in emergency situations, and be formed for the express purpose of dissemination of information to avert outbreaks of cholera or avian flu. However, unless they are extended after the emergency are unlikely to remain operational after the short project is completed.

10. AN EXIT STRATEGY

There are three critical components in an exit strategy.

1. TIME:

For a CHC to survive it must have been going for 2-4 years. Experience over the years has shown that the AHEAD approach in which the Community Health Club goes through a series of phases (Health Promotion, Water & Sanitation, Skill Development and Social Support) will usually ensure the sustainability of the CHC.

2. OWNERSHIP:

If members are made aware from the start that it is their own Club and does not belong to the MoH or to the NGO that initiated it, then there is likely to be less dependency on external assistance and exit is easier. It is also wise to get the CHC registered and have a bank account so it can source its own funds without dependency, and ideally the CHC should be given start up capital for projects through a revolving fund.

3. ACTIVITIES:

In order to keep meeting, groups must have ongoing activities. If the activities fail, the group is likely to stop meeting. Therefore plans have to be made by the NGO to ensure there are activities that are sustainable: annual competitions, netball health revision sessions, literacy groups and play schools are all simple things that have been done to provide an ongoing attraction to keep the club 'alive' with minimal funds.

TRANSFER OF ALLEGIANCE

The Community Health Club may have been started up under the MoH, but in the long term it may be more practical that the CHC is affiliated with local organisations such as the Women's Union, who already have mechanism for sourcing funding and training opportunities.

11. THE PARTICIPATORY APPROACH?

GOOD FACILITATION

Teaching adults is different from teaching children and a way to respect experience of adults is to allow them to contribute instead of dominating them. At school, the teacher usually instructs the pupils who often have to listen and learn without making any comments or decisions themselves. In the participatory approach, the *trainer* become a *facilitator*, and should not spend all the time instructing, although some knowledge has to be transferred. The word 'Facilitator' means 'one who makes things easier' and this is their main role. They should provides a good forum which encourages people to think for themselves. The facilitator must talk as little as possible and encourage others to interact and come up with their own ideas. They should not hold onto the pictures, like a flip chart and do all the talking but whenever possible they should hand out the pictures and give others a chance to express themselves. They should not hold the pen and do all the writing like a teacher at a blackboard, and that is why we seldom use paper and pen in the CHCs. The facilitator of a CHC is like a wise Chairperson at a meeting, carefully listening and ensuring the line of the debate continues and everyone has a chance to contribute fairly. This means calling on those who normally remain quiet and calming those who often take over the meetings. However, they do need to guide the group towards a positive conclusion where solid action will be taken.

APPROPRIATE VISUAL AIDS

As pictures help people to imagine issues more clearly, most the activities in CHC rely on the use of visual aids. For less educated people it is much easier to select ready-made pictures to express ideas than to write down these ideas in words. Some of these games are well known PHAST activities but CHCs try to minimize the use of flip charts and pen, because this has been found to be more difficult than simply using illustrated cards. The activities listed below are tried and tested 'games', which can be used for most sessions. By asking people to hold the cards up in front of the audience they can be with large crowds. Alternatively, the CHC can be split into smaller groups to enable more interaction.

1. MAKING STORIES

There are three main ways to use a story to get participants to identify problems and solutions:

- Open ended story: Each person takes a card and explains what they see and what will happen next.
- SWAG (Story with a Gap): Take two cards to show 'Before' and 'After' and explain what happened in between the two cards, so analysing how to get from one situation to another.
- Make a full story: Select series of cards to show a problem and how it was solved.

2. THREE PILE GROUPING

A variety of picture cards are given out, depicting a range of different hygiene practices or situations typical of the local area. Each participant must hold up a picture and decide if it is 'Good' (Safe) practices, 'Bad' (Unsafe), or 'Medium' in terms of health risk. Either put the cards into 3 piles or people with their cards form three groups, and discuss reasons for the grouping.

3. RANKING

Once the three pile grouping has been done, an extension to this activity is to rank the cards from best to worst. Everyone holds up the cards for all to see and one person is asked to arrange them in an order. Often this provokes debate and another person is asked to make their changes to the order. This continues until most of the people are satisfied with the ranking.

4. SANITATION LADDER or WATER LADDER

Often this shows a range of technical options such as water sources, or types of sanitation. The pictures will depict the least safe, or feasible technical option to the most favored solution. This enables a discussion to take place focused on a consensus achieved through brainstorming as to the advantages and disadvantages of each option.

