

DISTRICT HEALTH PROMOTION USING THE CONSENSUS APPROACH



'In Africa we sit under a tree, 'til we agree.'
(Julius Nyerere, the first President of Tanzania)

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Consensus Approach Concept: Africa AHEAD

Commissioned by London School of Hygiene and Tropical Medicine / WELL

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Front cover: A Community Health Club in Sierra Leone

July 2006

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EXECUTIVE SUMMARY

This manual is a guideline for those planners looking for a practical methodology for conducting a health promotion project at District Level. The focus is primarily on applying this approach to rural areas; however the approach is still applicable to an urban setting.

The manual takes approximately 1 ½ hours to read and is divided into three main sections:

Section 1

Thinking Globally - Acting Locally looks briefly at international efforts to engage countries in health promotion and focuses on the Millennium Development Goals (MDGs) as a target for halving the number of people living without safe water and sanitation before 2015. Having identified the main problem as the difficulty of getting people to change their behaviour, the text then outlines the **Consensus Approach**; a well-tried solution to this problem. A definition is given of **Community Health Clubs**, which is the main 'vehicle for development' using in this approach. The remainder of this section outlines the conceptual framework of the Consensus Approach, summarising core concepts such as the importance of 'common unity' as opposed to individual action, and the creation of a 'culture of health'. It shows how health clubs can empower women through information sharing and participatory activities, which according to research do meet an identified cognitive need. Having introduced the participatory PHAST approach, it describes how this training has failed to alter behaviour to any degree, but how the adaptation of this method combined with a more structured programme in Community Health Clubs has produced significant results. The importance of the membership card is emphasized and a brief description of the six month health promotion programme is given. The section ends with some frequently asked questions, which may also be answered in Section 3 with concrete examples.

Section 2

Acting Locally: District Health Promotion describes how to start up Community Health Clubs. It begins with a simple calculation to establish how to meet the MDGs in the district, halving the population without sanitation within 10 years. The four prerequisites to start the programme are then discussed in some length. This includes a discussion on which facilitators are the most suitable, the importance of mobility for field staff, the vital need for a pre-prepared toolkit of culturally appropriate visual aids, and the type of training that is needed to set up the programme. It then briefly describes the programme for a one year health promotion campaign. A final section is dedicated to the importance of monitoring and measuring behaviour change – given the dearth of well-reported studies available in the sector. It encourages districts to advocate at a National level using lessons learnt from the pilot project and provides rough guidelines to enable practitioners to publicise their findings internationally, so as to contribute towards more rigorous health promotion studies in the academic field.

Section 3 (Optional extra to this manual)

Drawing on more than a decade of experience in the field in Zimbabwe, Sierra Leone and Uganda, this section presents 12 reasons why the Consensus Approach is a feasible health promotion strategy at District Level. It demonstrates that Community Health Clubs can prevent a range of diseases, address multiple risk practices and achieve high levels of behaviour change. The approach provides an effective way to disseminate knowledge and invariably produces a strong demand for sanitation. It can be extended to a further stage where water supply is managed by the health club, and if taken to its full potential can go on to alleviate poverty and deal with fundamental social needs such as illiteracy, social support networks and human rights. Extension workers have found the approach rationalises their work-load and provides an easy way to interact with the community. The Consensus Approach is particularly strong in measuring outputs in terms of hygiene behaviour change, as well as enabling performance monitoring of the facilitators in league tables, by their superiors at District Level. In areas where health clubs are densely concentrated and have been going for a decade, there are strong indications of reduction of diarrhoea, bilharzia, skin diseases, eye diseases and acute respiratory infections (ARI) as reported at local health centres. Most importantly, the Consensus Approach is able to prove its cost-effectiveness at between 35-66c per person over a two year programme, and can demonstrate value for money when compared to more vertical interventions.

SECTION 1: THINKING GLOBALLY

The Importance of Health Promotion

While development in the Water and Sanitation Sector has been ongoing since the 1960's, health promotion was first highlighted at Alma-Ata in 1978 with a call internationally for 'Health for All by the Year 2000'. As safe drinking water was considered a primary prerequisite for good health, the 80's was designated the Water Decade and strenuous efforts were made to provide safe drinking water for rural communities.

In an effort to improve conventional health 'education', which had been purely a top-down transfer of information from experts to recipients, the Ottawa Charter (WHO, 1986) revised the concept, which was now termed Health Promotion, defined in much broader terms as:

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

The more people-centred 'participatory approach' in the 1990's attempted to involve communities in their own development, but by the year 2000 there were still 2.6 billion people without safe sanitation and 1.1 billion people living without safe drinking water. After almost 40 years, the health of impoverished rural families has failed to improve significantly, and today approximately 800,000 children in Africa alone, still die each year due to diarrhoeal diseases associated with poor hygiene, unsafe water and no sanitation (WHO, 2002).

The Millennium Development Goals

At the turn of the century, the United Nations declared the Millennium Development Goals (MDGs), in order to refocus international efforts once again, and called for the reduction by half, the number of those still without safe water and sanitation. Despite this focus, progress has been minimal, and with less than 10 years remaining it is unlikely that the MDG targets will be reached by 2015 in Sub Saharan Africa, unless governments can operationalise these ideals more effectively (WHO,2002). Provision of water and sanitation facilities alone will not suffice. Although the contribution of safe hygiene in improving family health is now established as more critical than either water quality or quantity (Esrey et al., 1991), communities themselves seldom adjust their hygiene behaviour. For this reason effective health promotion strategies are urgently needed to galvanise communities to manage their own health by changing their high risk behaviour.

How do we get people to improve their unhygienic habits?

Whether it is in industrialised society, or rural underdeveloped communities, changing public health behaviour has proved to be one of the most challenging aspects of development. Knowledge of the risk is not enough to persuade people to change their behaviour: even well-educated people who smoke, still refuse to give up this dangerous habit, even through they know that it causes cancer. Despite continual warnings, the known risk of unsafe sex is ignored and the scourge of HIV/AIDS continues, due mainly to risky behaviour. Most common communicable diseases that affect rural populations can be prevented by hygienic living conditions and safe practices, but it is clear that people seldom adjust their risk practices on the basis of knowledge alone (Curtis et al., 2000). Additional incentive for change is needed other than pure information to persuade people to change.

Different Approaches to Changing Hygiene Behaviour

The wide range of strategies that have been tried in the last few decades can be grouped according to the overriding incentive used to trigger behaviour change:

1. Regulation and Control

People only change when they are forced to do so by authority.

The traditional regulation by governmental control of areas through health inspectors is further reinforced by a system of *rewarding* compliant households from the proceeds of *finés* raised from those villagers who do not measure up to set government health standards. This *Carrot and Stick* approach can be put into effect immediately through government regulation without additional funding or NGO support, and will be most successful if health inspectors are well motivated by recognition and reward. (e.g. Busia District, Uganda)

2. Health Belief

People will improve their hygiene if they know the reasons why they should do so.

