

**COMMUNITY HEALTH CLUB
APPROACH AS A STRATEGY TO
EMPOWER COMMUNITY ACTION
TO IMPROVE HYGIENE AND
SANITATION**

BY

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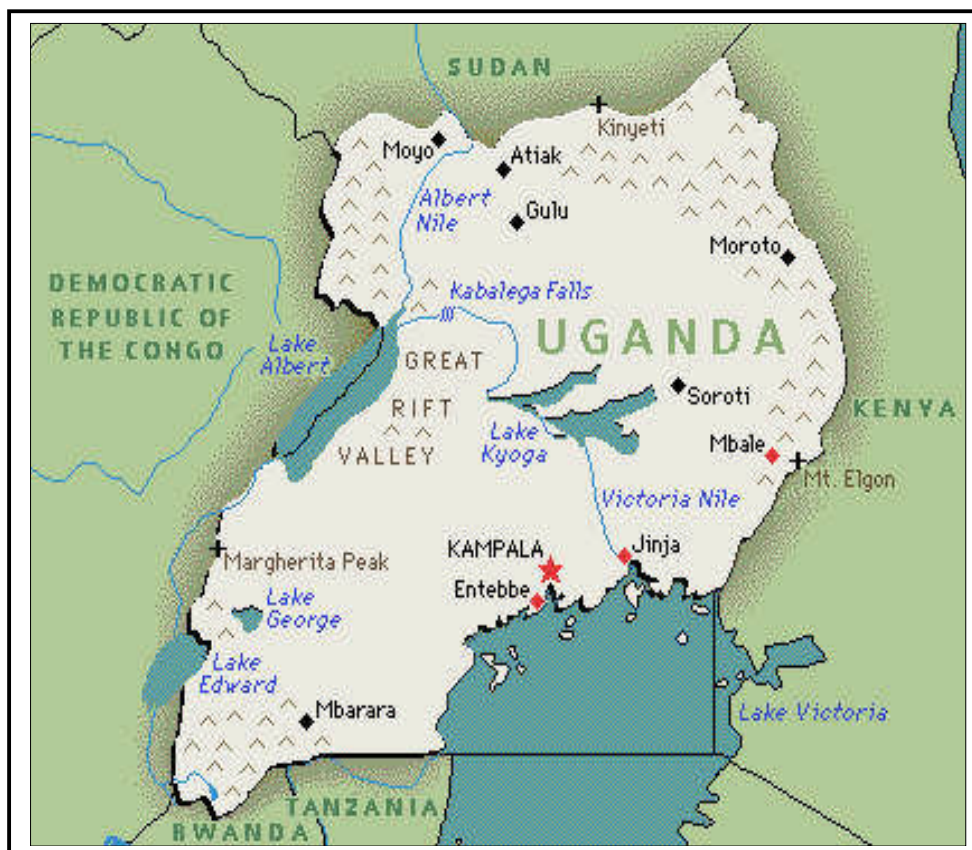
1. TITLE OF BEST PRACTICE:

Community Health Club approach as strategy to enable communities' focus on Health and other Development issues, Katakwi case study.

