



## Structured participation in community health clubs

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ZIMBABWE A.H.E.A.D IS a Non Governmental Organisation which has pioneered a innovative methodology mobilising rural people through the establishment of 'Community Health Clubs'. The organisation aims to improve family health through the provision of health education leading to safe sanitation and improved hygiene. This emphasis is reinforced by recent WHO studies confirming that whilst water quantity reduces diarrhoea by only 15% and water quality by 27%, sanitation is by far the most effective sole intervention with 37% reduction and good hygiene almost as effective with 35% success. (Esrey:1998).

Within the past two years, 200 Community Health Clubs have been established in 5 Districts of Zimbabwe, with around 10,000 members. They are proving that not only do they stimulate a strong demand for improved sanitation but that they actually promote positive behavioural changes leading to greatly improved levels of hygiene in the home.

This paper analyses Community Health Club from a social perspective, demonstrating how and why they are formed. It also explores the reasons for the popularity of the clubs and looks at the psychology behind the success of this new methodology.

### Developing a common unity

We are accustomed to use the term 'Community' to refer to beneficiaries, and this has an underlying assumption that they are already linked in a common bond, and will act as one. This misconception may be the root cause of many disappointments when the 'community' does not 'participate' according to expectations. The A.H.E.A.D methodology, by contrast, rests on the assumption that a group of rural householders living in the same area *need firstly to become organised as a group*, sharing the same norms and ideals, before any meaningful change can be expected. Thus we dedicate the first phase of any project to engendering this 'common unity' of purpose.

### Using health education as an entry point

One of the least controversial means of achieving this is through adult education. Improving family health has a broad appeal because it is not merely academic but applies to our daily lives. Every mother seeks to do the best she can for her family, and the chance to attend a health education course is seldom rejected. Unlike water and sanitation projects where there may be some sort of material subsidy, health education offers nothing but information and a certificate! This has the advantage that there is no rivalry

for gain. On the contrary, the discussion of health issues give neighbours a chance to get to know each other, not just as 'the mother of a child', or 'the one who lost her husband last week', but as a thinking individual, and for a change they can interact socially on an *intellectual* basis.

### Intellectual starvation

Another of the assumptions that direct the A.H.E.A.D. methodology is the perception that there is an 'intellectual starvation' in the rural areas of most Third World countries. Whilst education is a highly valued commodity, and parents are prepared to sacrifice their own needs to keep a child at school, this achievement is dissipated when he/she leaves school. Although now fully literate and intellectually awakened, the school leaver soon falls back into a bucolic mist where few academic challenges are placed before the mind. Early marriage, the demands of large families and the scarcity of reading matter in the rural areas does the rest. A mind primed for take off falls back to the earth.

What the Community Health Clubs offer is a regular chance to reawaken this intellect and to debate relevant topics, that empower them to take their families' health into their own hands and become an authority in the home. Hence the attraction of gaining a certificate which may be the first qualification since leaving school.

### Developing confidence

Planners often mistake the inertia of peasant communities as a sign of apathy, when in many cases it is a distrust of one's own subjectivity, due to a lack of knowledge. This lack of confidence in one's own judgement can be turned around to become a driving force for change once a person knows with full assurance that she understands all the implications. After meeting weekly for at least six months and debating health topics which include the germ theory, preventable diseases, and hygiene generally, an uneducated woman becomes an 'expert' and can take informed decisions accordingly.

### Community health clubs

The Health Club is the vehicle for this process, allowing a dedicated hour in the week to focus on health related issues. It is the means of bonding rural householders into more than just a collection of individuals. It fosters a shared ideology and a culture of self-improvement.

Women's groups and participatory training techniques

have been common for some time. However, the A.H.E.A.D methodology employs a *systematic* programme of ‘structured participation’, which puts these two aspects together into a sustainable strategy. This is not just a theory, but a highly effective and proven implementation model for mobilising communities to develop the capacity to manage and sustain effective Water and Sanitation projects or any other development they have identified.

