MSF Environmental Health Toolkit

Community Health Club Handbook

Tool kit component 1.2

MSF Zimbabwe mission

Abstract

This manual outlines the Community Health Club (CHC) approach and how this approach has been specifically used by MSF as a sustainable way of running water points and teaching communities on health and hygiene issues. The manual covers how community hand pumps and newly drilled boreholes have been upgraded to water points that provide communities with clean and safe drinking water. How communities have been trained on health and hygiene issues for behavior change and their involvement in running the water point to ensure sustainability. This approach has been implemented in low income, high density suburbs of Harare, Zimbabwe, which have been identified as the epicenter of diarrheal diseases.

The approach is ready to roll-out in the similar contexts where community involvement is crucial for the sustainability of the humanitarian interventions in WASH sector. This methodology has been implemented by MSF with the support of various stakeholders including City of Harare Department, Health Promotion Department, Ministry of Health and Child Care, Church leaders and Schools responsible (where water points were established), local community leaders and political leaders.

Acknowledgements

MSF would like to acknowledge that the Community Health Club methodology was an adaptation from Africa Ahead's methodology. As an organization, MSF is grateful to all the who made our work easy and successful. This includes MoHCC, City Health Department, Local governance authorities (D.Os), Political leaders in the communities, Institutions such as clinics, churches and schools, where water points were established so that communities could access clean and safe drinking water. MSF would like to thank all the communities worked with, for their support and embracing the methodology. Last but not least, MSF would like to acknowledge the great role played by community based health promoters and community based facilitators, who made the CHC Methodology dream alive on the ground through mobilizing communities to participate in the CHC Methodology.

Acronyms Table

MSF	Médecins Sans Frontieres
MoHCC	Ministry of Health and Child Care
C.O.H	City of Harare
CHP	Community Health Club
CBF	Community Based Facilitator
EHT	Environmental Health Technician
WPC	Water Point Committee
WASH	Water Sanitation and Hygiene
NGOs	Non-Governmental Organizations
DHPOs	District Health Promotion Officers
T.O.T	Training of Trainers
PHHE	Participatory Health and Hygiene Education
O & M	Operations and Maintenance
KAPs	Knowledge, Attitudes and Practices

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Background

Harare's low-income high density settlements have been the epicenter of recurring outbreaks of cholera, typhoid, dysentery, watery diarrheal and rotavirus since the 1990s climaxing in the well-known cholera outbreak between 2008 and 2010. There have been recurring spikes of typhoid (2010, 2011 and 2012) and diarrheal diseases each year since then. MSF responded to these emergencies by first intervening in the cholera outbreak in 2008. In 2011, MSF set-up 2 Typhoid treatment centers and 8 "safe" drinking water points in two suburbs of Harare. In 2014, MSF supported the City of Harare to carry out a water quality survey in various areas and installed 4 "safe" drinking points in Hatcliffe, Caledonia, Glenview and Mabvuku suburbs.

The WASH as Prevention Project was founded in 2015 in response to continuous outbreaks in the low income, high density suburbs of Harare, Zimbabwe; these have been termed epicenters of diarrheal diseases because of continuous recurrences. These epicenters have been Budiriro, Mbare, Glenview and Kuwadzana, and have been the main focus during the lifetime of the project. However there are other low income, high density suburbs that have benefitted from the programme because of their dire need for the availability of clean and safe drinking water. Since 2015, WASH as Prevention Project has been focusing on providing communities with safe and clean water as a strategy to prevent outbreaks of water-borne diseases such as typhoid and cholera. This has been done through drilling new boreholes and upgrading the existing ones with hand pumps to water points that have submersible pumps, tanks, taps and in line chlorinators. However it was realized that giving communities clean and safe drinking water is not enough without teaching them the need for behavior change, especially on issues of health and hygiene, thus roping in the concept of the community health club approach around a water point. The issue of the day to day operations of the water point and sustainability also strengthened the CHC approach, as the CHC members were roped in as primary custodians of the water points.

Definition of CHC

A community health club (CHC), by definition is a group of people from the community, brought together by a common understanding, and are willing to learn health issues that affect them as a community and are willing to become ambassadors of change in the community through practicing and sharing information learnt. The core goal of CHC is to share information with community members that will improve the overall understanding of health and hygiene behaviors, as well as help foster skills needed for self-initiated development of the community (Azurdy, 2007, 4). For MSF, the Community Health Clubs have been formed around water points, their purpose has been to

become ambassadors of health and hygiene in the community and to maintain and run water points, after being trained by MSF.

