



LEARNING NOTE

INTEGRATING SAVINGS AND INCOME-GENERATING ACTIVITIES INTO COMMUNITY HEALTH CLUBS TO IMPROVE LATRINE CONSTRUCTION IN ZIMBABWE

ABSTRACT

In rural Zimbabwe, the Amalima project implemented a project promoting Community Health Clubs (CHC) in collaboration with the Zimbabwe Ministry of Health to facilitate sanitation and hygiene behavior change. The cost of latrines were identified as a barrier to improving sanitation. Therefore, CHCs were encouraged to diversify into income generating (IGA) and

In Zimbabwe, USAID’s Bureau for Humanitarian Assistance (BHA) supports two development food security activities (DFSAs). This learning note highlights results, challenges, and lessons learned from the Amalima DFSA in regards to the integration of village savings and loan (VSL) activities and income-generating activities (IGA) into Community Health Clubs (CHCs) to facilitate sanitation and hygiene behavior change.

village savings and lending (VSL) activities, although not all decided to pursue this activity. A qualitative study was undertaken to better understand barriers and motivators to latrine construction and how/if the integration of these activities with CHCs improved uptake of latrine construction. Ten focus group discussions with CHC members and nineteen in-depth interviews were carried out with Environmental Health Technicians, Agricultural Extension Officers, and Community Based Facilitators. Data was transcribed and analysed using content analysis, and the results indicated that integrating VSL and IGAs into CHCs improved latrine coverage. This learning brief shares key findings along with additional lessons from implementation, including on engaging with ministry counterparts from the onset of the project design to encourage sustainability, developing a male-engagement strategy, and dedicating time and resources to sufficient capacity building, supervision, and monitoring from the earliest stages of program start-up.

INTRODUCTION

Although progress has been made towards [Sustainable Development Goal \(SDG\) 6](#) to “ensure availability and sustainable management of water and sanitation for all by 2030,” many people still lack access to safe water, sanitation, and handwashing facilities. Therefore, in line with the SDG 6, the government of Zimbabwe’s gender-sensitive Sanitation and Hygiene Policy has pledged to create an open defecation free Zimbabwe by 2030. In 2019, 37% of the population in Zimbabwe used basic sanitation facilities (43% in urban settings and 34% in rural areas).¹ While universal access to sanitation remains a challenge, innovative approaches to safe sanitation, including the Ventilated Improved Pit (VIP) latrine and the

¹ Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019). Zimbabwe Multiple Indicator Cluster Survey 2019, Survey Findings Report. Harare, Zimbabwe: ZIMSTAT and UNICEF.

Participatory Health and Hygiene Education (PHHE) strategy,² have supported increased coverage and practices of sanitation and hygiene behaviors in Zimbabwe. The Amalima Program, funded by USAID's Office of Bureau for Humanitarian Assistance (BHA), complements the Government of Zimbabwe's efforts towards improved food security, nutrition and health, including water, sanitation and hygiene (WASH). Amalima is led by Cultivating New Frontiers in Agriculture (CNFA) and implemented by a consortium of organizations: International Medical Corps, The Manoff Group, the Organization of Rural Associations for Progress, Africare, and Dabane Water Workshops. Amalima is implemented in four districts in Matabeleland South and Matabeleland North that are prone to low rainfall patterns and consequently are largely food and nutrition insecure.

In the Final Performance Evaluation of Amalima, the activity saw a significant increase (from 49.7% at baseline to 98.4% at endline) in the number of households safely storing drinking water and in the number of households (from 40.6% at baseline to 53.6% at endline) using improved sanitation facilities.³ The final evaluation noted that WASH improvements were likely attributable to the strong hygiene education conducted through trained community-based facilitators and the CHCs. Based on these findings, this learning note documents the strategies employed by Amalima to support effective WASH behavior change. This brief includes key findings and recommendations from a mixed-methods study conducted by Amalima, in cooperation with [PRO-WASH](#) and [TANGO International](#), and lessons from implementation applicable to future food security and WASH programs.