This model is based on the common sense theory, that if someone is well informed they will act on the basis of their information and belief. Thus health education was seen as a prerequisite to hygiene behaviour change (Janz & Becker, 1984). Modernisation takes place 'naturally' by the diffusion of this information or innovation from the fast adaptors and innovations and trickles down to those at the lower end of the scale by emulation (Rogers, 1983).

3. Status Appeal

People are more interested in being smart rather than to improving their health.

The appeal of status is more effective in creating a demand for a product than knowledge of the germ theory. **Social Marketing** often engages the private sector (usually soap manufacturers) in a '**public private partnership**' (PPP) to link with public sector in a media campaign to change behaviour using the subliminal messaging of commercial advertising.

Curtis (1993): Burkino Faso. www.worldbank.org

4. Collective Shame

People will change their behaviour when they are embarrassed publically.

Focusing on the human trait of **self-respect**, planners conduct a village 'walk of shame' with village leaders. When the village becomes a faecal free environment, with every household using a latrine the village is declared a faecal free environment. This **Community Led Total Sanitation** (CLTS) encourages village pride, whilst village leaders continue to enforce compliance. Kar (2004) WaterAid. India. www.wateraid.org

5. Group Consensus

People change when more easily everyone around them is doing the same thing.

Community Health Clubs are formed and a Culture of Health developed through knowledge and understanding in a series of participatory health sessions. Group consensus endorses essential values and group conformity results in high levels of behaviour change with communities monitoring and managing all preventable diseases. Waterkeyn & Cairncross, (2006) Zimbabwe. www.africaahead.com

These strategies are not mutually exclusive and all are aspects of the reason why people change, and each may be appropriate in different contexts. For example, Social Marketing and Regulation are more appropriate in urban areas, whilst CLTS and Community Health Clubs are more appropriate in rural areas. They can be used in conjunction with each other as each provides different ways of reinforcing the same key messages at different levels.

The principal purpose of this manual is to provide an overview of the Consensus Approach.

Conceptual Framework of the Consensus Approach

The Consensus Approach is a training methodology that aims to develop functional communities by modifying the determinants of health to ensure long-term hygiene improvement through positive behaviour change. The process ensures that communities are not just a loose collection of households within a geographical area, but that they are strongly bonded neighbourhood, defined by a 'common unity' of understanding on health and most importantly, the households have the capacity to act together effectively to improve family health. Two important observations underlie the reasons for using this approach:

1. *Most women are primarily interested in caring effectively for their family and will therefore be interested in the opportunity to improve their ability as mothers.*
2. *There is an intellectual starvation in developing communities, and many people have not had sufficient opportunity to learn, so they will respond to health information.*

These observations have been substantiated by qualitative research, which has conformed that many rural communities lack the opportunity for women in particular to come together regularly to understand their problems and work together to change and improve their lives.



What is important to you as a woman?

It is the discipline that I want and to care for my family and to care for my home and keep it clean. I wanted to learn more about health. I have done all the sessions and I have graduated and have got a certificate. All those topics are very useful, you learn a lot from them and I don't want to miss them so I made sure I attended all the sessions. I most like health education. Health Club Member

To meet this need a system has been developed that assists communities to start up community based organizations which can provide a regular forum for parents (mothers in particular) to meet and discuss key concerns in their lives. This is a forum where people meet weekly and through participating in problem solving activities they develop a common understanding of health issues, based on shared information and beliefs. They adhere to certain positive practices which become a way of life. This is achieved through participatory activities which enable bottom-up sustainable solutions to be found.

Consensus vs. Individuality

Health Promotion seeks to change people's hygiene behaviour. In the industrialised world, personal change is usually an individual act. However in largely 'traditional' rural communities the individual is perceived as less important than harmony of the whole: personal freedom is not often encouraged as it may divide society. In the past, development programmes have tended to appeal to each individual to change. This has ignored the fact that from a community perspective, an individual act will challenge the norm, which can start a chain of jealousy. The Community Health Club intervention uses the opposite tactic. If a decision is endorsed by the whole group, then the individual within the group can make the change, and need have no personal fear. Thus **group consensus** is achieved when all the individual members agree to conform to recognised standards adopted by the group.

Creating Common Unity and a Culture of Health

Community Health Clubs aim to create a 'common unity' of understanding and shared perceptions of disease, within an area. Social pressure and group conformity are, in this model, seen as more potent change agents than is the mere appeal to individual rationale through cognitive learning, although the latter is also recognised as being important. By adjusting norms and values, this health promotion strategy creates a 'culture of health,' which enables women to successfully control most preventable diseases and manage their family's health. By constant reinforcement of key messages, bolstered by group consensus, Community Health Clubs can develop self-efficacy enabling members to successfully challenge existing cultural practices that undermine good health. If the critical mass in a community change their core values and beliefs based on informed decisions, late adopters are likely to conform for social reasons. Thus positive behaviour change in hygiene is reasonably predictable if a person is an active member in a dynamic Community Health Club.

What are Community Health Clubs?

'Community Health Clubs' are free voluntary, community-based organisations (CBOs) formed to provide a forum for information and good practice relating to improving family health. They vary in size from 40 to 200 people, men and women of all levels of education, and are facilitated by a health extension worker trained in participatory health promotion activities.

The Importance of the Participatory Approach

Participatory Health and Sanitation Transformation (PHAST) was one of several similar participatory methodologies which were developed to address the top-down approach of the Health Belief Model of development in the 70's and 80's, which had tended to ignore the strengths of community resourcefulness. PHAST was introduced into Sub Saharan Africa (Kenya, Uganda, Zimbabwe, Botswana and Ethiopia) as a regional pilot project in 1994. A number of projects were initiated and a "tool kit" of illustrations (100-200 drawings) were developed in each country for participatory activities such as 'Nurse Tanaka', 3 pile sorting, Story with a Gap, Blocking the Route, and un-serialised posters.

Constraints of Standard PHAST programmes

Whilst the activities in 'Standard PHAST' projects successfully empowered communities, (UNDP/WSP/IWSD, 1999) and increased health knowledge, the training tended to target the whole community loosely with no specific membership. Ad hoc meetings with the broad community meant that different people would attend different sessions so that there was no clear target audience. If no water and sanitation programmes followed the health promotion, expectations of assistance of the community were raised whilst nothing materialised. Lack of base line surveys, lack of identified indicators of hygiene behaviour change and ill defined target population meant that hygiene change was difficult to measure. Furthermore the process was time-consuming and with insufficient monitoring and support, extension staff did not always follow through or provide the necessary reinforcement to ensure implementation took place.

