The Consensus Approach

Health promotion through Community Health Clubs

Introduction

People do not generally compartmentalize their health problems, but rather, they tend to perceive all threats to health as inter-related. The Consensus Approach builds on this, seeking to tackle all preventable illness and related diseases. It is a holistic, horizontal (i.e. deals with several issues) and long term model of sustainable, community development.

The key assumptions of this approach are: most women are primarily interested in caring for their family and want to improve their skills; many people in developing countries are deprived of the chance to learn and therefore respond readily to health education initiatives.

The Consensus Approach has worked effectively through Community Health Clubs (CHCs) since 1994. These are voluntary, information sharing Community-Based Organizations (CBOs). This approach has been scaled up from pilot projects in rural Zimbabwe to post-conflict areas of Sierra Leone and Internally Displaced People's camps in Uganda.

This Briefing Note describes the principles, implementation and impacts of the Consensus Approach through Community Health Clubs, using evidence based on successful case studies.

Health club members in Uganda present their homemade good hygiene banner

Headline facts

- The Consensus Approach deals with all of a family's health problems rather than single issues.
- Community Health Clubs (CHCs) are the main vehicle for this approach and demonstrate evidence of its success.
- CHCs promote a 'culture of health' which means that healthy living becomes highly valued, and in this way brings about behaviour change, through peer pressure and the desire to conform to social norms.
- CHCs offer a structured programme of learning to be applied in the home environment each week. Membership cards and attendance certificates are an important incentive to members.
- The benefits of CHC membership are wide ranging, including increased learning, social status, especially for women, and opportunities for income generation.
- Models for scaling up this approach exist, together with resources. Methods of measuring behaviour change are based on observation of good hygiene practice and allow calculations of cost-effectiveness to be made.

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Creating a Culture of Health

The most effective way to reduce the incidence of diarrhoea is to create a completely hygienic environment, which all members of the community support. However, this involves considerable effort on the part of housewives and mothers, which can result in a lack of commitment to carrying out the necessary tasks. Promoting a 'culture of health' means that healthy living becomes highly valued, bringing about behaviour change, through peer pressure and the desire to conform.

Community Health Clubs

Community Health Clubs (CHCs) help to promote this culture of health because people meet regularly to learn about and discuss ways to improve hygiene. The meetings are properly organized sessions with a registered membership, which should represent at least 80% of households in the community. Private behaviour then becomes a public concern, with the general consensus from the critical mass ensuring that all individuals are discouraged from poor hygiene behaviour in favour of agreed and accepted standards and norms.

Weekly meetings of CHCs can address up to 30 different topics over a six month period. Each session requires members to practice their new learning at home. This can involve simple changes like covering stored water or using a ladle. More demanding challenges include building latrines, which requires effort and resources but is the natural culmination of such behaviour change and comes from within the community rather than being externally imposed.

All members are issued with membership cards, listing the topics covered and recommended practices. This is important as it provides a sense of identity and encourages others to join, setting learning targets, acting as a monitoring tool for programme managers and preventing gatecrashers from reaping unearned benefits. At the end of the six month period, attendance certificates are awarded which confer important social status and are a huge incentive for members. They may be the first qualification ever gained by members and can lead to additional responsibilities in the community, as well as offering the chance to progress to the next stage of the programme.

Although CHCs can move on to wider development initiatives other than health education, this is a good first step and builds community understanding and consensus. CHCs become truly representative CBOs, with a tried and trusted leadership, handling considerable resources, and with the necessary monitoring systems in place.

CHCs are open to all, both men and women. However, for women especially, CHCs can make a real difference to their social standing. They report improved relationships with in-laws, due to their knowledge of health and hygiene issues, and with their children, who give them more respect as educated mothers. Marital relationships can also improve, with women gaining their husbands' support for attending meetings. Women can sometimes also earn extra income through their involvement with CHCs.

What CHC members say

Loike Munukwa, 70.
I wanted to do whatever everyone else was doing, so that is why I joined the club. Yes, I finished 20 lessons, although at times I did not attend because of illness or deaths, but I completed my card, and I graduated. Those lessons were very good. My head, my brain was woken up, you know that means stimulated. Brain stimulation.

Mrs Mukaesa, 50
My in-laws are now considering me as a very good asset at home because I have got the necessary knowledge and I am not the type of a wife who can just go around in the neighbours gossiping. I am now quite responsible at home and quite knowledgeable. In fact I cared for the relatives of my husband who were sick, two of them, and I was given a cow to thank me for the good work I did.

Naboth Toriro, 50
There is quite a lot of changes there, because there is a lot of this awareness in health … well let's go to water and sanitation, where do we put it to combat diarrhoea and things like that? Then let's go onto things like AIDS awareness. Let's go to things like drugs where you have some knowledge in things like medicine.

Andrew Muringanidza, Project Officer ZimAHEAD interviews Mrs Simisai, 30
You know my children are also participating in this thing. They are collecting flowers and plant them at home, and you see any fruit, they plant it. They participate in maintaining the yard and borehole. They each have a plate and cup, they don't use the same one.