CHC methodology

The Community Health Club (CHC) education model for hygiene was officially introduced in Zimbabwe in 1994 as part of the Africa AHEAD (Applied Health Education and Development) program. It had measured success in multiple African communities in achieving health goals, such as tuberculosis control and sanitation (Azurduy, 2007, 23). CHC's primary purpose is to encourage healthy behavior changes within a community by building a group consensus for these measures. Using structured, measurable and inclusive methods AHEAD recognizes that community development is a long-term process. CHC provides a relatively low-cost method that is easy to monitor, adjustable to regional customs, and works well with traditional forms of community organization (Waterkeyn, 2005, 1960). Through reinforcement, the CHC uses participatory learning methods to share information in a manner consistent with most traditional community gatherings. In addition, its club meeting structure has also been shown to develop leadership skills that aid in overall community strength. This is significant, since it has been established that community engagement and cohesion is vital to overall community success (McMillan, 1986, 8-9).

The core goal of CHC is to share information with community members that will improve the overall understanding of health and hygiene behaviors, as well as help foster skills needed for self-initiated development of the community (Azurduy, 2007, 4).

The Community Health Club approach relies entirely on community empowerment for health and development issues. There are three major components being implemented in phases. The first component is the Knowledge Base focusing on (i) mobilising and sensitizing the community on hygiene and sanitation through participatory approaches - PHAST, (ii) organizing communities into the 'club' arrangements based on voluntary basis, creating common unity and purpose of community health clubs (CHCs), (iii) conducting health/hygiene education through a card system and identifying practicable hygiene and sanitation interventions.

In relation to the above definitions and ideas of the CHC methodology, MSF has borrowed from Africa Ahead's methodology of the CHC approach. However MSF CHCs have been water point based. Their main focus is learning about health and hygiene to be ambassadors of change in the community concerning issues of health and hygiene. Secondly these community health clubs are in charge of operating and maintaining water points to ensure sustainability.

What is the purpose of this manual and who is this manual for?

The community health club approach is not new to development practitioners; however in this manual this approach has been adapted to MSF WASH as Prevention Project to sustain water points in urban contexts of Harare. This manual is a guide for organizations or development practitioners who want to provide communities with clean and safe drinking water through setting up water points that are self-sustaining.. This manual includes the processes and procedures on how to form a community health club around a borehole that will be transformed into a water point. It also details from site identification, identifying community cadres to work with, establishment of community health clubs, their graduation and formation of water point committees to run water points and ensure sustainability with support from funding partners.

Structure of the manual

MSF core mandate under the WASH program is provision of clean and safe drinking water in urban Harare through water points, hence the CHC methodology was water point oriented. This manual will therefore look at the following:

- Site identification by MSF in collaboration with other stakeholders
- Sensitization of stakeholders that are involved in the WASH program
- Identification of community health cadres to work with in establishment of Community Health clubs (Community Health Promoters and Community Based Facilitators)
- Formation of Community Health Clubs and all activities that run under health clubs until they graduate
- Establishment of water points and water point committees
- Supporting and strengthening water point committees for sustainability of water points

Working definitions

In this manual there are terms that will frequently be used and there is need to define them so that readers are conversant with these terms from the beginning of the manual.

Community Health Club (CHC); A community health club (CHC), by definition is a group of people from the community, brought together by a common understanding, and are willing to learn health issues that affect them as a community and are willing to become ambassadors of change in the community through practicing and sharing information learnt.

Water point; According to MSF ; when an already existing bush pump has been rehabilitated and upgraded, or a newly drilled MSF borehole is equipped with the items listed below, it then becomes a water point. The items/material needed for a borehole to become a water point includes;

- Water storage tanks,
- Submersible pump that is powered by electricity or solar.
- In line chlorinator
- 2 Aprons with taps
- Solar panels

Water point committee (WPC); this is a committee selected from the health club and will be in charge of the day to day operations of the water point. This committee usually consists of the Chairperson and vice, Secretary and vice, treasurer, and 2 committee members.

Hardware; hardware is a term that is often used in WASH programming. In MSF this term was mainly used to describe the tangible aspects of the program that often include setting up of the water points in various communities.

Software; this is another term that is used in WASH and often involves aspects of the program that are not tangible or not visual. This is often associated with training communities targeted at behavior change. With MSF, communities are trained on health and hygiene, operations and maintenance of water points, resource mobilization and management of water points.

Chapter 1 - Preliminary

Overview

This chapter will focus on how development practitioners can identify sites to work on, community health practitioners to work with and how to conduct a participatory health & hygiene education (PHHE), T.O.T

Objectives:

- By the end of this chapter, practitioners should know the steps to follow for community entry when working towards establishment of sustainable clean and safe drinking water.
- How to identify community health workers to work with and conduct a Training of Trainers (T.O.T)

Identification of sites/areas to work in

The MSF WASH program operates in the urban area of Harare, the priority areas have been suburbs that have been termed the epicenters of diarrheal outbreaks (Budiriro, Glenview, Kuwadzana, and Mbare). However there were other areas that were targeted that were not **diarrheal** epicenters, however there was need for them to be provided with water as they were ticking time bombs for outbreaks. These areas were Hopley, Stoneridge, Caledonia, Hatcliffe, Dzivarasekwa, Warren Park, Tafara and Mabvuku.