### Sustainable development

Most people in ‘development’ are now fully aware that the ‘participatory approach’ is the most effective means of training because it fully involves every person, eliciting individual opinions about issues, and this leads to a personal commitment towards a goal. As most project planners now appreciate, this is the key to sustainable development. Before anyone acts, they have to know *why* they should act. By spending time initially working through

health issues, the members become committed to improving their existing standard of living.

It has been shown that Community Health Clubs lead to behavioural change in all areas of personal hygiene, and create a strong demand for safe sanitation. Statistics gathered from one of the project areas reported cases of diarrhoea at the local clinic fell from 150 the previous year, to 79 during the year that Health Clubs had become active in the area. (a decrease of nearly 50%).

### Structured participation

However participatory training *on its own*, does not automatically lead to change. The well known participatory activities are merely amusing exercises unless they form part of a full Health Education *Campaign* that continually reinforces the messages that have been learnt. Thus a one-off health education session, although it may *enlighten* participants, will not be the trigger for change unless it is

**Table 1. Cost of health education per beneficiary in Gutu District, Zimbabwe for 1998 (RoE US\$=Z\$38)**

Ward	8		13/14		17		3		29		TOTAL
EHT	Chinamatira		Gwandure		Mushandu		Jeranyama		Mahofa		
Month	T & S	RfH	T & S	RfH	T & S	RfH	T & S	RfH	T & S	RfH	
March	220		180		—		270		250	226	
April	360		110		—		570		—		
May	540		140		160		375		110	106	
June	540		140		—		228		370	60	
July	520		—		580		350		270	47	
Aug	510		260		—		—		290	68	
Sept	480		330		—		—		340	64	
Oct	320	1986	449		910		—	2879	260	38	
Nov	2080	13656	1176		2860		—			5513	
Dec	1060	855	650		1430			12521	1560	2608	
Training	10000	2500	10000	2500	10000	2500	10000	2500	10000	2500	
Motorbike		25000		25000		25000		25000		25000	
<b>TOTAL</b>	<b>16630</b>	<b>43997</b>	<b>13435</b>	<b>27500</b>	<b>15940</b>	<b>27500</b>	<b>11793</b>	<b>42900</b>	<b>13450</b>	<b>36290</b>	<b>249,435</b>
No of clubs	3		7		10		12		12		44
HE sessions	127		64		83		69		88		431
Average attendance	81		54		68		42		86		80
Members	273		255		660		616		466		2270
Beneficiaries	1365		1275		3300		3080		2330		11350
Cost per member	Z\$165		Z\$160		Z\$65		Z\$85		Z\$80		Z\$109 US\$3.3
Cost per beneficiary	Z\$33		Z\$32		Z\$13		Z\$17		Z\$16		Z\$22 US\$.57

T & S = Transport and subsistence allowance (Gov. rates)

RfH = Riders for Health Organisation: mileage charges for motor bikes (only supplied in October)

HE Sessions refers to Health Education Sessions

Members refers to the number of card holding members of the Community Health Clubs

Beneficiaries refers to number of family members affected by improved hygiene of member (taken as 5 per household)