The AHEAD Model of Development

CHCs were first pioneered by the Zimbabwean NGO Applied Health Education and Development (AHEAD) in Makoni District in 1994. The AHEAD Model refers to the long term application of the Consensus Theory which has four stages, each of which focuses on different aspects, progressing to fully functional self-management of development initiatives at the end of four years:

Stage 1 Theoretical	Stage 2 Practical	Stage 3 Economic	Stage 4 Social
Community Mobilisation	Improved Hygiene	Skills Training	Care of Terminally Ill
Formation of Health Clubs	Water Provision	Income Generation	Care of Orphans
Health Education	Improved Sanitation	Financial and Management Training	Literacy Training
Hygiene Promotion			Human Rights

This is an idealized model of holistic development rather than a blue print and demonstrates the broad spectrum of issues which can be addressed.

A case study: Tsholotsho District, Zimbabwe

Tsholotsho District is one of the most arid and underdeveloped areas in Zimbabwe, with only 11% of the population having latrines according to Government estimates. In 1999, a water and sanitation programme was started by Zimbabwe AHEAD. To create a high level of demand for sanitation, it was decided to establish the new concept of CHCs. Within six months 32 health clubs, involving 2,105 households, had been formed, facilitated by three Ministry of Health field workers.

A post intervention survey showed that in the non-CHC areas, less than 1% had a latrine, while CHC areas showed 57% had built latrines, with the rest practising 'cat sanitation' (the practice of digging a small hole each time they defecate before covering the faeces with soil), thus eradicating open defecation. In addition, 98% were using individual plates and dishes; 89% were washing hands by the pouring method; and 65% were using a ladle for drinking water.

A case study: Ugandan Internally Displaced People's Camps

In Northern Uganda, 89% of the population of the Gulu District live in 33 Internally Displaced People's (IDPs) camps, each one housing between 10,000 and 68,000 people. Africa AHEAD with Care International assisted in training the new NGO Health Integrated Development Organization (HIDO) to provide health promotion to 120,000 people and to build 10,000 latrines in six months.

For this scale of latrine building, the Consensus Approach using CHCs was chosen to engender a sense of unity and shared ideals. Within a few weeks, trainers reported a massive response from IDPs to join the sessions, and a Sanplat production unit was established in each camp. Within four months, CHC members had constructed 8,504 latrines, 6,020 bath shelters, 3,372 drying racks and 1,552 hand washing facilities, in total benefiting 100,000 people. At the end of 8 months, targets were exceeded with 12,000 latrines completed.

'This is the first programme that has really come down to us, the people, and united us in our knowledge. Usually NGOs train a few people to go to each house to teach us, but in these clubs were are all trained together, so we understand it better. We can all be teachers, and we can teach others.' (IDP Community Health Club member)

Scaling Up the Consensus Approach

The table below provides an example of resources required to scale up to national level for a population of 10 million, to meet the MDG target for sanitation.

Item	Given	Example
Total pop'n		10,000,000
Sanitation coverage		50%
No sanitation	% remaining	5,000,000
No households	Divided by 6 per h/hold	833,333
Target of 50% latrines	Divided by 2	416,666
Total CHCs nationally	Divided by 100 per club	41,666
Total CHCs needed	X 2	83,333
CHCs needed per year	Divided by 10 years	8,333
Trainers needed nationally p.a.	10 per trainer	833
Trainers per district	52 districts	16

Establishing a national CHC

Four main resources are needed:

Trainers: Where trained government health workers exist, these are the preferred option for sustainability. Where this is not available, capacity can be built by using field workers from an implementing international NGO. Indigenous NGOs can also provide effective trainers, who integrate well with local communities. Alternatively, the NGO may need to train community members themselves, as a cost-effective and sustainable strategy, despite the steep learning curve involved.

Transport: This covers bicycles, motor bikes, vehicles and bus allowances. Access to the communities is vital in spite of insufficient transport funding.

Training material: Culture-specific visual aids are important. Their preparation needs formative research, with pre-testing to ensure that key messages are understood by all. Successful visual materials focus on single messages, with simple depictions of attitudes, objects and situations that are typical of the area.

Training: CHC intervention uses a training technique based on Participatory Health and Sanitation Transformation (PHAST) principles to empower people with a sense of worth and self-efficacy. CHC participatory sessions are planned within a defined structure of active application of good hygiene and sanitation principles. Materials used can be easily assimilated by all and are stimulating and fun. Each week,' homework' is undertaken, which is followed up at the next session.

Monitoring Health Promotion and Measuring Behaviour Change

Funding for health promotion projects can be difficult to find because the benefits are not as easy to quantify as counting, for example, the number of latrines built. However, using Community Health Clubs allows accurate measurement of specific targets. These can be the learning areas listed on membership cards, and the observed rates of uptake of explicit recommended practices. Membership can be accurately sampled, and hygiene behaviour change measured against the costs of implementation.

How to measure cost-effectiveness

The cost can be calculated because the method:

1. has a definite target population and the number of members can be counted accurately;
2. can count the number of beneficiaries: number of members x 6 (average family size);
3. can count how many health sessions have been held;
4. can count the number attending the sessions and the average attendance per club;
5. can count the cost of the trainer in terms of transport and allowances.

Therefore the cost per beneficiary can be calculated:

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

Evidence suggests that if risk practices associated with diarrhoea are routinely carried out, diarrhoea will be minimized. As it is difficult to measure diarrhoea incidence, it is more reliable to check proxy indicators i.e. whether the hygiene practices linked to diarrhoea have improved. House to house surveys can be used to ascertain levels of compliance with good hygiene practice. This can be done either by taking a base line survey followed by a post-intervention survey, or by comparing a CHC area to a similar area where there are no health clubs.

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Key references

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Photographs by Juliet Waterkeyn

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