5. BLOCKING THE ROUTE

This is the most useful activity for enabling a group to see how to prevent a certain disease. The transmission 'ROUTE' of the disease is represented in stages on different cards which are given out. Each person holds up one card and the group arranges the correct sequence of 'transmission'. The other cards that show how to prevent the disease are given out. Each person comes forward and shows which stage of the transmission can be blocked by the practice shown on their card. They stand behind the transmission card that they could block. When all cards have been shown, a discussion takes place as to the most effective interventions that can be done to 'block the route' of transmission.

6. SAFE WATER CHAIN or SAFE FOOD CHAIN

This activity is useful when a range of practices are needed simultaneously in order to prevent a disease, like diarrhoea, with its multiple causes, all of which must be practices in order to prevent the disease. The chain of good practice cards are distributed one to each person, including just one 'bad practice'. The people line up and show their cards. The group has to identify which is the weakest link (negative practice), that my spoil the safe water chain. The picture is then replaced with a picture of a good practice, so all the links in the chain are strong.

ACTIVITY 6 : SELECTION OF APPROPRIATE VISUAL AIDS:

Divide into groups of four participants.

Give out one topic of the visual aids to each group

Discuss the following issues:

- **What ethnic groups live in the project area?**
  - **Do they resemble the people in these pictures?**
  - **Do their homes and environment resemble those in the pictures?**
  - **Do the situations depicted represent the problems in your area?**

Three pile sorting

Look at each card and sort them into three piles: 1. Appropriate, 2. Not appropriate, 3. Possible to alter.

Once you have selected the cards that could be used in your area, make a list of the pictures that are missing.

In the workshop, feed this back to the main group to enable changes to be made by the artist.

- **Do you need to design a new membership card because the standard one is not appropriate?**
- **Do you need to design new visual aids for the Toolkit because the picture do not reflect your area?**
- **What are you going to use if visual aids are not available or are not appropriate?**
  - Use the pictures you have and explain to members that you are in the process of adapting them
  - Get a local artist to redraw the pictures to represent the local community
  - If an artist or funding is not available, take photographs as a temporary substitute.

12. PRETESTING THE TOOLKIT

The CHCs usually take some time to start up, so the programme should begin with a month of mobilising the community. This will involve spreading the information to all relevant leaders and officials in each district to ensure that they are fully aware and endorse the programme. Once this has been cleared the Village Health Workers (VHW) will be required to move around the selected area and mobilise interest to join the health club. This can be done in conjunction with pretesting of visual aids and a household inventory. Both these activities will raise interest in the CHC and members can be signed up immediately.

1. Random Sampling for pretesting pictures:

The VHW should make a list of each household within each catchment area (Annex 3), and then select every 3rd house to survey. N.B. To sure that there is no bias in selection, it is important that she does not go the nearby, easily accessible or neighbouring houses, or those households that she knows. Every third household on the list should be visited. These should be marked and numbered on the map.

The following should take place:

1. **Introduction:**
   The VHW should explain the purpose of the visit and what a CHC is and what will take place. Ask for the household head and preferably the wife, to be present if possible. She can then explain that there are pictures that need to be pretested. Ask if the respondent has time (30-60 minutes) to conduct this survey. The VHW must stress that they do not need to worry as this is not to test the household's knowledge but to help provide insight so that the training materials can be very appropriate and that it will be very much appreciated if she/ he can assist.

2. **Pretesting Pictures**
   Each household reviews the same number of pictures (10 - 20 pictures per household). A few people in each home can have a chance to do this, one at a time, so that a variety of ages and education levels is tested. Try not to get those with the highest education, as they will find the pictures too easy. Rather target the older people and less educated so that you can be sure that everyone will understand.
   The objective is to test three main things:

   1. COMPREHENSION: Can they interpret what is drawn in the picture correctly?

   2. APPROPRIATENESS: Does the picture show what is seen in the area, geographically and culturally, and the appropriate technology?

   3. INTERPRETATION: Does the picture convey the right message; if it is trying to show a positive situation is this understood by the audience.

ACTIVITY 7: PRETESTING OF PICTURES

OBJECTIVE: To practice how to pretest pictures in the field to ensure they are appropriate for your area

METHOD: Select ten pictures from one topic

Each picture will have a form of one page, with columns for responses from 10 respondents

Show the respondent one picture and give them time to look at it carefully.

Look at the picture on the front cover of this Manual

Then ask ***'What do you see in this picture?'***

They should be able to identify the different components.