In order to identify a site, the Hardware and Software departments work closely with the community Environmental Health Technicians (EHTs) and the Harare Department of water. Boreholes identified can be existing ones, in the form of hand pumps which need to be rehabilitated and/or upgraded. Rehabilitation includes fixing the issues which makes borehole water contaminated and upgrading includes removing the hand pump and replacing it with a submersible pump, tanks, in line chlorinator and taps stand). In other instances, MSF also drills boreholes and then equip them with hardware.

For the existing boreholes, the EHTs and Department of water staff work together with MSF team in mapping community boreholes in the target areas for upgrading. After boreholes have been targeted and mapped, hardware team then proceeds to do capacity tests and water quality testing. Capacity tests are done to ascertain if the borehole has enough capacity to sustain a submersible pump and water quality analysis to see if the water is safe to use.

Figure 1: MSF staff in the field conducting mapping and assessment of boreholes, Mbare, Zimabwe

With the above two steps completed, the boreholes are ready to be upgraded and the software component can commence.

Sensitization of Stakeholders

These are departments and personnel who have a direct bearing on the success of the program and range from ministries, to government departments and local district authorities.
They are appraised on the principles of the program and its methodology; this is done to get their buy in, as well as their support throughout the program to ensure sustainability after involvement of MSF stops.

Figure 2: Sensitization of stakeholders in Glenview, Zimbabwe

Identification of community Health promoters

Through the District Health Promotion Officers (DHPOs), Community Health Promoters are identified so that they work with communities in the areas targeted with boreholes for upgrading.

The purpose of identifying these community health promoters is to have health cadres on the ground that will ensure the smooth running of the program on a day to day basis. Community Health Promoters are volunteers from the communities, who are trained by the Ministry of Health to do sensitizations in the community on health related issues.

These health promoters apart from working for the MoHCC are also engaged by other NGOs who work in the communities to do work on their behalf. This then means that sometimes Health Promoters have a lot of work to do as they have to split their time and task between other organizations and Ministry work and this retards the progress. In light of this, the health promotion department decides to engage community based facilitators (CBFs) to help and support community health promoters (HPs) in their absence. CBFs are people identified from the communities by the DHPO and HP and they should have participated in community health clubs prior to their engagement so that they at least have some basic knowledge on public health issues as well as health and hygiene issues. Together Health promoters and CBFs are contracted voluntarily by MSF to work in the WASH program and to be the custodians of the CHC methodology.

Training of Trainers (T.O.T)

After identification of the HPs and CBFs through the DHPO, a training of trainers (T.O.T) is conducted for them. The objective of the training is to impart knowledge specific to WASH and Health and Hygiene. The T.O.T lasts up to 5 days and the following topics are covered:

- Diarrheal and cholera management
- Sanitation ladder, water ladder
- Kitchen hygiene and personal hygiene
- Waste management
- Oral fecal transmission route
- Safe water storage.
- Nurse Tanaka
- Pocket Chart
- Bilharzia Transmission
- Malaria Transmission
- Skin Disease

Figure 3: Participants from Stoneridge, Zimbabwe during a T.O.T

Figure 4: HPs and CBFs after finishing of T.O.T, Stoneridge, Zimbabwe

Before and after assessment of the T.O.T participants

In order to assess knowledge base of the participants before and after the training, a pre and post-test is administered to participants. Change in knowledge base should be clear after the post-test when the two results are compared; meaning post test results should improve significantly. For participants that do not perform well in the post test, they are supported more while they are in the

communities delivering their PHHE sessions. This is to ensure that, the right information is passed to the communities during these sessions.

Development of field action plan

As the training comes to an end, action plans are developed to make sure CBFs and HPs know how and when to do what, with deadlines. This helps with measuring the progress and standardizing activities that needs to be implemented within a given period. Normally the first PHHE session should take place in the community within 2 weeks after the T.O.T. The action plan naturally touches on the following;-

- Sensitization of program to key stakeholders at community level
- Mobilization of the community through door to door visits and at the community level to participate in the community health club.
- Registering participants who want to take part in the project as community health club members
- Kick starting PHHE sessions in the community.

Chapter 2 – Road map for the CHC establishment

Overview

The chapter focuses on the steps to follow to establish CHCs in the community, activities that should be done by CHCs throughout their life cycle leading to graduation.