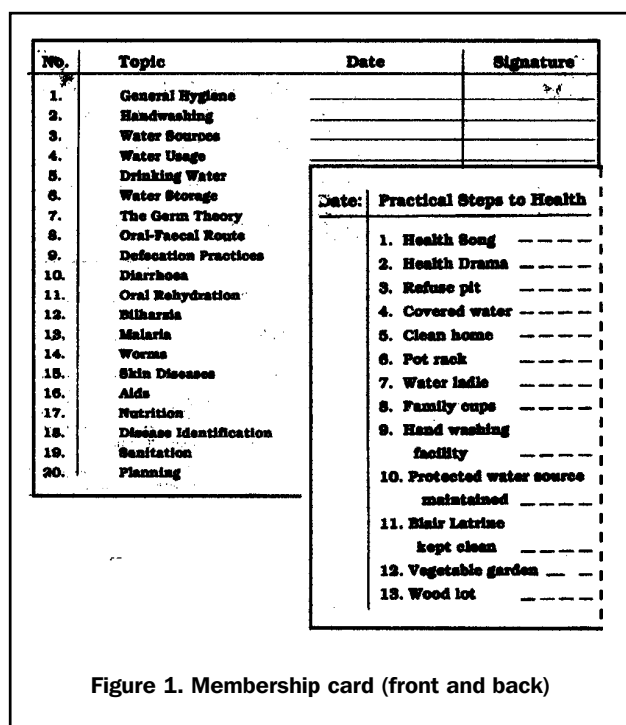


Figure 1. Membership card (front and back)

## Monitoring and evaluation

The membership card not only gives a sense of identity and purpose to the members themselves, but also ensures that the health worker responsible for facilitating these sessions is committed to the full programme. As many field staff will bear witness, this is not a programme for the faint hearted as they tend to find themselves driven by the enthusiasm of their communities. This invariably develops a real commitment within them to complete the course of sessions, and there have been cases where the field worker has even forfeited his leave to finish the course! Job satisfaction and the respect of the community are some of the real attractions of this methodology for field workers. As the facilitator must sign the membership card of each member, at each session, their own presence is recorded and can thereby be monitored by senior officers who can verify that their staff have completed the number of sessions claimed.

## Quantifying health education

This makes health education *quantifiable* and thus more attractive to donors and implementing agencies who want to be able to see where their money goes. In the past, sanitation and water provision has been more popular than funding health education, often because it is possible to visit these hardware installations. However Community Health Clubs are *just* as tangible and a *lot* more inspiring to donors who become infected with the high spirits and enthusiasm of club members.

## Issues of time

One of the most difficult challenges for the time-bound foreigner who is trying to achieve targets set in capital cities, is to get into 'field-work gear'. This is a more gentle approach to achievement, where 'what can be done today, can equally be done tomorrow' - not an easy exercise for the racy urbanised mind! When we start trying to change traditional structures we run up against cultural values that are the opposite to our own.

Firstly is the concept of 'cyclical' time, which is based on the regular rotation of the seasons, a natural rhythm which peasant cultures have tuned into to from time immemorial. By contrast, the Western-trained mind, divorced from nature, embraces *linear* time: the ever-onward arrow pointing to the future, implying progress. These two outlooks clash in development projects, and it needs the socialisation of new values within the Health Clubs to adjust 'cyclical' thinking to the 'linear' mode of progression.

Tied in with this, is the 'world view' that rests on 'present-day orientation', as opposed to 'future-orientation', which focuses on the need for daily maintenance in the interest of long term sustainability. Thus Community Based Management can only become a reality once the core values that control behaviour have adjusted towards a future orientation. This touches on issues related to poverty because a subsistence outlook is rarely accustomed to planing beyond the next harvest.

part of an on-going exercise. It is the difference between having an overdose of Vitamins by drinking a bottle in one sitting, or taking a spoonful a day so that the body is nourished slowly but surely. The Health Club system ensures that members meet once a week for at least 20 sessions over six months during which time the issues are constantly revisited. Peer pressure and support provide the impetus for change. The structure of the programme is provided by a definite syllabus for Health education sessions.

## Contract with the beneficiaries

Just as when *you* come to a conference you want to have a programme before you so that you can contribute your input as it suits you, so with rural householders who also appreciate knowing where they are going in a project. It is this aspect that seems to have been neglected in health education programs.

We have designed membership cards that provide the 'contract' with the beneficiaries, enabling them and the facilitator to have a shared commitment to the project. When the first gathering of people are issued with membership cards, they realise that this is a serious programme, and can see the way forward. They can see which topics are going to be covered and can plan which they would like to attend. There is the added incentive that if they manage to complete all the topics they will gain a certificate, and the status of being a 'star pupil' has encouraged a high attendance rate (See Table 1.) at Health Club Meetings. Clubs vary between 30 and 150 members, but the average attendance last year in 120 clubs has been 80 people per session.

