



## Health clubs - hygiene education in Bikita IRWSSP

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BIKITA INTEGRATED RURAL Water Supply and Sanitation Project (BIRWSSP) is situated in the south east of Zimbabwe, covering a district with a population of approximately 200,000. The project is de-centralized, managed by the Rural District Council, implemented by an integrated team from the government ministries of Health (MOH), DDF, MNAECC, Agritex, Forestry and Natural Resources, and is funded by DFID through the National IRWSS Programme.

### The place for health education

Health education is playing an important role in BIRWSSP, helping to promote improved knowledge, attitudes, behaviour and practice (KABP) towards improving the quality of life of the residents of the district. The way in which this is being done and the way in which we have sought to evaluate our work is an interesting development. With this paper we hope to share our ideas and pass on our experience to others who may find it useful as a model that can be adopted elsewhere.

### How the health club approach became adopted

In our search for an effective way of promoting health and hygiene education, we visited Makoni District in February 1997 where the indigenous NGO Zimbabwe AHEAD was developing health clubs as a pilot in three wards. We found it a new and exciting way of getting health education across and we decided to adopt this approach as the mainstay of our health education programme for all the 28 communal and small scale farming wards in our district.

### What is the health club approach

The approach is based around a club formed at village level, where villagers are encouraged to join a structured weekly course of participatory health education classes run by the MOH ward Environmental Health Technician (EHT). As part of this process each participant is given membership card, with topics on one side and on the other a number of suggested household improvements and activities in support of the lessons. These are signed off by the EHT when achieved. To date there are 72 active health clubs with on average in excess of 100 members, representing approximately 40 per cent of the district. This is continually expanding as the project progresses, and is proving popular with EHTs who find it a rewarding way of doing their work. The success of health clubs as a method is apparent

from their high attendance; the groups are free, open for all to join at any time, and topics are covered and recovered without generating any fall in membership. The popularity of this approach is as much the enjoyment of joining a group, as the desire to obtain health and hygiene knowledge. Sessions are entertaining and offer, along with church meetings and beer parties, a distraction from a hard week working in the fields and undertaking household duties. In Bikita District we have also linked the sanitation component of the project to the health clubs, to achieve maximum effectiveness of latrines as a physical amenity to break the faecal oral transmission route. This link may also have had an impact in encouraging health club membership, as there is a subsidy offered for latrine construction. However it needs to be emphasized that the popularity of the clubs is not solely related to cement for latrine building, as the clubs predated the provision of materials and members have continued to be active after they have built their own VIP latrines.

### Knowledge, attitudes, behaviour and practice (KABP) survey

The question remains however, are these health and hygiene education sessions at health clubs actually achieving results in terms of improved knowledge, attitudes, behaviour and practice (KABP) in the community? In order to assess this Bikita IRWSSP undertook a KABP study. The rest of this paper looks in some detail at how the study was conducted, who was involved, the results and the way in which these results are now being applied to further improve our approach to health education.

The study took a risk based approach, focusing on the health and hygiene risks which people are facing, so that the impact of the health clubs could be assessed and the outstanding risks targeted. This was approached both in terms of peoples knowledge, their lack of knowledge, and their practices in the home, at school and at social gatherings. Both qualitative and quantitative methods were used. Four villages were targeted for the survey in four different wards in the district; two of the villages had no health clubs and acted as the control, and two of the villages were chosen where health clubs were present.

The study team was recruited from other districts in the province in order to avoid bias; all mature trained health workers with knowledge of communities and local conditions, which might not have been the case with students. A gender balanced team undertook interviews and focus

group discussions; the male team members interviewed men and boys and the female team members interviewed the women and girls. This was found to be the best way to get people to open up and tell what they knew during the pre-test. It was interesting to find that men said that they felt intimidated if women were present during their sessions.

The time period allocated was sixteen days; two days were spent doing a pretest of the checklist questionnaire, another day orienting the team, and then three days spent in each village undertaking the questionnaires and focus group discussions (FGD), with a weekend day visiting social gatherings. Debriefing and discussing the results of the observation sessions took a further three days.

The quantitative methods adopted revolved around an 84 point knowledge checklist/questionnaire, a 17 point home visit observation checklist and a 15 point school visit observation checklist. The majority of the questions were scored as follows:

- A. for an un-prompted risk identification at interview, or healthy behaviour during observation.
- B. for a correct prompted answer with a correct explanation.
- C. for un-identified risk / incorrect explanation during interview or risky behaviour during observation.

To get a (B) correct explanations were sought to avoid the problem of team members misunderstanding responses during prompting by recording knowledge when respond-

ents were simply saying “yes” to every question without understanding it.