Objectives:

- By the end of this chapter, readers should be able to understand how to form a CHC, steps to follow in forming a CHC to ensure the establishment of CHCs around water points.
- Practitioners should be able to form a water point committee (WPC) from the CHC.

Establishment of CHC and Activities

Mobilization and registration of community participants

After HPs and CBFs have been trained, they start mobilizing community members to participate in CHCs. Mobilization is done through door to door visits and also during community meetings. During mobilization communities are told about the MSF WASH program and how it will benefit the community.

Community Health Club

Community members are urged to come and participate in the health club where there will learn about health and hygiene issues. This will be of importance to them as it means that they can improve their hygiene practices at home, and this behavior change coupled with accessing clean and safe drinking water at the water point is most likely to reduce diarrheal incidences in their homes and at community level.

Improved water point

Communities are also informed that an improved water point will be provided by MSF where they will be able to access clean and safe drinking water. The components of the improved water point will be a submersible pump solar or electrical powered tanks, taps, as well as an in line chlorinator. This water point will need communities who will be in charge of operations and maintenance as well as communities that are well informed on the importance of maintaining the water point and keeping it safe.

When the above activities have been made clear to the community, HPs and CBFs will invite those who are interested in taking part in the CHC, to register their names and decide on the time, venue and the day that they want to meet so that they can start PHHE sessions. The venue is usually the borehole that will be upgraded. When these processes have been completed, a CHC will have been formed. According to MSF, a standard CHC has a minimum of 15 people and a maximum of 50 people. Both males and females are welcome.

PHHE Sessions in the Community

Figure 5: A community health promoter during a PHHE session, Kuwadzana, Zimbabwe

Figure 6: PHHE sessions in the community, Budiriro, Zimbabwe

After the registration of CHC participants has been done, and the time and venue decided, the weekly meetings commence. A CHC meets once a week, for an hour with the HP and CBF as the facilitators of the sessions for participatory health and hygiene education (PHHE). (PHHE are educational sessions that are conducted in the community by CBFs and HPs for community health club members. In order for the facilitators to deliver sessions on PHHE efficiently and effectively, they are given a manual that contains tools kits to use for learning in the community.