Although standard PHAST has theoretically seven steps, (Problem identification, Problem Analysis, Planning Solutions, Selecting options, Planning for new facilities and behaviour change, Planning for monitoring and evaluation, and Participatory evaluation) in actual fact there is more planning than action, and the 'talking shops' do not always translate into sustainable behaviour change in the home. Despite the planning, communities may not be sufficiently functional to operationalise these plans.

In 2005, an assessment of PHAST programmes in Uganda concluded that it was difficult to assess the difference between communities exposed to PHAST as against those where no health promotion programmes had taken place. Although with an estimated 4 million beneficiaries the cost of the programme (US\$12 million) amounted to only 49c (US\$) per beneficiary, the levels of hygiene behaviour change were marginal. PHAST areas had only a 9% higher latrine coverage after a 4 year programme and a basic hygiene habit such as covering drinking water appeared 2% higher in areas where no health promotion had taken place (World Bank-WSP, 2006). The 17 indicators that were presented showed an average difference between the intervention area and the control of 5.6% (with no *p values* published).

PHAST within Community Health Clubs

However the fact that Standard PHAST has largely failed to prove its cost-effectiveness to-date does not mean that the approach should be completely abandoned, as where it has been used in conjunction with Community Health Clubs there have been significant success in changing hygiene behaviour. The Consensus Approach uses the standard PHAST training but has been more successful in achieving behaviour change with most areas achieving total safe sanitation, and can demonstrate an average of 47% difference of over 15 indicators ($p > 0.0001$). The community structure provided by a Community Health Club is the missing link, an effective mobilisation strategy that puts the final 'T for Transformation' in place.

Community Health Clubs ensures that participatory activities translate into action. Achievable hygiene changes are identified each week. Every session is backed up with homework for the week whilst group consensus and peer pressure to encourages the compliance of members.

In addition cost-effectiveness can be more easily measured in Community Health Clubs because:

- There is an identified membership
- There is a more structured programme of sessions
- There are pre-determined proxy indicators

PROGRAMME STRUCTURE:

The importance of a membership card

'Structured Participation' may sound like a contradiction in terms. However whilst the Consensus Approach uses the empowering effect of participatory activities, (which is the strength of PHAST) it positions this within a more structured framework with an achievable set of targets. ***This additional structure accounts for a highly significant increase in rates of behaviour change.*** It is achieved by a small but subtle ploy: the use of a membership card.



Fig.1. The membership card gives an identity and commitment to the health club ethos of learning about health and practising good hvaiene.

A membership card is issued to each member, listing the topics to be covered and recommended practices. It should be developed in conjunction with the health workers, and programme managers at the training workshop based on formative research within the community.

It has been found that when membership cards are distributed at the first health club meeting, they mobilise others to join, because people are convinced of the seriousness of the programme and want to join so that they too can have a card.

The membership card is the key to the structure of the whole project and is essential in a number of ways:

1. It provides a sense of identity
2. It encourages people to join
3. It shows the seriousness of the project
4. It gives members an overview of what they will learn
5. It provides targets in terms of recommended changes
6. It enables the facilitator to quantify community attendance
7. It allows the community to hold the facilitator accountable
8. It provides a monitoring tool for programme managers
9. It is an overt symbol of the Community Health Club
10. It prevents gatecrashers from reaping unearned benefits

Fig 2: Example membership card, used in Northern Uganda

No.	Topic	Date	Signature	Homework	Signature
1.	Safe Water Chain			Cover water; 2 cups	
2.	Safe Food Chain			Pot rack; hanging basket	
3.	Sanitation Ladder			Clean latrine; cat sanitation	
4.	Sanitation Planning			Dig pits	
5.	Diarrhoea ORS			Build latrines	
6.	Hand washing			Hand washing Facility	
7.	Cholera/ typhoid			Water Source Cleanup	
8.	Skin/eye disease			Bedroom Cleanup	
9.	Worms			De-worming	
10.	Nutrition			Food processing	
11.	Good kitchen			Lorena Stove	
12.	Drama and songs			Practice drama	
13.	Environment			Hay basket	
14.	Malaria			Drainage & clearing	
15.	Coughs and colds			Mats and ventilation	
16.	Bilharzia			Bathing Shelter	
17.	TB			Community Project	
18.	HIV/AIDS			Community Project	
19.	Home based Care			Community Project	
20.	Family Planning			Community Project	

Membership of a Community Health Club

The club identifies itself publicly by a specific name representing its objective; it has a constitution outlining its rules; a democratically elected executive committee, with annual elections, headed by a chairperson, secretary and treasurer.

Membership of a Community Health Club is gained by free registration. Health Club members meet every week at an agreed place and time. They take part in health sessions which are facilitated by a Health Club Facilitator (HCF), who has been well trained with specific training materials developed for the country to be culturally appropriate. The HCF provides facilitation for 20 and 30 sessions over a 6-9 month period. This culminates in a large public Graduation Day, when all those who have completed the course are rewarded publicly with a certificate of full attendance.

Club members often want to identify themselves by uniforms, and a banner is usually made proclaiming their ethos or showing a map of the club area (See Fig.3). Each Health Club has its own health songs and slogans denoting their commitment to the ethos of good health (See Fig 4).



Fig.3. **Identity:** Health club members in Uganda present their homemade banner with a good hygiene slogan



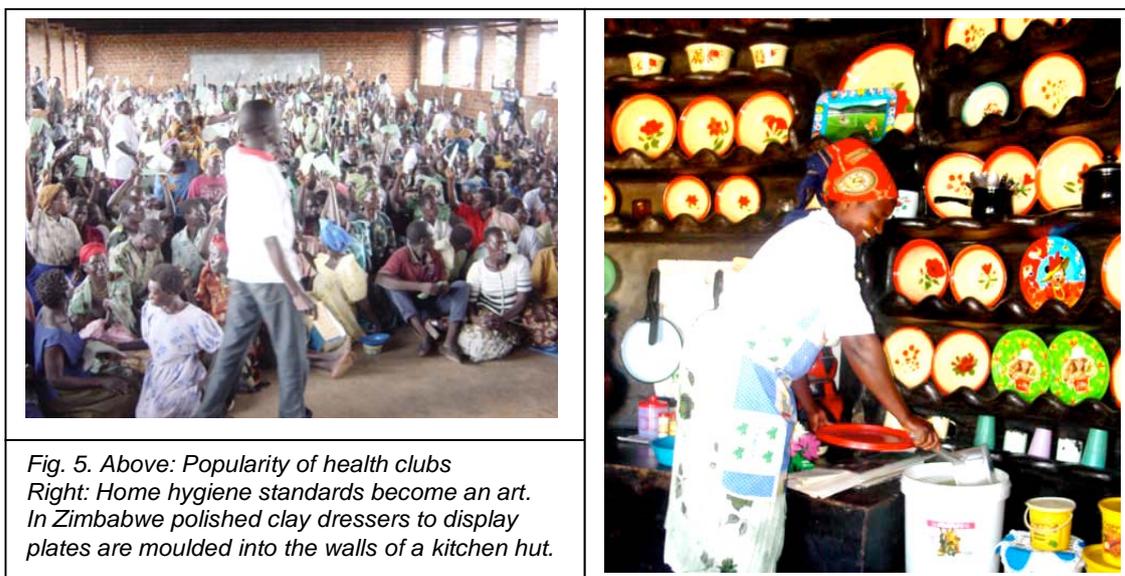
Fig.4. **Common Unity:** Singing and dancing members of a health club arrive at a graduation ceremony