## Conformism

Another striking difference between the cyclical peasant culture and the linear urban culture, is in terms of conformity. We may tend to overlook this aspect, but it is another key value that determines the ability to accept change. For example on a sliding scale between individualism and conformism, the one extreme is American culture which tends to value individualism, whilst at the other end African culture places strong emphasis on conformity as a positive virtue. Children here are socialised to defer to adults' views, wives to the husband, and young intellectuals must respect their uneducated elders and conform to traditional behaviour. By contrast bourgeoisie parents tolerate their precocious off-spring because of they are trying to develop their children's drive and ambition. Whilst in rural communities the need to conform can be used in a positive way to achieve solidarity, it is also responsible for the PHD (Pull him Down) syndrome! The strategy of the Community Health Club is to use this cultural norm creatively, and harness it towards promoting change.

## Consensus verses competition

It was once said by Julius Nyerere, that whilst in the West political democracy involves the antagonism of two oppos-



Figure 2. Badza stand and wash hand facility with soap: a standard requirement for all club members in Tsholotsho

ing parties, 'in Africa we sit under the tree until we agree'. This is exactly what happens in the Health Clubs, and it takes time. Individuals are not comfortable in taking a unique stance and swimming against the tide. The culturally acceptable thing to do, is to be the *same* as your neighbour. Therefore the only way to affect change is to bring everyone up together and this requires a lot of resources and a lot more planning.

However, once a group decision has been made, all members aspire to achieving these goals, and are encouraged by the club to conform. For example, it becomes mandatory for a club member to have a 'badza (hoe/jembe) stand', with soap and a wash hand facility in their homestead, so that the family can practise safe sanitation even if it does not yet have a latrine.

In areas where there are active Clubs, project planners have been hard pressed to keep up with the demand for sanitation. Peer pressure or in sociological terms, 'majority influence' provides the impetus for change. The need to conform is a cultural value that can be harnessed to bring about change by consensus, or 'common unity'. Once this is achieved the group can now properly be called a 'community'.

## Capacity building in the community

What started off as health education meetings becomes a regular organisation on the ground that can be useful to other development agencies. Agricultural Extension officers often join the Health Workers and use the same session to do their business and local arrangements can be made. Leaders emerge naturally, and the club becomes a pressure group for progress. It develops the capacity for planning systematically and making informed and democratic decisions. The Health Club methodology achieves this 'capacity building' by promoting intellectual activities that lead to behavioural change. This is engendered by a sense of a *social* rather than *personal* identity and encourages solidarity. With a successful project they attract attention from the outside world which gives the members a feeling of worth as they are contributing to something larger than their own village.

## Holistic development

*Applied* Health Education and Development (A.H.E.A.D.) is the central concept of the Community Health Club methodology. The Organisation tries to implement projects with a holistic approach that takes the form of three main phases of operation. This approach has proved so effective in the Makoni Health Education Pilot Project that it has now been replicated in five other Districts in Zimbabwe within the past year. The first phase is Health Education which leads to a natural demand for improved water and sanitation (i.e. *applied* Health Education), followed in the third phase by an effort to address the *underlying* problem which is, of course, poverty.

Once the clubs have been going for a few years they move on to a variety of development activities to improve their standard of living. For example in an area where clubs were established in 1995, there is now a viable hand-made paper industry which last year generated nearly US\$ 2,000 for the area, involving over a hundred people. There are now 25 skilled paper makers and their support teams collecting and processing locally available fibre. Women can subsidise their income locally, on a part time basis, and learn skills that augment their family income.

### Conclusion

The organisation of rural householders into a community is one of the foundation stones of any development. To try to implement a project without a social structure in place is like throwing words to the wind. Communities are not just 'out there' waiting to benefit from projects, they have organise themselves first so as to take an active and informed lead in their own development.

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