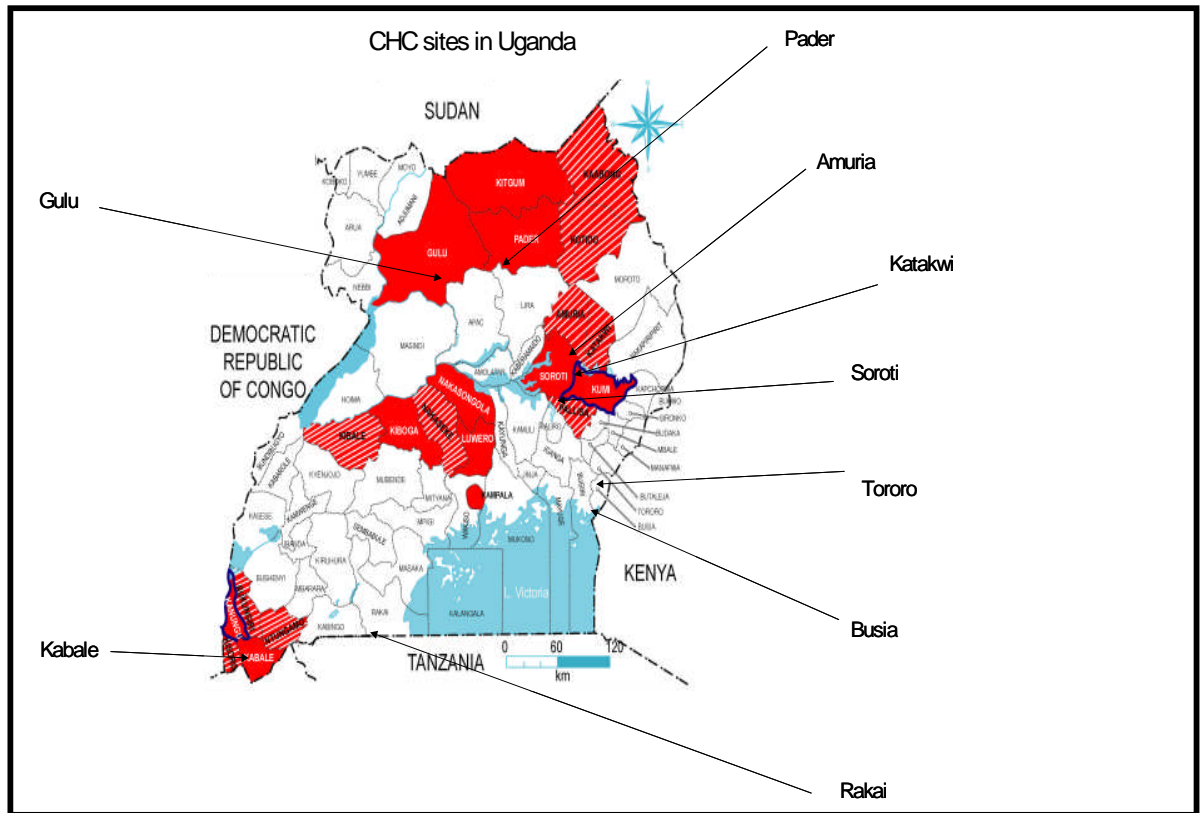
2. COUNTY: UGANDA

Districts, Gulu, Pader, Katakwi, map of the above districts.

MAP OF UGANDA SHOWING BORDERS



AMAP OF UGANDA SHOWING WHERE CHC CONCEPT HAS BEEN TRIED OUT



In Gulu and Pader- the concept of CHC was centered around internally displaced peoples camps (IDPC) only while in Katakwi was both in IDPC and formal villages

3. INITIATOR OF THE “BEST PRACTICE”

The initiative was first tried out by CARE Uganda based in Gulu who contracted a National Trainer to articulate the participatory Hygiene and Sanitation Transformation concept. In the process the idea of CHC was integrated in the training of the extension staff of care and district as well so as to form a basis for organizing committees into smaller units.

In the long run through information sharing, Lutheran World Federation – Katakwi got interested in the CHC concept and on contacting care Uganda were linked to the PHAST and CHC concepts.

Similarly was the Health Integrated Development Organisation (HIDO) a CBO that was operating in 8 IDP camps in Pader District.

4. BACKGROUND OF THE INITIATIVE – KATAKWI CASE STUDY

- Lutheran Worlds Federation (LWF) which has been working in internally displaced persons (IDP) Campus and villages in Katakwi District for over the last five years had a cause to improve on Hygiene and Sanitation
- Having seen that the Hygiene and Sanitation works was not in Water Supplies decided to pilot the community Health Club concept.
- In August 2000, project staff and local govt government Health Assistants were trained and the CHC concept introduced in one resettled community in a village called iningotomei and in an IDP camp O bulengorak.
- Pictures of training in secession

5. DESCRIPTION OF THE INITIATIVE

The major component of the initiative are four but applied in a phased manner

PHASE I - Knowledge base

This involves:

- Mobilization
- Club Formation
- Creation of common unit and purpose
- Health / Hygiene Education
- Hygiene Interventions

PHASE 2 - Practical Skills:

This involves improvement of WATSAN infrastructure i.e. construction of water, sanitation and Hygiene facilities, compound improvements and cleanliness.

PHASE 3 - Economic Empowerment

- E.g. Skills training
- Promoting income generating activities
- Improvement of financial management
- Environmental management skills / initiatives

PHASE 4 - Social Activities / Initiatives

Involved in: -

- Literacy training
- Care of HIV /AIDs victims / orphans
- Other social community development initiatives

6. MAJOR DRIVERS OF THE PROCESS AND SUCCESS.

- Frequent sessions were held by the trained staff with the community.
- The community formed their own voluntary units known as community Health Clubs (CHC).
- Each club member was issued with a membership card to which their photograph was affixed.
- After each session the facilitator and the participants both signed against the topic covered during the session
- After seven to eight months of intense, focus on health education, the status of sanitation and hygiene in the two communities improved.

7. RESOURCES

The resources were mainly from the implementing organizations such as: -

- Human
- Financial
- Material
- Time

Financial resources were mainly needed for re-training of the extension staff, staff salaries and allowances and maternal development.