Amalima is a Ndebele word for the social contract by which families come together to help each other engage in productive activities, such as land cultivation, livestock tending, asset building, and development initiatives. The Amalima DFSA aimed to improve household access to and availability of food, community resilience to shocks, and nutrition and health among pregnant and lactating women as well as and boys and girls under the age of two.

WHAT ARE COMMUNITY HEALTH CLUBS?

Community Health Clubs (CHCs) are a cost effective and participatory-based approach that support the uptake of key water, sanitation, and hygiene (WASH) behaviors.⁴ They were first piloted in Zimbabwe in 1995⁵ and subsequently adopted into the National Sanitation and Hygiene Policy.⁶ For these reasons, Amalima selected this approach with the Zimbabwe's Ministry of Health and Child Care (MoHCC) during the project design. CHCs use a Participatory Health and Hygiene Education (PHHE) curriculum as a social marketing approach.

Since 2013, Amalima has supported the establishment of 525 CHCs, each comprising of 15-30 members. Approximately 34% of 60,000 households that Amalima is reaching have a family member in a CHC.

² Government of Zimbabwe (2017). The Zimbabwe National Sanitation and Hygiene Policy 2018-2022. Zimbabwe. Available at: <http://newfour.ncuwash.org/wp-content/uploads/2017/08/National-Sanitation-and-Hygiene-Policy-Draft-2017.pdf>

³ IMPEL. (2020). Final Performance Evaluation of the Amalima Development Food Assistance Project in Zimbabwe (Vol. 1). Washington, DC: The Implementer-Led Evaluation & Learning Associate Award. Available at: https://pdf.usaid.gov/pdf_docs/PA00WHZ4.pdf

⁴ Waterkeyn J, Cairncross S. Creating demand for sanitation and hygiene through Community Health Clubs: a cost-effective intervention in two districts in Zimbabwe. *Soc Sci Med.* 2005;61(9):1958-1970. doi:10.1016/j.socscimed.2005.04.012

⁵ Comparative Assessment of Hygiene Behaviour Change and Cost-Effectiveness of Community Health Clubs in Rwanda and Zimbabwe in *Healthcare Access - Regional Overviews*. DOI: 10.5772/intechopen.89995

⁶ Government of Zimbabwe (2017). The Zimbabwe National Sanitation and Hygiene Policy 2018-2022. Zimbabwe. Available from: <http://newfour.ncuwash.org/wp-content/uploads/2017/08/National-Sanitation-and-Hygiene-Policy-Draft-2017.pdf>

Community Based Facilitators (CBFs), 90% of which are also Village Health Workers,⁷ facilitate the CHC meetings with support from Zimbabwe’s MoHCC Environmental Health Technicians (EHTs). Together, club members complete the modular PHHE curriculum over an average of six months.

During this time, groups meet once every week or every two weeks to follow participatory hygiene promotion lessons on

how to make practical adjustments to improve hygiene in the home. This includes constructing latrines, building “tippy tap” hand washing stations and kitchen pot racks, and digging garbage pits. At the end of each meeting, members commit to making these improvements in their own homes and to practicing these behaviors. All club members must make these improvements to “graduate.” Ahead of the graduation, the CHC members select a “model home” by taking into account the home’s hygiene-enabling facilities, as well as the cleanliness of the environment (e.g., well-swept yard with no animal excreta, disk drying rack, tippy tap and trash pit, and a clean presentable kitchen and with covered water storage containers). This prospect of being selected as a model home that will be recognized during the graduation ceremony motivates CHC members to participate and to undertake home hygiene improvements.

During implementation of the CHC approach, routine monitoring data indicated that members faced barriers related to the costs of purchasing cement needed to build a latrine and there was no systematic approach to address these barriers. While historically, the government subsidized latrine costs through direct distribution of cement, this is no longer available. In addition, the economic situation in Zimbabwe has resulted in hyperinflation, exacerbating the financial situation. More recently, families dependent on remittances from family members working abroad were affected by the stay-at-home orders in parts of the Southern Africa region, downturn in economic activities, and voluntary repatriations to Zimbabwe.