In this picture: *Boys swimming in water, woman washing pots, woman collecting water, buffalo drinking, ducks swimming, woman throwing out waste, houses and trees, and rain water catchment.*

If they miss something, point to it and ask them,

'What is this?' Note any difficulties in understanding in form provided.

Then ask: ***Is this a common situation in your area?*** Note the response

Finally ask: ***Is this a good or a bad situation?*** Note the response

Answers should be filled in the form provided (See Annex 4).

Codes for answers are as follows: 0 = No: 1 = Yes, 2 = Sometimes/perhaps, 3 = not applicable

Write any remarks below that can help the artist to make changes

All forms should be analysed and appropriate changes recommended.

13. EVALUATION : The Household Inventory

The Household Inventory is a spot observation of the facilities that indicate the hygiene behaviour of each household. It is very important that the VHW actually ***observes*** the facilities and does not rely on the householders ***report*** on such things. This is because respondents often try to save face by claiming that these facilities or behaviours are done, when in fact this is not the case. We need to get a true picture of the situation in the village; otherwise when we check after the program, it will seem that the situation has hardly improved, because the base line was artificially high (due to incorrect information). All VHWs must have a good training in how to observe the indicators for the Household Inventory, so that standards are agreed that are the same throughout the project.

SAMPLING

Use the same Sampling Frame as for the pretesting (see Section 12). If the time and resources permit the enumerators should complete the following Household Inventory for ***all*** the members of the Community Health Club. If time is short then in at least 30 households in each Club, (where pretesting was done), using every third CHC member on the sampling frame.

TIME PER SURVEY

It is estimated that the time taken for this preliminary introduction (including pretesting pictures and household survey) should be about one hour per household, and that five households can be done per day. That means that at least six days should be allocated to this base line survey with one day for training. MoH is ascertain if this budget exists to support this design of community monitoring.

DEFINITION OF THE INDICATORS

An indicator is a tangible object and empirical evidence that shows that a certain behaviour is being practiced.
All the indicators that are used in the household survey have been chosen because they represent one of the recommended practices on the membership card.

The Code Sheet for the responses should be laminated to ensure it is more durable. The respondent's demographic details are filled in on the Registration From (Annex 3). On the Response Form (Annex 6) the values for each of the questions are recorded using the codes from the code sheet.

Example of a completed Household Inventory Form

		Respondents									
ID	**Questions**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Any eye disease visible in family?	0	0	0	0	0	1	1	0	0	0
2	Any skin disease visible in family?	1	0	1	0	0	1	1	0	0	1
3	Name 5 ways that diarrhea is transmitted?	2	3	2	2	4	0	0	2	4	1
4	Do you know how to make SSS?	0	0	0	0	0	2	2	1	1	0
5	Is there a special hand washing place?	0	0	0	0	0	0	1	0	0	0
6	Is soap available near the hand washing	0	0	0	1	1	2	1	0	0	1

	place?										

ACTIVITY 8: LEARNING HOW TO DO THE HOUSEHOLD INVENTORY

Look through the Inventory as a group and ensure that everyone is clear about the definition of each indicator as this will guide the enumerator so that the same standards are observed in every household, in every CHC, and in every Province .

Divide into pairs and look at the sample of the response form (p.24) above.

Answer the following questions using the Code Sheet (Annex to understand the responses:

Which respondents have the cleanest home?

Which respondents have the worst situation?

Which respondents have diseases visible in the family?

Which respondents know the most about diarrhoea transmission?

ROLE PLAY:

One person should be the respondent and the other the enumerator. Complete the survey pretending to be a community member.

FIELD VISIT: Try out the household survey in the community and survey one household for practice

14. THE CULTURAL FAMILY

The CHC training is designed to tie in with already existing criteria for a Cultural Family which has the following criteria:

1. No common infectious diseases (skin, eye disease)
2. No food poisoning cases (no diarrhoea due to poor food /water hygiene)
3. Presence of a clean latrine
4. Presence of a well drained bath room
5. Use of a safe water point

The first six month of training in CHCs focuses on all these issues.

It is recommended that Stage 2 of the CHC training will deal with the following topics so that in one year all the criteria for a Cultural Family will be met.

6. Family practice health lifestyle with exercise
7. No addiction to alcohol, drugs or smoking
8. Pregnant women have at least 3 antenatal check ups
9. Prevention of injuries at home

10. Children immunised as required
11. No child malnutrition

ANNEX 1: CONCEPTS AND DEFINITIONS OF THE CHC METHODOLOGY

COMMUNITY HEALTH CLUB (CHC)
A CHC is a community based organisation, made up of voluntary men and women dedicated to improving the health and welfare of the community through **common knowledge**, **common understanding** and the practice of safe hygiene in the home leading to **common unity** and **common welfare**.