A Health Promotion Campaign

A six month health promotion campaign is launched with weekly health sessions to discuss appropriate ways to improve health. The members of each Community Health Club work together through a series of topics to achieve a consensus of understanding leading to agreed action. This provides individual members with a secure platform for change, enhanced by peer pressure and support resulting in strong community support for water and sanitation programmes.

These weekly activities follow key guidelines identified in the Ottawa Charter, namely :

- To create a supportive environment to ensure good hygiene
- To strengthen community action to manage health
- To develop the personal skills of each individual club member



*Fig. 5. Above: Popularity of health clubs
Right: Home hygiene standards become an art.
In Zimbabwe polished clay dressers to display
plates are moulded into the walls of a kitchen hut.*

Community Health Clubs enable easy interaction with the community

Wherever Community Health Clubs have been started the response from the community has exceeded expectations. Field workers, previously used to a low turnout for meetings, have been surprised that so many people should attend health sessions so regularly and particularly when no material incentives are offered and no food provided. In Zimbabwe and Uganda between 80 and 200 people joined the health club, with an average attendance rate of 80% weekly attendance over a six month period. In Sierra Leone every household in the newly resettled villages was required by the imam to be represented by a health club member.



Fig 6: Participatory PHAST Activities enable health clubs to discuss issues and achieve consensus

FREQUENTLY ASKED QUESTIONS

Why should members want to join a club?

Members join a club because they want to be associated with like-minded people. They have a common interest of improving their family's health, a love of learning and knowledge and enjoy being with friends participating in interesting activities on a weekly basis. It is a chance to get smart and have fun together, singing, dancing, playing games and sport. They understand each other, speak the same language, and dance to the same drum. This is also in line with traditional cultural practices throughout Africa that have always accentuated consensus; the importance of togetherness and a sense of conviviality. They provide a weekly opportunity to have time off from household chores and be with friends, in a productive forum for information sharing.



I always enjoy meeting other people and learning more from others. Whenever I know this is our meeting day I am very happy because I know I shall get one or two ideas from others. When the EHT came around he called for a big meeting and told us he wanted to give us more knowledge and maybe share ideas on how they are going to prevent diseases, so that's why I joined the club so that I could also learn how to prevent diseases and also to get any other ideas from the others around.

What happens to those outside the club?

Are they, the non-members, not the very people who need the most support?

As there are no qualifications to becoming a member, a Community Health Club is, in fact, not an elitist group, as anyone can join, at any time. It is open without charge, to men and women of all ages, all levels of education and religion. The aim is to be as inclusive as possible so that the majority of homes in each village have a representative within the club. There are privileges and opportunities within the club, which are not open to non-members, but this makes it all the more desirable (and worthwhile) to become a member. This strategy is designed to spread the benefits as widely as possible whilst maintaining standards. Health clubs can be compared to a church congregation, or a scout group: both operate from a strong set of values, an ethos to which all members aspire.

Obviously not everyone is interested to join as group membership not appeal to everyone. However the marginalised and vulnerable members of a community can benefit substantially from this opportunity. Reasons given by non-members for not joining include: too distant from the home, too elderly or infirm, they may be pregnant or unable to leave children, not a full-time resident all year. If health sessions roll on for a second intake, those who have been slow to join often register. The ideal situation is to start a new intake every six months to ensure over 80% household coverage in every village.



Some did not join because they were stopped by their husbands.

While some just lacked the interest whilst their husbands were encouraging them to join. We also have quite a number of men who have come forward to join but they are no longer attending their lessons but they have those membership cards.

What incentives are provided to attract members?

Community Health Clubs does not use any material incentives to attract membership. There are no T-shirts distributed, equipment or cement. The appeal is purely on the grounds of acquiring knowledge. The only reward for attendance is a certificate to show that all sessions have been attended. It does not even indicate the level of knowledge of the member, so no one is excluded on the basis of intellectual inability. It appears that to be recognised publicly is a great incentive to many and they are prepared to sacrifice a lot of time and energy for this accolade. It is therefore of critical importance that this small incentive is forthcoming, and every individual should be acknowledged by name on the certificate. If possible District officials and traditional leaders should officiate and token prizes should be raised

locally to honour those who have contributed more than their peers. The cultural norm of public introduction is a standard politeness throughout Africa and the executive committees and other office bearers treasure their position in their community and are compensated for their efforts by such recognition. No allowances are given to office bearers in each health club, although ward co-ordinators who oversee all health clubs in their area can be given the incentive of a bicycle or uniform to assist their voluntary work.

An additional rule developed within health clubs to safeguard dedicated members, is that only those who have a certificate can continue if there is a next stage of a water and sanitation programme, where there may be material inputs such as cement. In only one area, (Makoni District in Zimbabwe), health clubs have continued into a Post Watsan stage with a broad range of community initiatives. This long-term process of development is the true fulfilment of the potential of the Consensus Approach to alleviate poverty using Community Health Clubs as a vehicle for development.



When we joined we were actually told we are going to learn about disease prevention so I think on the knowledge part my expectations were met although we didn't get a lot of inputs. When I look back to my last days compared to what we are doing now it was very different.

I feel very proud and motivated when I talk about this.

Can't existing structures be used for a health club?

Although there may already be many groups in the community, it is not advisable to graft a health club as the leadership may resent changing the purpose of the original group and will seldom share the same ethos as a Community Health Club. New health club leadership should grow from the group itself. The freshness of a democratically chosen leadership based on an ethos of good health, rather than existing social status, is often the key to the success of the health club. If grafted, the health club may become controlled by existing powerful elites that may have commandeered benefits in the past.

An example: Health Clubs have their own agenda

In the one ward in Makoni District, Zimbabwe, a situation arose whereby the health clubs were operating in the same area as a farming project which was started simultaneously by the counsellor of the area. This was a saving scheme to raise funds for buying seeds and fertilizer, and money saved by the group was doubled by outside donations. The counsellor opposed the health clubs because it was conflicting with the other group. Zimbabwe AHEAD NGO proposed combining the two programmes, but the health club members themselves refused to allow the two groups to fuse. They maintained that their objectives were different, and they did not want to be absorbed by a group with 'a different culture'. Importantly health club leaders did not want to be under the control of leadership nominated by the counsellor.