Despite these barriers, some groups had established trust and social cohesion and were interested to continue working



Community Health Club meeting.
Photo Credit: Amalima



Community Health Club members hold goats, which the whole group used to raise funds for building hygiene facilities in the members’ homestead.
Photo Credit: Amalima

⁷ CBFs were selected from VHWs and from HIV/AIDS home based care workers with a background in health and interpersonal communication to ensure that facilitators had previous exposure to core nutrition, health and WASH concepts, as well as, the effective interpersonal communication skills.

together on activities after graduation. It was envisioned that, if CHCs could build on this trust and cohesion to develop income-generating activities (IGAs) and village saving and lending (VSL) activities, funds could be used to address the financial barrier for latrine construction. Funds could also sustain the sanitation and hygiene costs at the household level after the life of the activity.

Therefore, Amalima promoted IGAs and VSL activities for CHCs after graduation. After completing the PHHE curriculum, each CHC participated in a guided session to discuss the CHC's plans, including potential IGAs and VSL activities. Members then decided on what activity, if any, they wanted to embark on. VSL groups are formed after the CHCs, only for those CHCs that showed interest. They then subsequently received training on group formation, constitution development, group fund development, loans and loan appraisal, and recordkeeping. This allowed groups to build savings to fund their activities. A subsequent training on selecting, planning, and managing an IGA was then provided, along with ongoing support on the specific activity. No other financial or material resources were provided through Amalima. To date, 28% of CHCs have diversified into VSL activities and IGAs, which also include investments and loans focused on supporting the purchase of small livestock and horticultural activities. IGAs were more successful and members were more enthusiastic when the activities related to gardening and livestock versus other activities, such as baking scones. This may be because of the importance placed on subsistence farming and livestock. It appeared that CHCs with VSL and IGA activities constructed more latrines than those without VSL and IGA activities.⁸ This distinction was noted to determine if this modified approach should be recommended to future activities.

Raising Goats to Improve Sanitation and Hygiene

After graduating from their CHC in 2015, 11 of the 33 Sifisimpilwenhle CHC members formed a VSL group to fund an IGA of raising goats. Amalima provided targeted, ongoing support by training the group on livestock management, nutrition, breeding, health, housing, and marketing. Members donated two goats each (for a total of 22 goats) and have since expanded the group's herd to over 100 goats. A portion of the proceeds supports further expansion of the income-generating activity and helps CHC members construct latrines and other home hygiene facilities. In the future, the group hopes to use the proceeds to support other community members. One group member stated that:

"As a group, we are preparing to drill our own borehole, if we manage to raise funds, so that we improve our health and hygiene practices. This will be an advantage to us and the surrounding community who don't have access to adequate and clean water."

[Click here](#) to read more about the Sifisimpilwenhle CHC.

QUALITATIVE ASSESSMENT OF THE INTEGRATION OF INCOME-GENERATING ACTIVITIES AND VILLAGE SAVINGS AND LOANS ACTIVITIES

In an effort to better understand the ways in which VSL and IGA activities support CHC members to overcome financial barriers, Amalima undertook a qualitative study to explore how and if the integration of VSL and IGA activities within CHCs improved uptake of latrine construction among

⁸ Out of 158 CHC+ households that had no latrines before joining CHCs+ at least 59% have constructed and are utilizing the latrines whereas out of 160 households of standard CHC members, only 32% have since constructed latrines (Amalima outcome monitoring data).

beneficiary households. The primary purpose of this study was to document learnings to inform future programming, and the specific research questions for the study were as follows:

- Do CHCs integrating VSL activities and IGA activities (referred to as CHC+s) have improved uptake of latrine construction compared to CHCs without (referred to as standard CHCs)?
- What motivates (i.e., motivating factors) standard CHCs and CHCs+ to construct latrines?
- What limits standard CHCs and CHC+ to construct latrines?