COMMUNITY comes from the two words Common and Unity. This is the ideal 'community', where all households share a common culture: beliefs, attitudes and behaviour. In other words they understand each other and share a 'Culture of Health'.

HEALTH is often used to mean the opposite of disease. If someone is not ill they are healthy. However in this programme we understand health as being not only being strong in body but also in mind: that means unstressed and able to cope with our lives successfully.

COMMUNITY HEALTH is when a community can manage all preventable diseases and has a healthy environment: i.e. safe water, Zero Open Defecation (ZOD) and safe hygiene practices.

NORMS : how you usually behave

VALUES : what you believe is good

ATTITUDES: the way we think

BELIEF: What we decide is true for us

BEHAVIOR: the way we conduct ourselves physically

GROUP CONSENSUS: agreement within a group on a certain issue

POSITIVE PEER PRESURE: people conform to the expectation of the group because they are admired

SOCIAL CAPITAL: a level of trust and mutual helpfulness within a community based on social networks

HOUSEHOLD INVENTORY: a spot observation and method of recording facilities and hygiene behavior in a home

SAMPLING FRAME : a list of households so that random samples can be done of every without bias

INDICATOR: a tangible, visible object that gives empirical evidence that a certain behaviour is being practiced.

ANNEX 2: MEMBERSHIP CARD

ID	TOPICS	Date of Session	VHW Signature
	REGISTRATION		
1	COMMON LOCAL DISEASES		
2	PERSONAL HYGIENE		
3	DIARRHEA TRANSMISSION		
4	DIARRHEA TREATMENT USING SSS		
5	HAND TRANSMISSION OF DIARRHEA		
6	HAND WASHING FACILITY		
7	KITCHEN HYGIENE		
8	RAT CONTROL		
9	FLIES TRANSMISSION OF DIARRHEA		
10	FLY CONTROL		
11	WATER SOURCES		
12	WATER TREATMENT & PROTECTION		
13	REVIEW SESSION: HEALTH DRAMA		
14	ENVIRONMENTAL PROBLEMS		
15	SAFE SANITATION		
16	SANITATION IMPROVEMENT		
17	DOG CONTROL		
18	PIG CONTROL		
19	ACUTE RESPIRATORY INFECTIONS		
20	AVIAN AND SWINE FLU		
21	MOSQUITO CONTROL		
22	A CULTURAL VILLAGE		
23	COMPETITION PREPARATION		
24	GRADUATION		

ID	Recommended Practices	Signature of VHW	Membership Card
			Community Health Club
1	No skin diseases at home		
2	Bathroom in home		Number:
3	5 ways to transmit diarrhoea		Name
4	Know to make SSS		ID
5	Use of soap for handwash		Village
6	Handwashing facility in home		Commune
7	Kitchen area with storage		Facilitator
8	Rat control methods used		Date started
9	Fly swat used		Date finished
10	Fly nets used		Date of Graduation
11	Well maintained water source		Household survey
12	Water treated and stored safely		Household visit
13	Knowledge of health song		
14	Garbage managed well		
15	Clean latrine		
16	Improvements to latrine		
17	No worm symptoms		
18	Recommended livestock pens		
19	Fuel efficient fire / no smoking		
20	Clean surfaces and floors		
21	Mosquito nets used		
22	Model home		
23	Health drama		
24	Certificate		

Logo MoH

ANNEX 3: REGISTRATION FORM FOR CHC MEMBERS

Respondent number	Respondent name	House number	Ethnic group	Gender	Age	Education	CHC member Number
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							