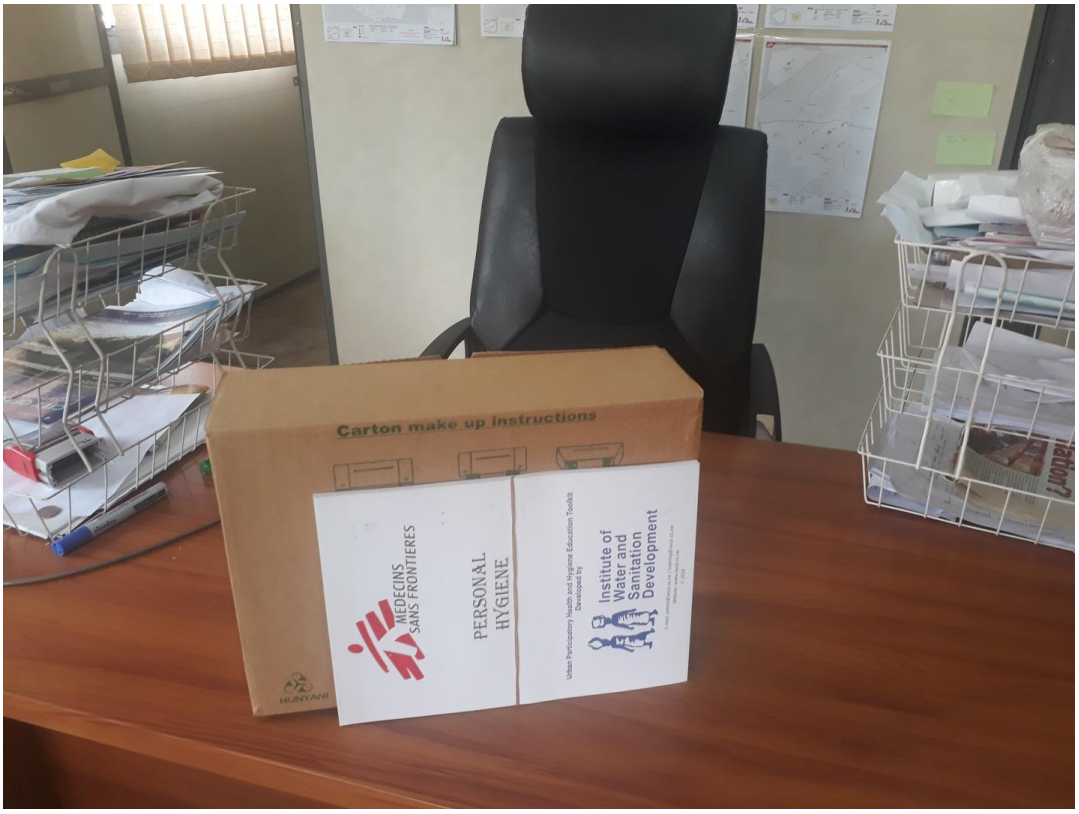

Figure 7: Picture showing an example of the toolkit that is used for PHHE

Modules (tool kits) with topics on health and hygiene are adopted and designed by MSF and converted into a manual, which then guides trainers in the community to train health club members. The manual has a total of 13 toolkits (modules) with different topics that are discussed in the community. In order for a community health club member to complete the standard curriculum, 8 modules should be covered from the manual and after that graduation takes place. The remaining toolkits (5 modules) are used for learning as the club continues to meet after graduation.

MSF Health promoters support during PHHE sessions

Figure 8: Msf staff supporting trainers in the community, Hatcliffe, Zimbabwe

With the commencement of the first PHHE sessions at community level with health clubs, HP's and CBF's are urged to invite MSF personnel to support them at community level for the following reasons;-

- To explain to the community about MSF, its values, mandate and operations narrowing down to the WASH program
- To validate the WASH program at community level, this is done through explaining the evolution of the program, why it's there, the issues that it seeks to address, intended outputs and issues around sustainability

It is during this support meeting that the following are outlined to the community:

- The project seeks to provide the community with clean and safe drinking water as an alternative when there is no running water in their homes.
- The need to chlorinate the water to make sure that there is no contamination.
- The community will also be sensitized on the importance of their participation as the owners of the water point when it's completed, hence the importance of their involvement at every stage of the program which begins at CHC level.
- Lastly the issue of sustainability is discussed with the community, which is existence of water points after the exit of MSF; this includes the importance of day to day operations and maintenance, repairs and replacements on the infrastructure, making sure that chlorine is always available at the water point and the need to put security around infrastructure provided so that it is not vandalized or stolen.

Making a water point committee

With the CHCs established and meeting once a week, the club members choose a committee among themselves. This club committee is made up of the following people;-

- Chairperson and vice chairperson
- Secretary and vice secretary
- Treasurer
- 2 committee members

These members who are elected to become the club committee, in turn become the water point committee. This committee will be in charge of the day to day operations and running of the water point and will be trained on how to manage the water point.

Cleanup campaign

When community health clubs complete their 8th module on PHHE, they will be eligible for graduating and receiving certificates of participation from MSF. However before graduation takes place, the health club as part of the CHC methodology should conduct a cleanup campaign in the community that they live. The purpose of the cleanup campaign is to show case to the community that there is now a health club that is operational in the area and secondly to show case to the rest of the community, the need for clean communities and importance of waste management. For the cleanup campaign, MSF provides materials for using such as rakes, brooms, gas masks, plastic aprons, gloves and bin liners. The CHC club committee approaches local authorities, the district office so that a truck comes to collect waste that cannot be burnt and will have been put in bin liners.

Figure 9: CHC members during a cleanup campaign, Kuwadzana, Zimbabwe

Figure 10: Clean-up campaign by CHC members in Mbare, Zimbabwe

Figure 11: MSF staff members supporting the community during a clean up in Warren Park, Zimbabwe

Graduation

With the cleanup campaign complete, the CHC is now ready for graduating and receiving certificates. Graduation is for club members that have attended 8 PHHE modules and this is ascertained by the attendance register and membership cards. For the graduation ceremony the CHC is in charge of the planning and the execution of the program for that day. The CHC is in charge of coming up with events of the day such as song, drama and dance focusing on health and hygiene issues learnt. They are also in charge of inviting stakeholders and authorities that they want. MSF provides refreshments for the program, certificates of participation and t-shirts for every club member graduating.

Figure 12: Song and dance during graduation in Stoneridge, Zimbabwe

During the graduation ceremony, health club members also get a chance to win prizes. Prizes are given to best performing or most improved households in terms of health and hygiene. These households are selected by HPs and CBFs, through home visits before the program starts and after the 8 sessions on health and hygiene. Households that will have done exceptionally well in terms of implementing issues learnt at household level are the prize winners. During the graduation ceremony, CHC members that are graduating receive a certificate of participation and a t-shirt from MSF.

Figure 13: Participants receiving certificates during graduation in Budiriro, Zimbabwe

CHAPTER 3 – Sustainability of water points through communities

Overview

This chapter of the manual focuses on how communities can ensure sustainability of water points established by NGOs and activities that can be done to ensure sustainability of these water points.
Objectives:

- After this chapter, development practitioners should be able to create water points that are sustainable through establishment of WPCs.
- They should be able to conduct trainings that are key to the sustainability of these water points.