Amalima developed mixed methods research protocol and data collection tools with support from [PRO-WASH](#)⁹ and [IDEAL](#).¹⁰ The study employed focus group discussions (FGD), in-depth interviews (IDIs), and a review of the quantitative monitoring data on outcomes for CHCs. The research was conducted in two districts (Mangwe in Matabeleland South province and Tsholotsho in Matabeleland North province) across four purposively selected villages in November 2019. Tsholotsho district was selected by default as the only program district in Matabeleland North. Mangwe district was randomly selected from the three program districts in Matabeleland South. Villages within those districts were selected based on their location relative to markets and if they had CHCs with and without VSL and IGA activities. FGDs were conducted with CHCs that had diversified into VSL and IGA activities and CHCs that had **not** diversified into VSL and IGA activities. These two groups are referred to as:

- **CHCs+:** CHCs that had diversified into VSL and IGA activities
- **Standard CHCs:** CHCs that had **not** diversified into VSL and IGA activities

Prior to data collection, the protocol and data collection tools were reviewed by the Amalima technical learning unit team, [PRO-WASH](#), and [IDEAL](#). Following the pre-testing of the data collection tools, ten FGDs (5 with CHC+ members and 5 with standard CHC members¹¹) and nineteen IDIs with CBFs, EHTs and Agritex Officers were conducted. Observations were held in a sample of households with CHC members who have diversified into VSL and IGA

activities to identify and verify latrine construction. Participants gave verbal consent prior to participating in the study. Interviews were recorded in the Ndebele language and then transcribed directly into English for data analysis and reporting. Data was managed in Excel, and coded by themes by Amalima analysts for content analysis.¹²



⁹ PRO-WASH is an initiative funded by USAID's Bureau for Humanitarian Assistance (BHA). PRO-WASH aims to improve the quality of activities, strengthen the capacity and skills of BHA implementing partners in WASH, and improve the level of knowledge and practices around WASH.

¹⁰ The IDEAL activity, funded by BHA, works to support the United States Government's goal of improving food and nutrition security among the world's most vulnerable households and communities.

¹¹ A total of 254 participants were in the FGDs of which eight were men. Overall, only 14% of CHC members are male and 86% are female which explains the low participation of men in the FGDs.

¹² Hsieh H., Shannon S. (2005). Three approaches to qualitative content analysis. *Qual Health Res*;15(9):1277-1288.

KEY FINDINGS

Do CHCs integrating VSL and IGA activities have an improved uptake of latrine construction compared

To answer this research question, Amalima analyzed the CHC routine monitoring data and compared standard CHCs to CHCs+. The routine monitoring data indicated that there was a notable difference between CHCs+ and standard CHCs (59% of CHC+ members had latrines versus 32% of standard CHC members). The qualitative assessment identified that some CHC+ groups pooled together funds and followed a rotational system. On a month-by-month basis, a few members benefited from receiving money from the pooled fund to construct latrines for all members in the group without latrines. For those who already had latrines, funds went towards IGA activities. These funds were a form of social capital for CHC+ members. For group members without latrines the priority was latrine construction. For those with latrines, the priority was to develop IGAs for needs, such as school fees and buying small livestock. The CHC+ activities also expanded beyond the club by promoting the formation of new standard CHCs and to encourage the construction of latrines by nonmembers. CHCs+ established as far back as 2014 were still actively meeting to undertake VSL activities. This strongly suggests that VSL and IGA activities may be contributing to the sustainability and continuation of CHCs. However, hygiene promotion did not always remain a core component of groups' activities once they graduated and embarked on other VSL and IGA activities.

What motivates and limits standard CHCs and CHCs+ to construct latrines?