ANNEX 4. Sample Form for pretesting of Visual Aids

Topic Number	**Respondent numbers**											
Picture Number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**	**Result**
Comprehension of picture **1= understood; 0= not understood** What do you see here?												
Appropriateness to area **1=yes; 0 = not appropriate** Is this seen in your area?												
Interpretation of picture **1= correct; 0 = not correct** Is this good or bad situation ?												
Picture Number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**	**Result**
Comprehension of picture **1= understood; 0= not understood** What do you see here?												
Appropriateness to area **1=yes; 0 = not appropriate** Is this seen in your area?												
Interpretation of picture **1= correct; 0 = not correct** Is this good or bad situation ?												
Picture Number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**	**Result**
Comprehension of picture **1= understood; 0= not understood** What do you see here?												
Appropriateness to area **1=yes; 0 = not appropriate** Is this seen in your area?												
Interpretation of picture **1= correct; 0 = not correct** Is this good or bad situation ?												
Picture Number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**	**Result**
Comprehension of picture **1= understood; 0= not understood** What do you see here?												
Appropriateness to area **1=yes; 0 = not appropriate** Is this seen in your area?												
Interpretation of picture **1= correct; 0 = not correct** Is this good or bad situation ?												
Picture Number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**	**Result**
Comprehension of picture **1= understood; 0= not understood** What do you see here?												
Appropriateness to area **1=yes; 0 = not appropriate** Is this seen in your area?												
Interpretation of picture **1= correct; 0 = not correct** Is this good or bad situation ?												

ANNEX 4: HOUSEHOLD INVENTORY CODE SHEET

ID	Questions	Answer Codes
1	Any eye disease visible in family?	0= none; 1= pink eye; 2=trachoma, 3=poor eye sight/glasses 4= poor eyesight/ cataract 5=poor eyesight/injury
2	Any skin disease visible in family?	0=none 1=scabies 2=ringworm 3= unidentified rash
3	Can you name five ways that diarrhea is transmitted?	0= don't know any; write number of correct answers 1-5
4	Do you know how to make SSS?	0=don't know; 1= partial knowledge; 2 = full knowledge
5	Is there a special hand washing place?	0= no special handwashing place; 1= share common bowl 2=tap, pour to waste 3=bucket/basin, pour to waste 4=Hand washing facility (HWF)
6	Is soap readily available near the hand washing place?	0=no soap in household 1=soap but not near handwashing facility 2=soap near handwashing facility
7	Is there a bathroom?	0=no bathroom, wash outside 1=bathing place with drainage, but no shelter 2= simple shelter without drainage 3= good shelter with drainage 4= inside house, piped outflow, cement/tile
8	Where is left over food stored?	0=no left-over food 1=left-over food uncovered 2=covered in cupboard 3= covered in pot 4=fly net 5=hanging basket
9	Where are the plates stored?	0=no storage place, left lying around 1=stored in basin/basket inside 2= stored in cupboard 3=stored on pot rack outside
10	How do you protect yourself from flies	0=not applicable (no flies) 1= flies common but no protection done 2=fly traps 3= fly swats 4= fly spray/chemical methods

		5= keep food covered in cupboard 6=keep food covered with fly net 7=cover latrine to stop breeding
11	Is there an orderly kitchen area?	0=no kitchen 1=basic cooking area outside 2= kitchen shelter with only fireplace 3= kitchen area with storage and eating area 4= high standard with tables/cupboards
12	What cooking method is used?	0=open fire outside 1= open wood fire inside unventilated 2=open wood fire inside, ventilated 3= fuel efficient wood stove 4= coal burner 5= paraffin burner 6= electric cooker
13	Is drinking water container clean?	0=no storage of drinking water 1=container dirty and open 2 =container dirty but sealed 3=container clean but open 4=container clean and sealed
14	What is your drinking water source?	0= open source (river/pond) 1= rainwater collection from roof to open container 2= rainwater collection into sealed tank 3= shallow family well open (no cover) 4= shallow family well (protected with cover) 5=Gravity flow system into open container 6= gravity flow system into closed container 7=Tube well with handpump 8= tube well with electric pump 9= piped water supply system to public tap 10= piped water supply in-house connection
15	Do you treat your water before drinking?	0=not necessary, water is clean 1= purification with alum 2= sand filter tank 3=disinfection with Chloramine B or T 41== disinfection by boiling 5= any of the above as well as boiling
16	Are there any human faeces seen in the compound?	0=no faeces seen in compound 1= none in compound but no latrine 2=latrine but faeces visible 3=latrine but no faeces visible but uncovered hole 4= latrine covered and clean
17	Is there any solid waste (garbage) littered in the compound?	0=no garbage visible in compound, no rubbish pit 1= No garbage visible, and pit used for disposal of all 2= no garbage visible, separation and burning regularly 3= some garbage seen in compound, no pit