Water Point Management

What is a water point?
According to MSF; when an already existing bush pump has been rehabilitated and upgraded, or a newly drilled MSF borehole is equipped with the items listed below, it then becomes a water point. The items/material needed for a borehole to become a water point includes;

- Water storage tanks,
- Submersible pump that is powered by electricity or solar.
- In line chlorinator
- 2 Aprons with taps
- Solar panels

The implication is that, as many as 12 people can now fetch water at one goal compared to a hand pump where only one person fetches water at a time. Also at the water point as the water passes through the chlorinator, it is chlorinated and is safe to drink.

Figure 14: Before upgrading a water point, community in Kuwadzana, Zimbabwe

Figure 15: Upgraded Water point in Kuwadzana 1, Zimbabwe

Who operates the water point and how is it operated?

The CHC that has been trained on PHHE is in charge of running and maintaining the water point, through the Water Point Committee (WPC).

Operations and maintenance trainings

The Watsan from MSF are in charge of training the WPC on **basic operations and maintenance of the water point**. This basic training touches on the following;-

- Making sure WPCs know the different parts that make up a water point and how they are operated.
- How to replace the chlorine tablet and to tune the valves to the correct level
- How to test for chlorine once a week to make sure it's at the right level when people consume the water
- To deal with the maintenance issues that they cannot deal with, by themselves.

Resource mobilization and water point management

To complement the operations and maintenance training, the Health Promotions department from MSF also trains the WPCs on resource mobilization and water point management. This training focuses on;-

- How to manage a water point and the importance of managing a water point.
- The importance of a WPC, roles and responsibilities of committee members at a water point
- Resource mobilization at a water point as a way of sustainability and community ownership of the water point.
- Accountability of resource mobilized funds to stakeholder, authorities and the community at large

Figure 16: Resource mobilization and water point management training in Stoneridge

Why resources mobilize at a water point?

There is need to mobilize resources at water points established by MSF so that WPCs are able to run these water points effectively. Resource mobilization is done in the form of collecting cash at the water point to people who come to fetch water. The money charged per household is 1USD per month and for that amount households can fetch water at the scheduled times. Money collected goes towards covering the following:-

- Purchasing of chlorine for treating the water at the water point
- Maintenance of the water point, for example replacing worn out items, or stolen taps, or broken down items
- Most importantly resource mobilization is done to put security around the water point so that infrastructure is safe from vandalism and theft.

Figure 17: Water point before raising funds for putting security in place, Kuwadzana, Zimbabwe

Figure 18: Water point where community has resource mobilized for security, Kuwadzana, Zimbabwe

Figure 19: Water point in Glenview 3, have managed to secure taps and working towards fencing

Strengthening and support of WPCs

Once water point committees are established there is need to support and strengthen them, until they can run the water points smoothly by themselves, also until they can solve problems on their own with minimal supervision and interference from MSF. Support and strengthening is done in 2 ways:-

1: Visiting WPC committees as they are giving water to the community. During the visit, MSF personnel check to see if committees are adhering to what they were taught during the Operations and Maintenance (O and M) and Resource mobilization and Water point management training. This is also a chance to find out problems that the committee will be facing and how these problems can be solved. During this time the MSF personnel also interact with community and find out if there are any challenges that they are facing when they come to fetch water and if there are areas that need clarification from the development partner (MSF).

Figure 20: Support visit to water point in Kuwadzana, Zimbabwe

Figure 21: Support visit to water point in Hatcliffe, Zimbabwe

2. WPCs are also supported through review meetings. These are done away from the community at a selected venue. All water point committees come together for this meeting and it is very beneficial as it serves as a sharing and learning platform as well as reviewing progress made by water point from project conception. During these review meetings the things looked upon are the progress done by the communities, challenges being faced and how these challenges can be addressed. Solutions to challenges mostly come up from the different water point committees as they share

ideas. The review meetings also present an opportunity to find out if committees are adhering to measures set by MSF, and review meetings are carried out once a quarter.

Figure 22: Participants from Budiriro and Glenview during a review meeting

Look and learn visits

Look and learn visits are an activity facilitated by MSF for water point committees that are not performing well.

This includes the committees facing challenges in resource Mobilization challenges with local leaders' especially political leaders, failing to work together as a committee at the water point for the benefit of the community and not adhering to operating standards of the water point set by MSF. Such a water point committee becomes eligible for a look and learn visit. This visit is to another water point that is doing well in terms of operations. The purpose of the visit is exactly as the name suggests, seeing how the best water point is operating, how they are dealing with challenges and finding solutions and then coming back to their water point and trying and implementing what they will have learnt

Chapter 4 – Monitoring and Evaluation

Overview

This chapter focuses on how Practitioners who want to ensure the sustainability of water points through CHCs, can measure behavior change for CHC members through the use of baseline and end line surveys. Baseline and end line surveys provide important information to assess if learning has taken place and if there has been behavior change amongst CHC participants. It focuses on the steps to follow when conducting Knowledge, Attitudes and Practice (KAPs) (baseline and end line) survey for participating households in CHCs.