Both standard CHC and CHC+ members reported being motivated to build latrines because of their desire to reduce diseases, such as cholera and diarrhea among humans and to reduce the risk of cow measles (*bovine cysticercosis*). This results

"[The CHC] helped those who did not have latrines. You can use the money to buy cement and construct the latrine. Some members used money from VSL and others already had the latrines. To a greater extent, we used the money to buy cement and pay the builders."

- CHC+ member

in livestock being condemned at the abattoir. Communities place great value on owning livestock as a form of wealth and, therefore, the desire to construct latrines is high. While fewer standard CHC members had constructed latrines due to financial barriers, they highlighted learning disease prevention from the PHHE sessions along with CHC+ members, EHTs, and Agritex officers.

Shame, embarrassment, disgust, and the desire to have ones' own latrine also encouraged latrine construction according to FGDs with standard and CHC+ members, and IDIs with CBFs. In Mangwe and Tsholotsho, both standard CHC and CHC+ members stated that it was not easy to share a latrine with their neighbors as often times "derogatory" signage would be written/inscribed by the latrine owner such as "do not mess the toilet." Some members were motivated because they did not want their poultry to eat human excreta as, in turn, when they (CHC members) eat the chicken intestines, they would be eating their own or their neighbors' excreta.

Social support was also cited as a supporting factor. Both CHCs+ and standard CHCs indicated that “helping each other” in activities, such as brick molding, was an enabling factor in latrine construction. This sentiment was echoed more strongly amongst CHCs+.

“Some [members] do not have latrines and also do not have the money to buy cement for building the latrines, especially the aged. Then they end up not attending lessons because they know it might be hard for them to construct the latrines.”

- Key informant interview (community-based)

Perceived social cohesion was stronger among the CHCs+ as they cited that there was a “spirit of supporting each other.” It is important to note that, when a CHC had group cohesion, the group reported that this helped them embark on VSL and IGA activities as a group. Some groups, despite the economic crisis, managed to contribute money to different activities. For example, some clubs identified those who were less fortunate in their community, such as the elderly, and supported them. The Asisizaneni CHC raised thirteen chickens through a poultry project to fund latrine construction for community members who did not yet have latrines. Other clubs contributed money to have the same uniform to wear at meetings, as they were proud of being a member. Having husband support and local leader support was also mentioned as motivating factors for latrine construction. In some groups, “social pressure” from the children played a role in latrine construction. CBFs reported that social pressure from children in the households, fascinated by the tippy taps they saw in other homes, was a push factor for handwashing stations and latrines as the project promoted the two items together. In addition, members in Tsholotsho expressed concern that others could use feces from open defecation for rituals, which could be prevented by using the latrine. CHC members also reported that having locally available skilled builders, easy access to cement at the local market, and locally available resources (such as river sand) or access to a soil type that could be molded into bricks made it more likely to construct latrines.

One barrier to latrine construction included lack of water for brick making, as districts were drought-prone and faced water shortages. To overcome this barrier, members had to either use their own transport or hire transport to bring water from boreholes located farther away which resulted in additional time lost and costs. In some cases, CBFs, EHTs, and agricultural extension officers cited that a lack of local leadership/support became another barrier to the construction of latrines.

The only key difference identified in enabling factors and barriers for latrine construction between standard CHCs and CHCs+ was that the CHCs+ had “access to money” from the VSL and/or IGA activities. This alleviated the financial

“To a greater extent, VSL helped as I used the money to buy some of the stuff that I needed to construct a latrine. And we do other small businesses such as those of vegetables, poultry, jiggies (savory snacks), airtime (mobile phone airtime), soups and we even bake scones.”