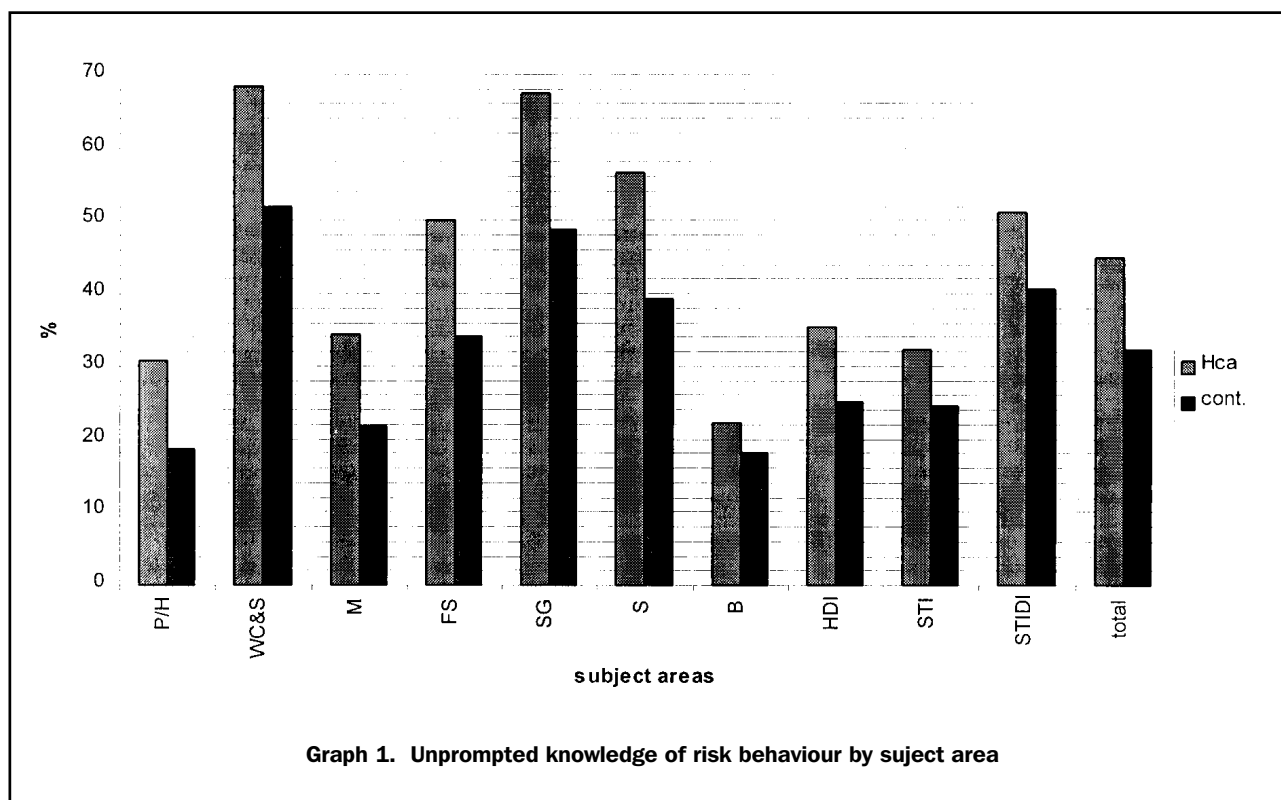
The qualitative side of the survey used focus group discussions, and visits to social gatherings such as beer parties and church groups, though checklists were also used to record and guide the researchers. Video and group work was used in the de-briefing sessions to record as much as possible from the researchers observations and insight.

### The Results

The results from the quantitative side of the survey were entered into the computer using the “Excel” spreadsheet, and graphs were used for illustration. The results from the control areas appear in the darker colour and the results from the areas with health clubs are in the lighter colour. Note that the higher the percentage the greater the knowledge.

Table 1 shows a clear trend of increased knowledge in areas with health clubs. This information has been fed back to the EHTs to give a greater understanding of the impact of their lessons and to assist them focus more effectively.

With Table 2 individual risk factors have been isolated to show the percentage of un-prompted responses by both the health club area and the control area. The most pronounced change in knowledge is using separate cups for drinking water (risk 3) which is one of the health messages that has been specifically promoted by the health clubs. Changes in knowledge are however not always so pronounced as shown in the examples above, awareness of the



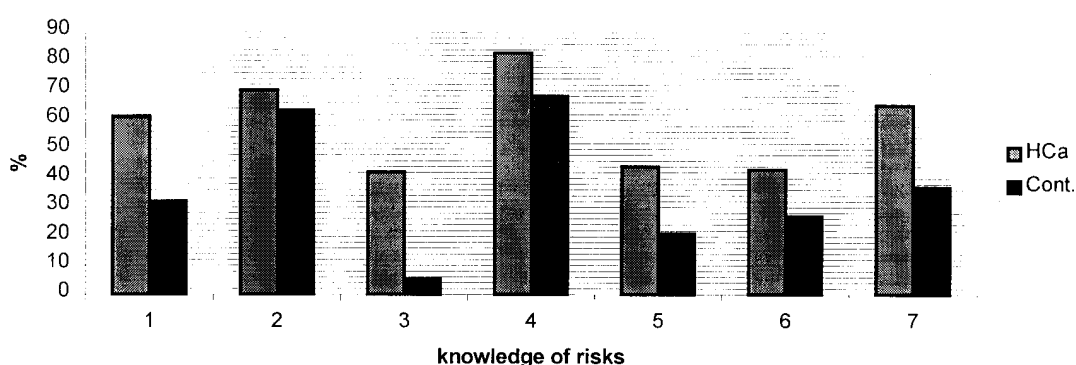
risk behaviour associated with bilharzia was found to be very low in both the health club group and the control group, a risk which needs to be addressed as 4,519 cases were recorded at clinics in the district during 1998. An example of an STI indicator is given by Risk 7 and shows that health clubs are having some impact in this vital area. With HIV /AIDs now the new number one killer in Africa and average life expectancy in Zimbabwe down from 60 to just 39 years, it is important that health education is not restricted to purely hygiene related topics.