- The households contribute local materials needed for improvements without any subsidies
- The organization (LWF) also spends resources for rewards / incentives for best performers.

SUCCESS STORIES

POOR SANITATION AND PLANS TO MEET THE MDGs

The LWF watsan programme aims at enabling the communities Iningo-Otomei achieve a 100% sanitation coverage within the MDG timeframe BUT.....!

The situation In August/September 2006



A mobile toilet supplied by the district during emergency days lies on its side, unused in one



A drying rack at a primary school not properly used – note the cups lying on the ground

WHAT DID THE PEOPLE DO ABOUT POOR SANITATION AND HYGIENE?

Planning for sanitation improvement using Sanitation Ladder



Training in Community Health Clubs concept for promotion of sanitation and hygiene.

LWF supported communities with training to introduce and understand how Community health Clubs work. Participatory tools based on PHAST (Participatory Hygiene and Sanitation Transformation) were used e.g. sanitation ladder to assess the current sanitation status, identify road blocks to improving sanitation and identifying the level community members want to attain (incremental gains on sanitation);



WHAT HAS BEEN ACHIEVED ? – SANITATION AND HYGIENE IMPROVEMENTS

SANITATION COVERAGE UP WITHIN SIX MONTHS



Six months since the introduction of CHC, all 27 households visited in Iningo-Otomei had latrines and 24 with hand washing facilities and were evidently in use! In another village (Obulengorok IDP camp) 37 latrines have been completed and are in use. up from only one latrine seen in August/September 2006.

IMPROVED HYGIENE PRACTICE



Safe water chain – a raised drinking water pot, with separate cups for drawing and drinking water.

WHAT HAS BEEN ACHIEVED ? – COMMUNITY ORGANISATION

FORMATION OF COMMUNITY HEALTH CLUBS

Iningo-Otomei village 6 functional clubs

Obulengorok – 4 functional clubs

- In Wera (iningo-otomei) All 6 groups have a one overall leader, 1 overall mobiliser and 1 drama group with a minimum of 3 representatives from each club.
- **Drama group** has one resource person (trainer – volunteer), rehearses twice a week Mondays and Thursdays
- **Drama shows** once a week on Sundays (so far 4 drama shows conducted in the village)
- **Small groups:** foot ball clubs with one leader; netball club – 1 leader; ajosi group – 1 leader
- LWGF office facilitated with 2 footballs, 3 netballs, 1 pump
- Drama supported with costumes

bers attending a community health club meeting at Iningo-Otomei



- Adoption of CHC concept and use of participatory approaches generally for promotion of sanitation and hygiene.
- Over 20 technical staff (project assistants) to facilitate implementation of CHC for promotion of safe water, sanitation and hygiene
- Integration of CHC implementation plans into overall LWF programmes
- Involvement of district and sub county extension agents in CHC training , implementation and follow up



The District Director of Health Services hands over a certificate of attendance to one of the staff who attended the CHC training.

Status of sanitation after seven months of intensive education and follow up.

VILLAGE ININGOTOMEI

Item	Before	During	Total
Latrines	20	49	69
Bath shelters	50	53	103
Drying Racks	19	77	96
Rubbish Pits	3	48	51

OBULENGOROK ID CAMP

Item	Before	During	Total
Latrines	4	36	40
Bath shelters	30	96	126
Drying Racks	9	130	139
Rubbish Pits	4	102	106

Note: From the figures above:

- ★ Settled community of Iningotomei adapted faster than that of Obulengorok IDP Camp
- ★ In Obulengorok over 50% of latrines had hand-washing facilities. On Iningotomei more than 75% of latrines has hand-washing facilities.

LEASSONS LEARNT

- ✓ Clubs provide a unity of purpose among the members in areas of hygiene and sanitation promotion
- ✓ Membership cards are a powerful incentive and give a sense of belonging
- ✓ Strong and exemplary leaders are essential for the Community Health Clubs
- ✓ By-laws help to cement the groups and encourage slow takers
- ✓ Members are analytical in terms of linking poor hygiene to poverty
- ✓ Demonstrations raise a lot of interest as it enables the members to try out acquired knowledge.

FUTURE PLANS

- **CONSOLIDATING CHC AT COMMUNITY LEVEL**

- Continue with community level reviews of CHC activities
- Formation of more clubs in neighbouring villages
- Support drama shows (training, sanitation themes, costumes, reaching out to other areas)
- Carry out exchange visits between villages where CHC has worked
- Promote IGAs

- **MONITORING PROGRESS AND EVALUATING IMPACT**

- Establish community based monitoring
- Evaluate impact after some time (say 1 – 2 years after)
- Develop and share case studies

- **SCALING UP**

- Strategise on reaching out to other communities (fast track and increase coverage)

For contact information:

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