- CHC+ member, FGD

burden of constructing a latrine, particularly when it came to purchasing cement or paying builders. This aligns with findings from another study on participatory sanitation in Zimbabwe where a household's ability to own a latrine depended heavily on the ability to afford the costs of construction.¹³ The

¹³ Whaley, L and Webster, J, 2011. The effectiveness and sustainability of two demand driven sanitation and hygiene approaches in Zimbabwe. *Journal of Water Sanitation and Hygiene for Development*, 1(1), pp.20–3

reported benefits of the VSL and IGA activities also extended beyond improvements in sanitation and hygiene as CHC+ members accessed funds to purchase cattle, pay school fees, and undertook other livelihood opportunities.

This study supported that having VSL and IGA activities integrated into CHCs allowed for more stable, reliable, and consistent sources of income to be used for latrine construction, along with other factors such as access to markets/products and social/local leader support for latrine construction. CHCs+ were successful in building social cohesion among community members and providing additional WASH resources to vulnerable households. The benefits of increased social capital from CHC members undertaking VSL and IGA activities and the role that social norms and social cohesion play to support the successful uptake of improved WASH behaviors have also been documented in other studies¹⁴ and research.¹⁵

However, there are several limitations to this study. The researchers were project staff and may not be strictly impartial. However, strong efforts were made to minimize resultant bias by using external reviewers ([PRO-WASH](#) and [TANGO International](#)). The presence of program staff during data collection may have also influenced the participants' responses (courtesy bias). Finally, the selection of CHCs was not entirely random and not representative of all CHCs.

Learning From Conducting Qualitative Research

This qualitative research was also an opportunity for staff learning, including the importance of building in adequate time and resources for qualitative research on sanitation and hygiene. Amalima noted that the original qualitative research protocol that they developed was very ambitious. There was a need to narrow in on key research questions. Using voice recorders and transcribing data helped to capture valuable information but managing the amount of data generated by the FGDs and IDI was challenging. Careful translation ensured that key information was not lost in translation from Ndebele to English. Future projects should build in time and resources for qualitative studies given the richness and utility of the data generated.

“Even after collecting the data, we spent lots of time making sure to spend a lot of time really looking at the data and not rapidly drawing conclusions...It was the first time I was hearing about these myths. Had we known about these from the project onset we could have come up with other ways to address these. For example, there were concerns around feces and witchcraft. We could have come up with different SBC strategies/approaches to address these myths.”

- Amalima team member

KEY RECOMMENDATIONS

For Amalima:

- Share findings with Zimbabwe's Ministry of Health and Child Care (MoHCC) to consider integrating the VSL and IGA trainings into the PHHE curriculum

For community-based facilitators (CBFs):

¹⁴ Cameron L.A., Olivia S., Shah M. Initial Conditions Matter: Social Capital and Participatory Development.

¹⁵ Dickin S., Bisung E., Savadogo K. Sanitation and the commons: The role of collective action in sanitation use. *Geoforum*. 2017;86:118–126. doi: 10.1016/j.geoforum.2017.09.00

- Engage husbands, other men, and local leadership in CHC activities to support sanitation and hygiene behaviors
- Promote a one bag cement model where access to water and/or money is a barrier to latrine construction
- For CHCs+, CBFs should conduct quarterly “refresher sessions” on hygiene promotion to support behavior change and to ensure that sanitation and hygiene remains a core component of the group

For the Government of Zimbabwe and Supporting Partners:

- Integrate VSL and IGA trainings into the National PHHE curriculum
- Standardize trainings so that CHCs receive VSL and IGA training after completing the standard PHHE curriculum to encourage the prioritization of latrine construction as a part of the VSL/IGA
- Support WASH market strengthening activities to facilitate local cement procurement
- Build in adequate resources/time for qualitative research to document what is working and not working when it comes to supporting WASH behavior change and infrastructure improvements
- Assess differences in behavioral uptake between co-ed CHC+ groups versus all male/female CHC+ group to inform future programming

LESSONS LEARNED FROM IMPLEMENTATION

The following sections provide additional details about Amalima’s CHC approach, including how certain components helped reinforce promotion of WASH behaviors and investments in WASH infrastructure. In order to address some of the potential challenges programs face when implementing and sustaining sanitation and hygiene behavior change, Amalima focused on participatory approaches and four core components:

- Engaging with ministry counterparts during project design to encourage sustainability
- Dedicating time and resources to sufficient capacity building, supervision, and monitoring from the earliest stages of program start-up
- Developing a male-engagement strategy that addressed key barriers to participation
- Leveraging complementary platforms to encourage hygiene and sanitation behavior change

Engaging with ministry counterparts from the onset of the project design to encourage sustainability:

Sustained engagement with national and local government stakeholders was ensured through joint trainings, strengthening the links between Environmental Health Technicians (EHTs) and CBFs, and engaging village health workers as CBFs.¹⁶ Amalima leveraged existing district and provincial-level water and sanitation sub-committees and ensured regular participation and reporting. These government-mandated structures also engaged in monitoring the CHCs. This joint engagement with the Ministry of Health helped manage the time burden on volunteers. While most CBFs were village health workers eligible for a government stipend, care was taken to ensure that the project was not taking too much of their time. In villages where there was strong interest in CHCs, the number of CBFs increased so that each CBF had a limited number of clubs to facilitate. Several PHHE lessons were combined to reduce the number of meetings before graduating, thus reducing the time burden on CBFs and club members.

Dedicating time and resources to sufficient capacity building, supervision, and monitoring from the earliest stages of program start-up:

Zim AHEAD (Applied Health Education and Development), who pioneered the CHC model in Zimbabwe,

¹⁶ Most Village Health Workers serve as both care group volunteers and as CBFs. As Care Group sessions happen once a month and CHCs weekly to bi-weekly, it was possible for the volunteers to manage their time commitment.

supported the set-up of the CHCs. Amalima field officers, the government of Zimbabwe EHTs, and the initial groups of CBFs were trained by Zim AHEAD. This capacity building early on and engagement with the MoHCC's Department of Environmental Health developed a support system for the CBFs and helped to ensure quality and effectiveness.

Contextualizing the approach and adapting the curriculum to the project's districts was important. For example, some community members had previously been in a club and were interested in re-joining a club, whereas others (such as some youth) wanted to develop a separate club for their age group. Routine monitoring using standard checklists ensured quality and aided to refine the CHC approach. Monitoring allowed routine assessment of CHC members' progress. At the start-up of a club, an inventory counted how many members had pit latrines, handwashing facilities, and garbage pits. This was repeated at the midpoint and endpoint of the curriculum. For those members lacking hygiene facilities at midline or endline, CBFs and EHTs provided support and coaching. Holding annual review meetings with all CBFs and EHTs to meet and discuss areas of success and improvement allowed for routine adjustments to the approach, fostered relationships, and encouraged peer-to-peer learning.

Developing a male-engagement strategy that addressed key barriers to participation:

While all genders are encouraged to join CHCs, monitoring data indicated that only 14% of CHC members were male. The few male participants were more likely to participate in male only CHCs, when there was a village or traditional leader CHC member, or when the time commitment of the activities were shorter. These findings fed into a targeted [male-engagement strategy](#). The Ministry of Gender and local leadership identified male champions who, similar to a CBF, promoted sanitation and hygiene behaviors while keeping the time commitment shorter. Through this strategy, more men began participating in CHCs and some started to form male-only CHCs, as highlighted below. Yet, due to economic migration, few men were available to participate. However, males engaged in other meaningful ways, such as by digging the household garbage pit, constructing the tippy tap, collecting construction resources, and supporting improved hygiene practices in the home. This understanding of how men prefer to be engaged and the barriers and motivators to male engagement in hygiene and sanitation activities is an important lesson for future program design and aligns with other studies that highlight the importance of seeing and valuing the differences in work, skills, and concerns of both men and women.¹⁷ The qualitative assessment of the CHC and VSL and IGA activities also pointed to the importance of men supporting



¹⁷ Cavill, S., Mott, J. and Tyndale-Biscoe, P., with Bond, M., Huggett, C. and Wamera, E. (2018) 'Engaging men and boys in sanitation and hygiene programmes', *Frontiers of CLTS: Innovations and Insights* 11, Brighton: IDS

latrine construction. As concluded from other studies, engaging males can make CHCs more effective and help in addressing gender disparities in WASH.