Objective:

- By the end of this chapter, facilitators should have an appreciation of the importance of measuring behavior change after conducting PHHE sessions for CHC members, and how to measure behavior change.

5.0 Baseline and End line surveys as a means of measuring behavior change for communities participating in Health Clubs

The core objective of MSF WASH as Prevention Project is to provide clean and safe drinking water to the communities living in vulnerable situations. However coupled with this, the need to train communities on health and hygiene for behavior change is also crucial. This behavior change in health and hygiene, coupled with clean and safe drinking water provided by MSF is aimed at reducing diarrheal outbreaks. At the end of the graduation after having undergone 8 weeks of training on PHHE, there is a need to examine to which extent communities members' behaviors have changed from project inception. To measure that, a tool is developed by MSF, in the form of a questionnaire, which is used for the KAPs survey (Knowledge, Attitudes and Practices), *see appendices.*

Baseline survey

Baseline survey is conducted using the questionnaire developed. It is conducted a week after the establishment of CHCs and the HPs and CBFs have registered members who are participating in the club. With the questionnaire they conduct door to door visits to their club members, to assess their knowledge, attitude and practices in relation to health and hygiene before they attend the 8 weeks training. The purpose of the baseline is to create a source document which can be used to assess if there has been change after the PHHE sessions.

End line survey

This is similar to a base line, in the way it's conducted and the same tool is used. The only difference is that, unlike baseline, this is done at the end of the sessions, which means when the 8 PHHE sessions have been completed, HPs and CBFs, conduct door to door visits to the same households they visited during baseline. This visit is to assess the households' knowledge, attitudes and practices after being trained in PHHE. The expectation is that there should be behavior change in terms of health and hygiene practices in households that will have participated in PHHE sessions and this should come out when results from baseline and end line of a household are compared at data analysis.

Data encoding and Analysis

Through a database created by MSF, data from the questionnaires is entered by data encoders, for both the baseline and end line data. After data entry, and data cleaning, the epidemiologist does the data analysis and produces results which lead to the write up of the report. Generally an expected result from the survey is improved hygiene behaviour at end line compared to baseline.

Lessons learnt

- Ideally it would be best for community health promoters to conduct baseline and end line surveys. However some of them because of age and literacy levels are unable to administer the questionnaire and end up collecting wrong information. Therefore it is sometimes better to hire independent enumerators for baseline and end line surveys.
- After data encoders have entered information into the database, there is need for data cleaning and also cross checking of entered information to rule out errors during data entry.

ANNEX

WASH KAPS SURVEY

QUESTIONNAIRE NUMBER
DATE OF INTERVIEW ……
SUBURB……..
ENUMERATOR NAME ……
CHC NAME…….

HOUSEHOLD DEMOGRAPHICS

Name of household head…… Gender of household head M ☐ F ☐

Age of household head…….. Household size……..

Name of respondent…….. Gender of respondent M ☐ F ☐
Age of respondent……..

Accommodation
Rented ☐
Owned ☐

KEY

S Scoring
NS Not scoring

(NS)1. Did you receive or attend awareness sessions related on good hygiene practices by MSF through CHCs

a. yes
b.no

(**NS)2. If yes, who did you receive the health and hygiene education lessons from? (Enumerator to read out and circle answers given)**

a. CHCs through the 8 sessions on health and hygiene
b. Door to door health and hygiene sessions
c. General awareness sessions
d. CHC awareness
e. Other organizations

Knowledge

(S)3. If yes, what are the topics covered in the sessions (*Enumerator to read out answers and circle the ones mentioned by respondent*)

a. Importance of safe excreta disposal and usage of latrine
b. Importance of 4 star diets for children under 5 years of age

c. Importance of hand washing using soap during key times
d. Disease caused by poor water, sanitation and hygiene (WASH) practices
e. The 5 killer diseases in children under 5
f. Household water treatment
g. Importance of proper solid waste disposal
0…….0 to 1 answers correct
1……2 to 4 answers correct
2…..5 correct

(S)4. What do you think are the causes of diarrhea, typhoid and cholera? (*Enumerator to read out answers and circle the ones mentioned by respondent*)

a. Drinking dirty water
b. Not eating a balanced diet
c. Eating food contaminated by hands unwashed after defecation/in contact with faeces
d. Bewitched by neighbors
e. Eating contaminated food due to flies in contact with faeces lying in open field, drainage
f. Poor water storage
g. Poor water withdrawal methods
0…….0 to 1 answers correct
1……2 to 4 answers correct
2…..5 correct