Has your membership to the club had an effect on your family?

My husband is so happy when he comes home. He sees a great improvement. He can see the difference between the past and the present. He is showing me his appreciation. I don't wait for him because he is away but I have to do the things on my own and he appreciates this. He loves me. You know my children are also participating in this thing. They participate in maintaining the yard and borehole. Each one has each plate and a cup - they don't use the same one.

SECTION 2: ACTING LOCALLY: DISTRICT HEALTH PROMOTION

The challenge is to translate abstract international guidelines such as '*halving the number without sanitation*', into an effective local strategy on the ground in each district.

The Consensus Approach provides a clear training strategy for health promotion at District Level which has, over the past decade, provided measurable and cost-effective health promotion successfully engaging communities in:

- ▶ managing their own water and sanitation projects
- ▶ achieving high rates of latrine construction, and zero open defecation through a strong demand for sanitation from the community
- ▶ Improving levels of health knowledge within communities and understanding for the need for good hygiene
- ▶ Changing their hygiene behaviour change in over 15 critical risk practices

Mrs Josephine Mutandiro has worked in Zimbabwe for 30 years as a Development Worker in Zimbabwe and since 1999 has co-ordinated the Zimbabwe AHEAD Programme in Makoni District, taking health clubs beyond the initial Health Promotion, Water and Sanitation Stages into a self sustaining CBOs, with viable income generating programmes. She has also pioneered an innovative home-based care programme for alleviation of opportunistic diseases associated with HIV/AIDS, setting up over 4,000 nutrition and herb gardens and training over 400 carers to use herbal remedies for which Makoni District is now renowned.



'The Health Clubs are sustainable. They are like a family now, they miss each other, they compete and they know each other. The counsellors now understand the health clubs. They know the people will always go there because they are so constructive. No one gets paid, there is no material incentive and yet the people just go for the knowledge. The Chief said to the other NGOs that work here, 'Don't spoil our people with your things, and give them the rod to fish like ZimAHEAD does.'

Our health club co-ordinators will continue because they are so dedicated to their people, they respect the health clubs. If anyone comes with something they will say that is fine but you must come into the community through the health clubs because that is our history.

It is good to train women with all the skills they need, to cope with the sick people. Why can't we do this in every district? These methods are a miracle to me. You know I have worked using all these methods, but this PRA (PHAST) is incredible. The mothers in the health clubs, if they are given time to analyse and find their own solution; that is real development. But it takes time.

We cannot just do this advertising technique. We can't say 'Do this or do that because this will make you smarter!' No! People have to know what they are doing and then they will agree easily and they will change. I always tell people in workshops. We must participate!

Development is a process! People change slowly, one by one. I believe people can make changes anywhere using health clubs.'

HOW TO START UP COMMUNITY HEALTH CLUBS

Planning the extent of a programme

Using the Consensus Approach it is fairly easy to calculate how to plan the extent of the programme in order to halve the number without sanitation in a district before 2015. Experience from past projects has shown that:

- ▶ each health club can be as large as 100 members
- ▶ one trainer can manage 5 health clubs every six months to one year

How many facilitators are needed?

Taking the following example we can work out how many facilitators would be needed to run health clubs to cover the population of a district. For example (See Table 1):

- ▶ If each district is made up of 30 wards with 5 villages in each ward, there would be 150 villages in total. Assuming that each village has an average of 200 households, within the first year, with one health club established, health promotion coverage would be about 50%, by the second year, with a new intake of members (or the establishment of a second CHC) full coverage can be expected.
- ▶ If the programme only lasts for 2 years, there would be 15 trainers each running 10 health clubs (one per village/year) by the end of the second year, and within 4 years each would run 20 clubs.

Setting a sanitation target: Meeting the MDGs

General sanitation coverage varies from one country to the next and internally within the country; in order to explain the estimation process, we can take an example setting of a rural district in a country that already has a 50% sanitation coverage (See Table 1 below):

Level	Division of a country		Health Promotion Programme	
	Consists of	Population	One year	2 years
National	8 provinces	10,080,000 (1,680,000 h/holds)	1,680 Trainers	840 Trainers
Provincial	7 districts	1,260,000 (210,000 h/holds)	210 Trainers	105 Trainers
District	30 wards	180,000 (30,000 h/holds)	30 Trainers	15 Trainers
Ward	5 villages	6,000 (1,000 h/holds)	10 CHCs	5 CHCs
Village	200 h/holds	1,200	2 CHCs per village	1 CHCs per village
Household		6 people		

Table 1: Calculating the number of Health clubs needed to meet MDGs

- ▶ Using the example above, a district with 180,000 people would have approximately 30,000 households (taking an average of 6 people per household).
- ▶ If 50% of these 30,000 households already had latrines, we would be left with 15,000 without safe sanitation.
- ▶ If we take the MDG target of halving the number without sanitation we would have a target of 7,500 households.
- ▶ We know from experience that at least 50% of members will build a latrine within a year of joining a club, particularly if assisted through a project.
- ▶ Thus with 150 health clubs within two years and approximately 1,500 households we could expect 750 latrines.
- ▶ At the rate of 750 latrines per year it would take ten years to achieve the target of 7,500 to meet the Millennium Development Goals in a district of this size.

This example is an idealised model and does not allow for population growth. The size of the programme is directly related to number of facilitators available.

RESOURCES NEEDED: THE FOUR T'S:

To start up a programme using Community Health Clubs four main resources are needed :

- ▶ **Trainers:** A dedicated cadre of health workers who can be committed full time to the programme
- ▶ **Transport:** The means for trainers to move easily around their area to access and monitor communities.
- ▶ **Training Material:** A 'Toolkit' of culture specific visual aids, appropriate to the country or sub culture, is pre-prepared to be used for participatory activities.
- ▶ **Training:** An intensive one week workshop on planning and running CHCs and participatory activities (PHAST).

1. Trainers**Who are the best people to run this programme?**

There are various alternatives, depending on the degree of organisation within the country concerned, the implementing agency and the resources available.

Ministry of Health extension staff

The most sustainable option is, of course, an existing cadre of government health workers who have already been trained in public health. In this case all that is necessary would be to train them in the Consensus Approach and participatory training methods so that this becomes their standard way of working. In this way communities will benefit from on-going support and long-term initiatives can be planned within government system. However, this presupposes that this government cadre exist and in many countries this is not the case. Sometimes the structure is nominally in place but there are few posts which are filled.