Table 2 refers to knowledge, but what of practices? have these been changed by the health clubs? In this case the higher percentage indicates the greater risk.

In this Table 3 the hygiene risks observed at the homesteads of the respondents are shown. The beneficial effects on behaviour change in health club areas is evident. Thus the health clubs are shown to be having a beneficial effect on both behaviour change and knowledge.

The information collected in the focus group discussions with adults supported the questionnaire work, with greater

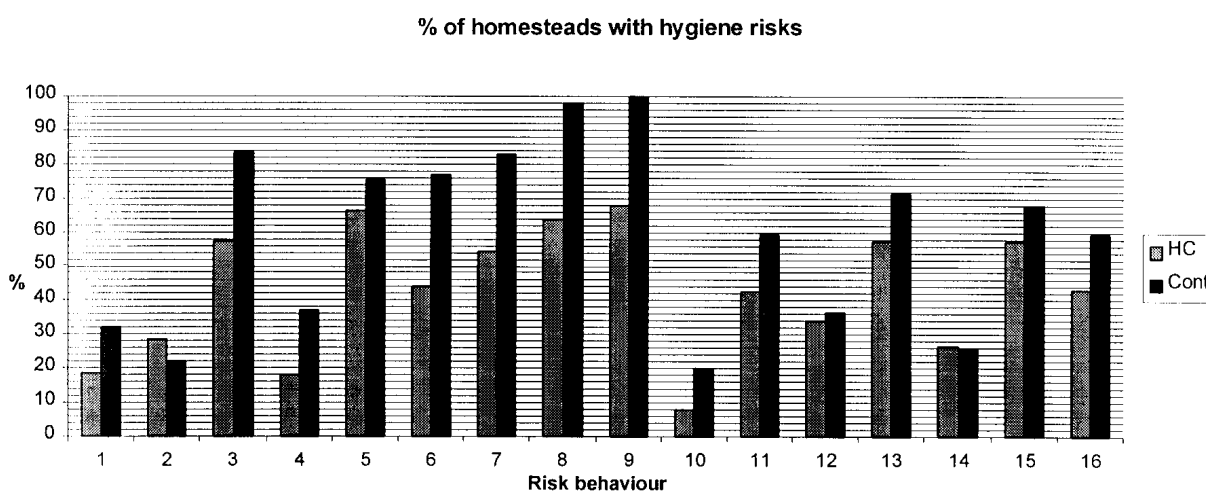
**Graph 2. A selection of risks identified by respondents without prompting**



The headings are as follows:

- Risks Identified: 1 = not hand washing after visiting the latrine, 2 = not hand washing before handling food
- 3 = not having separate cups for drinking water, 4 = using streams and rivers for drinking water
- 5 = not covering faeces in the fields, 6 = leaving children's faeces in the yard
- 7 = having sexual intercourse with prostitutes

**Graph 3. % of homesteads with hygiene risks**



knowledge aparent in the health club areas. The observations and questionnaires at schools showed only a minimal rise in health knowledge in health club areas, suggesting that little is being passed on from parents to children. This has helped to justify the decision to initiate school health clubs this year. The results of the visits to social gatherings such as beer parties and church meetings were also eye opening. Health and hygiene risks are a major problem at these gatherings with the difference in behaviour between control and health club areas was less apparent. Lack of facilities at the gatherings results in unsafe practices, such as defecation in the open, and little or no attempt at hand washing or the effective cleaning of beer mugs and other utensils. More worrying however were the high levels of promiscuity that became clear to the study team. This would seem to have become a cultural norm and so a more radical approach is required to change this risky behaviour. In debate with the study team the suggestion was made that influential leaders such as chiefs, kraal heads, religious and

political leaders be involved to use their influence. It is difficult to see how even the dynamic intervention of health clubs can on their own hope to overcome this.

The information presented here is only a small proportion of the total data produced during the KABP study in Bikita. This information is being used by BIRWSSP to further study and assess the impact of the health clubs and to develop the health and hygiene education strategy in the district.

From this experience we can categorically state that health clubs are a successful method of promoting health and hygiene education, resulting in beneficial behaviour change.

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