(S)5. How can you prevent diarrhea, typhoid and cholera? (Enumerator to read out answers and circle answer given)

a. Safe disposal of faeces by using safe toilet
b. Drinking clean, treated water
c. Eating and drinking consistently
d. safe water storage in clean and covered container
e. Protecting drinking water from contamination
f. Eating fruits
g. Washing hands before eating and preparing food and after handling/contact with stool
0…….0 to 1 answers correct
1……2 to 4 answers correct
2…..5 correct

(S)6. Which are the critical/important times to wash your hands? (Enumerator to read out answers and circle answer given)

a. Before preparing food
b. When you wake up
c. Before eating
d. Before feeding your children
e After preparing food
f. After handling children's stool
g. After using the toilet/defecating
0…….0 to 1 answers correct
1……2 to 4 answers correct
2…..5 correct

(S)7. Is there rubbish lying around in or near the house (*Enumerator to observe*)

a. yes

b.no

1……a

2……b

(S)8. In what way can one prevent malaria at household level (Enumerator to read out answers and circle answer given?)

a. Cutting grass around the household

b. Washing hands

c. Getting rid of stagnant water

d. Sleeping under treated mosquito nets

e. Wearing loose long clothing at night

f. Spraying and using insecticides

g. Using smoke in the household to smoke out mosquitos

0…….0 to 1 answers correct

1……2 to 4 answers correct

2…..5 correct

<u>Attitude</u>

(S)9. Do you think it is important to have CHC/Water Point Committee?

a. yes

b.no/ don't know

1……a

2……b

(S/NS) 10. Who is responsible for your drinking water source? (Enumerator to read out answers and circle answer given?)

a. Political leaders (MPs & Councilors)

b. Myself

c. Community

d. CHC

e. City council

f. MSF

g. Other NGOs

0…….a, e, f, g

1…….b, c, d

(S) 11. Are you willing to pay/ contribute for an improved water point?

a. yes

b.no

1……yes

2……no

(S) 12. If cash, how much have you contributed over the past 2 months?

a. 0

b. 0.50 to 1USD

c. more than 1USD

0…….a

1……b

2…..c

Practices

(S) 13. Do you use different sources of water for drinking and domestic purposes?

a. yes

b. no

1……a

2……b

(S) 14. Where do you get your drinking water?

a. Hand dug well/shallow well

b. Public hand pump

c. Public hand pump with inline chlorinator

d. CHC water point/ upgraded borehole with submersible pump

e. piped water in house

f. Water truck/ water vendor

g. Rain water

0……a, b, f

1……..e

2……..c, d, g

(NS) 15. Source of water for domestic use?

Hand dug well/shallow well

b. Public hand pump

c. Public hand pump with inline chlorinator

d. CHC water point/ upgraded borehole with submersible pump

e. piped water in house

f. Water truck/ water vendor

g. Rain water

(S) 16. What do you do to the water to make it safe for drinking? (Enumerator to read out answers and circle answer given?)

a. Boil

b. Add water guard/bleach/Aqua-tablets

c. Collected chlorinated or treated water

d. Nothing

0……..d

1……a, b ,c

(S/NS) 17. How is the container for drinking water? (*Enumerator observes and ticks what applies*)

a. Covered and clean

b. Covered but dirty

c. Not covered but clean

d. Not covered and dirty

e. Narrow mouthed

f. Wide mouthed

0……a, b, c, d, e, f

1……..a + e (combination of a and e gives one point)

(S) 18. How often do you clean your drinking water containers?

a. Everyday

b. Each time before storing water
c. Once a week
d. Once a month
0……..c, d
1……a, b
(S)(NS) 19. Can I see the method you use to withdraw water from storage container? (Enumerator observes)
a. ordinary cup
b. ladle or scooping cup with long handle
c. ladle or scooping cup with short handle
d. small pot with handle
e. plate
f. water glass
g. tap on bucket
0……..a, c, d, e
1……..b, g
(S) 20. What kind of toilet facility does your household use?
a. Toilet connected to piped sewer system
b. Toilet connected to septic tank
c. Pit latrine
d. Ventilated improved pit latrine
e. Bush/ Open defecation
0…….e
1……..a, b, c, d
(S) 21. Presence of hand washing facility/station (***enumerator to observe***)
a. yes
b.no
0……no
1……..yes
(S)22. Presence of hand washing agent at/near the hand washing facility (*enumerator to observe*)
a. No soap/ash
b. soap/ash present
0…….no
1……..yes
(S)23. How do you dispose of your household waste?
a. Burn
b. Bury
c. Council waste collection
d. Open disposal in bushes/dumping areas
0……d
1……a, b, c

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