		4= a lot of garbage seen in compound, no pit
18	If there is a toilet, is there a habit of reusing human faeces?	0= no reuse of human faeces 1= regular reuse of human faeces (fresh) 2 = safe use of human faeces (dry)
19	If there is a toilet, what type?	0= no toilet 1=traditional pit latrine, uncovered 2= traditional pit latrine covered 3=pour flush latrine 4=double vault composting latrine 5=Ventilated improved pit latrine 6=Biogas Tanks 7= septic tank latrine
20	What do you do to control rats?	0= nothing , rats no problem 1= cats 2=rat traps 3=poison 4=bucket traps 5=cone on cupboards
21	Does the family have any signs of worms?	0=no children 1=one child shows worm symptoms (extended belly) 2= more than one child have worms 3= adults have worms 4= children and adults have worms
22	Are there any pigs/buffalo? If so is the pigsty/buffalo stall kept clean?	0=no pigs 1=far from house and cleaned daily, good drainage 2= near house but cleaned daily, good drainage 3= near house but not cleaned daily, good drainage 4= near house, dirty and badly drained 5= free range, no sty/stall
23	Are there any poultry /ducks? If so are poultry kept out of living area?	0=no poultry 1=poultry cage far from house,cleaned daily, good drainage 2=poultry cage near house but cleaned daily, good drainage 3= poultry cage near house, not cleaned, good drainage 4= poultry cage, dirty and badly drained 5= free range poultry, around compound and kitchen
24	How do you protect yourself from mosquitoes?	0=no mosquitoes, no need of protection 1= mosquito net for all family members 2= mosquito net only for adults 3=mosquito net for children and pregnant mothers 4= cover all water containers 5= clear vegetation around house 6= keep fish in water tanks 7= spray in homes or burn mosquito coil / cow dung 8= spray of water sources by authourities
25	Does anyone in your household smoke?	0= no smokers 1= husband/males only

		2= wife and husband 3= most family members
26	What kind of house is it?	0=mud and pole with thatch 1=mud and pole with corrugated iron sheeting 2= mud and pole with tiles 3= bricks and thatch 4= bricks and iron sheeting 5=bricks and tiled roof 6= mixed construction/some mud/brick
27	Are the tables/floors in the house clean?	0= dirty: all dusty and sticky (cement or mud) 1= Mud clean but could do better 2= Cement clean but could do better 3= very clean mud 4= very clean cement/ polished and tiled 5= Excellent: model home
28	Is the bedding / sleeping area in the house clean?	0=dirty, unmade, messy clothes 1= tidy clothes but dirty bedding 2=tidy clothes and clean bedding 3= very tidy with cupboards for clothes, unclean bedding 4= very tidy with cupboards for clothes and clean bedding 5= excellent: model bedroom
29	How many people eat together?	Put number #
30	Estimated income level?	0=very poor, no extra goods 1=poor, some extras, bicycle 2=middle income, cell phone, furniture 3=higher than average: bicycle, radio, furniture 4=very high: TV, all mod conveniences

ANNEX 5: HOUSEHOLD INVENTORY RESPONSE FORM

		Respondents									
ID	**Questions**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1	Any eye disease visible in family?										
2	Any skin disease visible in family?										
3	Name 5 ways that diarrhea is transmitted?										
4	Do you know how to make SSS?										
5	Is there a special hand washing place?										
6	Is soap available near the hand washing place?										
7	Is there a bathroom/ wash shelter?										
8	Where is left over food stored?										
9	Where are the plates stored?										
10	How do you protect yourself from flies										
11	Is there an orderly kitchen area?										
12	What cooking method is used?										
13	Is drinking water container clean?										
14	What is your drinking water source?										
15	Do you treat your water before drinking?										
16	Any human feces seen in the compound?										
17	Any solid waste littered in the compound?										
18	If toilet, is there a habit of reusing human feces?										
19	If there is a toilet, what type?										
20	What do you do to control rats? Can I see?										
21	Do the family have any signs of worms?										
22	Are there any pigs/buffalo/cows? If so is the pigsty/buffalo/cow stall kept clean?										
23	Are there any poultry /ducks? If so are poultry kept out of living area?										
24	How do you protect yourself from mosquitoes?										
25	Does anyone in your household smoke?										
26	What kind of house is it? What building materials										
27	Are the tables/floors in the house clean?										
28	Is the bedding / sleeping area in the house clean?										
29	How many people eat together? write number #										
30	Estimated income level?										

ANNEX 6: USEFUL REFERENCES FOR FURTHER READING

Borghi et al (2002) "Is Hygiene Promotion Cost-Effective? A Case Study in Burkina Faso." *Tropical Medicine and International Health* 7 (11): 960–69

.

Kar.K. (2003) *Subsidy or self-respect? Participatory total community sanitation in Bangladesh.* IDS Working Paper 184

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

For all information on Community Health Clubs see: www.africaahead.com

Millennium Development Goals