International NGO field workers

The most rapid method of training the community is to use readily available and well resourced field workers from an implementing International NGO. Whilst this maybe ideal for the NGO in terms of reaching targets, it does not lead to a sustainable programme because NGO projects are often short term or move their area of operation, leaving communities half-mobilised, and disappointed. This may cause problems for future programmes as the community is disillusioned with previous unfulfilled promises from outsiders.

Indigenous NGO field workers

An alternative is to build the capacity of an indigenous NGO that is rooted in the same area so that it can provide effective facilitators who are well resourced and trained.

Semi-Voluntary Community Members

If neither of the three options above are feasible the NGO may need to train up community members themselves. However with lack of specialised training they may find more complex health issues a challenge and may be less competent facilitators. However this is a cost-effective and fairly sustainable strategy because the Community Health Workers will likely to remain in the home area providing a local human resource for each health club. Problems arise if they are used to allowances as they may discontinue their work if funding ceases. In addition there are often real problems of credibility from their neighbours who fail to have faith in one of their own.



Fig 7. A field worker is only as effective as the wheels that carry him!

The ideal is to have Community Health Workers as voluntary counterparts in addition to external Ministry of Health facilitators, as together they provide a strong team, the former facilitating at less complex sessions, whilst the sessions can be overseen by Environmental Health staff when necessary.

2. Transport

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 which requires him or her to visit a different village every day. Unfortunately, after the continual failure of districts to maintain vehicle fleets over the past 30 years, there is distinct donor fatigue and consequently insufficient funding transport. However, unless there is some method of keeping trainers mobile their productivity will remain low. The issue of incentives is one which is highly contentious as it provides an opportunity for some agencies to galvanise more interest in their particular programme because they can offer better incentives in terms of transport and /or allowances. This may undermine productivity in the long term when allowances are discontinued. This is where a National Policy and five year plan can regulate to insure that all stakeholders in a district adhere to the same terms and conditions when supporting field workers. Transport is also an issue on the macro level between Ministries competing for resources, and individual attempting to benefit personally. This can be overcome by an effective District Development Committee, and a sub committee (District Water and Sanitation Coordination Committee) that can set the rules for use of vehicles. It is vital to have the main stakeholders in Local Government working as a team.

3. Training Material

The training materials must be prepared in readiness before the training of facilitators takes place. This means either finding and adapting existing material, or developing new material. If the later is this case this can take several months and needs expert assistance if sound material is to be produced. In the five countries (Kenya, Ethiopia, Botswana, Uganda, and Zimbabwe) where PHAST has been undertaken in the past training material probably already exists. If not, it is worth contacting International and local NGOs working in the area that may already have developed training material (WaterAid, Care International, Oxfam etc.). For Central Africa countries (Zimbabwe, Zambia, Malawi, South Africa, and Mozambique) Africa AHEAD has an extensive tool kit that can be purchased ready-made. TALC has many training materials that can be used and adapted and free CDs available with Africa AHEAD Training material. In every country the content of health and hygiene training will vary according to the main problems of the area.

Although it would be more inclusive to encourage communities to develop their own training material, this has been tried and it was found that in fact trainers have found it time consuming and difficult to arrange. The lack of ready made visual aids has often been a key constraint to trainers. For the participatory approach it is easier for the facilitators to have pre-prepared, well illustrated visual aids that are part of established activities that have been proven to provoke conversation and interaction between participants.

One of the reasons that the health clubs have proved so popular is that people have enjoyed the visual aids that have been prepared. Illustrations have to be drawn to reflect the people and the local culture so that members can easily recognise themselves in the illustrations and identify strongly with the problems that are depicted. This requires **formative research** to ensure that the illustrations are culture specific (reflect the culture) and appropriate (i.e. address the most pertinent local health issues).

Illustrations need thorough **pre-testing on an individual basis**, (Fig. 8) to ensure that the key messages in each picture are understood by everyone who attends the sessions, whether literate or not. The complexity of the illustrations varies depending on the level of education of the health club members, but in general it is best to aim for the lowest literacy level to ensure no one is excluded. This means visual aids must be carefully drawn to ensure that there is no ambiguity or confusion in interpretation, and this type of illustration is called **ethnographic illustration**. It requires artists who are aware of development issues and constraints and are prepared to alter their drawings until the community are able to interpret them without any misunderstanding.

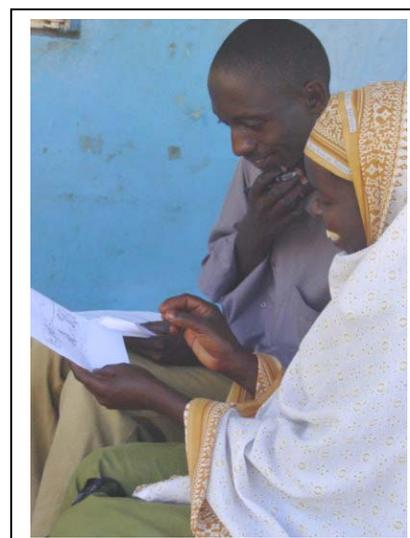


Fig. 8. Pre-testing pictures with individuals



Fig 9: Justin Otai, experienced PHAST Trainer for Ministry of Health in Uganda trains HIDO Staff at a Training workshop run by Africa AHEAD/ CARE

4. Training of Facilitators

Once the training material is completely ready, having been pre-tested and finalised, the facilitators can be chosen and a workshop arranged to train all those who will be running health clubs. It is usually politic to invite not only the facilitators to the workshop but also those who are the gatekeepers in the community, i.e. the main political leader (perhaps a councillor) of each village or area. This will enable them to have a full understanding of the proposed programme so that they can go back and prepare their community. Councillors do not have to stay for the whole workshop, but only the planning aspects. The more practical sessions that entail learning how to use the visual aids in a participatory way are more suitable for the facilitators only.

The workshop usually takes 5-10 days and should include the following:

- ▶ Health Promotion Theory: Consensus Approach vs other approaches
- ▶ Social-psychology of Community Health Clubs
- ▶ Planning for content of the training: developing the membership card
- ▶ Planning areas of operation
- ▶ Roles and responsibilities of all stakeholders
- ▶ How to pre-test illustrations (if they are being adapted)
- ▶ Practical use of all visual aids in participatory activities
- ▶ Field practice with participatory activities
- ▶ How to do a base line survey
- ▶ Monitoring and evaluation methods
- ▶ How to write a constitution
- ▶ Mobilising the community
- ▶ Motor bike training for zero breakdown (optional)

DEPLOYMENT OF TRAINERS AND COMMUNITY MOBILISATION

After the training the membership card will have been developed and this will need printing urgently. Whilst this is being done the facilitators are deployed to their posts within the community and will start community mobilisation. This is usually done by local leadership, who call a meeting and introduce the facilitator and the aims and objectives of the programme. It is sometimes useful to arrange for a local drama group to present a health play, so as to attract a large crowd. Everyone who is interested in joining Community Health Clubs is invited to attend at a set time and place.

1st Month

Once the membership cards are ready, the first meeting is held and all those wanting to join are registered and given membership cards and numbers.

2nd meeting:

It is useful to do a mapping exercise to get an idea of local facilities and issues. This can later be transferred onto a cotton banner and embroidered for a permanent map for each club to enable a good record of number of latrines constructed.

Research should be started and a household inventory made of all the community health club members as they join. This can be done by training local volunteers.

3rd Meeting

A role play can be done simulating an imaginary clinic. Members are asked to come and present their ailments, whilst someone acting as a nurse diagnoses. This is an exploratory activity to enable both the community and the facilitators to find out more about their current level of health knowledge and what the main health problems are.



Fig. 10. A health drama is held at the first session to attract a large crowd after which people are invited to join the health club as

4th Meeting;

A name for the club as well as an election for the executive committee can be done. By this stage the number of member will have risen dramatically and the health sessions can commence.

The Health Promotion Campaign

2nd- 7th Month

If possible the health promotion sessions should be arranged to coincide with the dry time of the year to enable easier attendance and less distraction from agricultural demands.

Each week a different topic is chosen, relating to the season e.g. 'Malaria' before the rainy season

8th-10th Month

If sanitation activities have not commenced already, the health club members should now turn their attention to digging pits, making slabs, and the construction of latrines. Meanwhile repeat sessions can be held for those who have missed some topics and want to complete their membership cards. Certificates would be printed in preparation. Often there are model home competitions or health quiz, song and drama competitions for the finals in the next month.

11th-12th Month

This is a time for celebration of those who have completed their membership cards. Graduation Days become a weekly event and District Health Officers must be prepared to support facilitators and attend these festive occasions, to present certificates and prizes. Local media should be involved and as much publicity as possible given to the achievements in the press, radio and television. This will encourage a roll-on to a new intake the following year should funding allow.

MONITORING HEALTH PROMOTION AND MEASURING BEHAVIOUR CHANGE

As discussed earlier it is important to measure the cost-effectiveness of a project so that funding will be easier to attract.

Using Proxy indicators

There is enough evidence to show that if all the risk practices associated with diarrhoea are routinely done, diarrhoea will be minimised. Therefore instead of asking people when they last had diarrhoea, or if anyone in their family has had diarrhoea in the last week, it is far more reliable to check the **proxy indicators** of diarrhoea, because these are empirically observable, and verifiable (can be rechecked by others). A house-to-house survey using proxy indicators will show whether good hygiene is being practised in the house. A standard check list is prepared and a random sample of homes selected (See below). Enumerators observe what is in place at the time of inspection. Empirical or observable data is used as reported information is not usually as reliable.

There are two ways to measure the effectiveness (outputs):

1. Before and after in the same community:

By doing a household inventory before and after the project; the difference in practices can be observed and therefore measured within the same households.

2. Comparing two communities

If a base line survey has not been done prior to intervention a survey can be done on the Community Health Club area and then compared to a similar area where there have been no health clubs.

Random Sampling

There are seldom enough resources to monitor every single member of the health clubs so to achieve results that are accurate it is important to take an accurate sample of the whole population. This is done by random sampling which is an unbiased way of ensuring that every single household would have the same chance of being selected. For example a sampling frame could be made from an alphabetical list of all health clubs operating in the area, and if every fifth club in the list is chosen, all clubs have a fair chance of being chosen, and there will be minimal selection bias. If the number of household surveys is at least 30% of the whole population the results should reflect the rest of the population. By using a statistical analysis that indicates how high the probability (p) of being true to the real picture, the data will be more convincing. Standard deviation (SD) and p values and can be done on computer packages such as *SPSS* or *Stata* and will greatly enhance the credibility of the results.

How to measure Cost-effectiveness

As explained above the 'Consensus Approach', this methodology is particularly strong in its capacity to calculate cost -effectiveness.

Community Health Clubs can quantify the number of:

- ▶ members
- ▶ beneficiaries :number of members x 6 (average family size)
- ▶ health sessions have been held
- ▶ attendance at each of the sessions per club

This can be balanced with the cost of the trainer in terms of transport and allowances:

$$\text{Cost per beneficiary} = \frac{\text{cost of trainer} + \text{training} + \text{transport}}{\text{Number of beneficiaries}}$$

AVOCACY AT NATIONAL AND INTERNATIONAL LEVEL

A District that succeeds in creating a demand for sanitation and improving sanitation coverage should advocate for the Consensus Approach at National level for the program to expand into other districts. It is far more convincing for Central Government to be able to see on the ground concrete changes than to read reports. Therefore if there is National Forum which can provide a platform for this information to be disseminated it would be a good opportunity to provide a model from which the approach can be scaled up to National Level. This will provide an opportunity for advancement for the facilitators to become national trainers in the Community Health Club Methodology and PHAST Approach. It will also attract additional funding to the districts, which are successful. Regional Conferences such as the annual WEDC Conference encourages practitioners in Africa and Asia to write up their achievements and allow others to learn lessons from their experience.

It is important for the Water and Sanitation Sector that Health Promotion practitioners, who have seen some success in their programmes, present their findings to the larger academic community so that other may learn and emulate their achievements. If a paper is submitted at a conference but not accepted in a peer reviewed journal it is unlikely that it will be noticed by academics who will discount the findings as 'grey literature'. This is most unfortunate as despite the fact that many projects have achieved some outstanding breakthroughs in community development, the academic world are still decrying the lack of rigorous studies, particularly those which can convincingly demonstrate cost-effectiveness of hygiene behaviour change. It is therefore most important that project planners should record findings in a scientifically acceptable way, and present it to the academic community. Assistance and advice can be sought from any university to achieve this standard.

The Need for Rigorous Health Promotion Studies

Loevinsohn (1990) has produced guidelines that, if followed, will enable others to seriously consider their achievements in the light of an academic scrutiny. Unfortunately after finding at 67 Health Intervention Studies he could only find three articles that reached this high standard. A later review (Cave and Curtis, 1997) found only five more. As so few studies were able to meet this demanding criteria, this was subsequently modified (Ahern, 2000) into **essential** attributes and **desirable** attributes of a rigorous study, which are easier to achieve (See Table 2 below) To meet the 3rd criteria, it is easier to find an economist or statistician to assist with working out **p** values, and confidence intervals (CI) as these can be readily calculated by computer once the process is understood. If these are included the paper will have much more validity.

Essential Attributes

1. Description of target audience, including level of education
2. A controlled study with 60 individuals or two clusters
3. Adequate description of the promotion techniques resources and processes to enable replication
4. Outcome variable measured with p values and/or CI as well as measured before and after intervention
5. Confounding, bias and caveats addressed

Desirable Attributes

1. Socio-demographic characteristics of intervention and control group measured and comparable
2. Details of cost of the intervention
3. Details of distance between groups and how cross-contamination was avoided
4. Details of project sustainability
5. A study based on explicit theory
6. Time-table for baseline survey, intervention and follow-up survey and evaluation

Table 2. Essential and desirable attributes for a rigorous Study (Ahern, 2000)

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WEBSITES

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LIST OF ABBREVIATIONS

A.H.E.A.D.	Applied Health Education and Development (Zimbabwe AHEAD, Africa AHEAD)
CHC	Community Health Club
DFID	Department for International Development (UK)
EHT	Environmental Health Technician (Zimbabwe)
IRWSS	Integrated Rural Water Supply and Sanitation (Zimbabwean Organisation)
HIDO	Health Integrated Development Organisation (Ugandan NGO)
LSHTM	London School of Hygiene and Tropical Medicine (University of London)
NGO	Non Governmental Organisation
MDGs	Millennium Development Goals (United Nations)
PHAST	Participatory Health and Sanitation Transformation
PRA	Participatory Rural Appraisal
RWSG-ESA	Regional Water and Sanitation Group, East and Southern Africa (World Bank)
SARAR	Self esteem, Associative Strength, Resourcefulness, Action-planning and Responsibility
TALC	Teaching Aids at Low Cost (UK Organisation)
UNDP	United Nations Development Programme
VIP	Ventilated and Improved Pit Latrine
WEDC	Water Engineering Development Centre, Loughborough University, UK
WELL	Resource Centre Network for water, sanitation and environmental health (DFID)
WHO	World Health Organisation

Glossary of Terms:

Community : a number of people who share a distinct location, belief, interest, activity or other characteristic that clearly identified their commonality and differentiates them from those not sharing it, (Hoffman, 1994).

Community Based Organisation: (CBO) A common-interest association operating at village level, founded and run by community members themselves for their own objectives.

Cognitive Need: Intellectual interest in knowledge

Cognitive Learning: Informed decision-making based on understanding factual knowledge

Community Health Clubs: voluntary, common-interest associations at community level, formed to provide a forum for health information and good hygiene practice with the aim to improve family health.

Community Led Total Sanitation an innovative methodology for mobilising communities to completely eliminate open defecation. by participatory facilitation, community analysis and action, and no hardware subsidy (Kar & Pasteur 2005).

Conformity: The strong inclination to be similar to the majority within an identified group; sharing values, belief, attitudes and behaviour

Consensus Approach: a training methodology that aims to develop functional communities by modifying the determinants of health to ensure long-term hygiene improvement through positive behaviour change (Waterkeyn, 2006)

Cultural change: the alteration of norms and values between two opposing worldview's thorough innovation, diffusion, cultural loss and acculturation, (Haviland, 1993).

Culture: A set of shared ideals, values and standards of behaviour which is the common denominator that makes the actions of an individual intelligible to the group (Haviland, 1993).

Culture of health: voluntary adherence to the norms and values, beliefs and actions that are focused on achieving the ideal of good health.

Empowerment: enabling individuals or communities to enhance their ability to control their immediate environment or to make personal choices, which make effective use of available resources.

Gender: The elaborations and meanings assigned by cultures to the biological differentiation of the sexes (Haviland, 1993).

Group consensus: the general agreement within a group as to basic understanding of an issue, the acceptance of certain information as true and the ability to work together to achieve agreed objectives

Health education: refers only to the *actual transfer of factual information* on health and hygiene, which forms part of the training content within the health sessions.

Health Belief Model: attempts to identify beliefs interact to influence and the way they may interact to influence individuals conscious decision to undertake certain health related activities (Janz & Becker, 1984)

Health Promotion: the process of enabling people to exert control over the determinants of health and thereby improve their health

Key message: a one sentence slogan containing core information on a topic provided to assist rapid assimilation of an important health fact.

Methodology: a method used in training or organisation

Membership card: an identification document, listing particulars of a Community Health Club member, and health topics attended, and hygiene recommendations adopted, signed weekly by the facilitator

Model: a temporary conceptual construction used to assist our thinking prior to the formation of a proven theory (Bunton and Macdonald, 2004).

Millennium Development Goals: international declaration at the 2000 Millennium World Summit on Sustainable Development Plan of Implementation

- Norms:** expectations by a group of people about appropriate behaviour, which serve as common guidelines for social action (Abercrombie et al., 2000).
- Participatory Activities:** training games that involve and empower people, enabling them to contribute their ideas.
- Perspective:** Core assumptions about how a certain theory is generated (Bunton and Macdonald, 2004).
- Reciprocity:** The exchange of goods and services of approximately equal value between two parties (Haviland, 1993).
- Self-efficacy:** Perceived personal ability to affect change (Bandura, 1977).
- Society:** A group of people who occupy a specific locality and who share common cultural traditions (Haviland, 1993).
- Social Capital :** Features of social structures, such as levels of interpersonal trust and norms of reciprocity and mutual aid, which act as resources for individuals and facilitate collective action' (Coleman 1990)
- Social Marketing:** the planning and implementation of programs designed to bring about social change using concepts from commercial marketing, such as popularising the product by subliminal messaging.
- Social Structure:** The relationships of groups within a society that hold it together (Haviland, 1993).
- Standard PHAST:** An initiative introduced by RWSG-ESA, World Bank, based in principles of SARAR methodology, adapting participatory training for the promotion of hygiene and sanitation at the PHAST Training (Harare, 1993) in the pilot projects in Zimbabwe, Botswana, Mozambique, Uganda and Kenya
- Structured participation:** A health promotion methodology that uses the same participatory training activities as PHAST, but within Community Health Clubs and with set standards of hygiene.
- Sustainable Livelihoods:** A concept of poverty eradication through programmes than can be continued by the community without reliance on outside assistance (promoted particularly by DFID)
- Tradition:** cultural practices within a modernising society, which may oppose new forces of differentiation and integration (Haviland, 1993).
- Traditional Culture:** the norms of an indigenous culture, prior to absorbing of alien values
- Theory:** Systematically organised knowledge applicable in a relatively wide variety of circumstances devised to analyse, predict, or otherwise explain the nature or behaviour of a specified set of phenomena that could be used as the basis for action (Van Ryn & Heany, 1992).
- Values:** a fundamental outlook recognised by the group of people in question, which provide a general standard by which the group or society maintains a certain identity which informs their most likely action.
- Vehicle for development:** a structure within a local community that has the mandate to manage local initiatives
- World View:** The conceptions, explicit and implicit, of a society or an individual of the limits and workings of its world.