In March 2016, Amalima supported the creation of the first all-male CHC in Zimbabwe: **the Asisizaneni CHC**. After attending a WASH mobilization session, men decided to form a club because they realized that their families were practicing poor WASH behaviors. The group has helped break down traditional perceptions on gender roles, and members are inspired to share household roles traditionally performed by women (such as fetching water) as a way to improve family health. The group was faced with some skepticism by other community members for challenging traditional gender roles. Group members used this skepticism as an opportunity to educate other men about the importance of shared household responsibility in regards to WASH practices.

Leveraging complementary platforms to encourage hygiene and sanitation behavior change:

Research has shown that using a blend of social behavior change methods is effective at promoting handwashing and sanitation behavior change.¹⁸ For this reason, Amalima leveraged complementary platforms in addition to the CHCs, including Care Groups (CGs), cross-learning visits, demonstrations at healthcare facilities, and multi-sectoral messaging at food distribution sites. Both CG volunteers and CHC members were recruited primarily from village health workers to ensure the streamlining of sanitation and hygiene lessons. CG members were comprised of pregnant/lactating women and caregivers of children under two. Amalima adapted the CG lessons to include WASH topics to expand the sanitation and hygiene reach beyond just the CHC members. Lessons were also incorporated into the CG health and nutrition curriculum, such as through visual flipcharts that guided participants towards small doable actions. For example, if a family cannot afford cement in the immediate term for sanitation construction, the next best option is “cat” sanitation or covering feces with sand or ash to reduce environmental contamination. About 60% of the CHC members also participated in CGs, which reinforced knowledge and practices. While CG membership is limited to the period of pregnancy up until the child is two years old, CHC membership is lifelong, allowing for the continued reinforcement of the sanitation and hygiene messaging received during their child’s early infancy in the care groups.

Clinic staff acknowledged positive results from the installation of handwashing stations at health centers, including community uptake of handwashing outside of the health center.¹⁹ Supplementary food ration distribution sites were also leveraged to communicate key hygiene and sanitation messages through drama/song and to encourage participants to join CHCs. This cross-fertilization of topics fostered integration within the project and reinforced key behaviors.

Through peer-to-peer learning, members struggling to implement the VSL/IGAs visited groups who had made more progress with these activities. This motivated groups to work together towards achieving the successes visible in the visited group through developing a plan for areas of improvements. These relationships are a sustainable structure for support among members beyond the life of Amalima.

Although multiple channels focused on handwashing with soap and tippy taps, challenges remain around using ash instead of soap and on maintaining and sustaining tippy taps. The Amalima final performance evaluation reported minor improvements in the percentage of households with soap and

¹⁸ De Buck, E., Van Remoortel, H., Hannes, K., et al. (2017). Approaches to promote handwashing and sanitation behaviour change in low- and middle-income countries: a mixed method systematic review. *Campbell Systematic Reviews*, 13(1), 1-447.

¹⁹ IMPEL. (2020). Final Performance Evaluation of the Amalima Development Food Assistance Project in Zimbabwe (Vol. 1). Washington, DC: The Implementer-Led Evaluation & Learning Associate Award

water at a handwashing station.²⁰ Conducting a specific barrier analysis or other formative research on handwashing could develop a tailored strategy, which along with sustained follow-up could address this challenge.²¹

CONCLUSIONS

Amalima's agile and adaptive management practices that included using real time monitoring data allowed the original project design to be adapted to include VSL and IGA activities to support the adoption of sanitation and hygiene practices. VSL/IGA activities allowed for a more stable, reliable, consistent source of income for latrine construction. Government engagement, sufficient capacity building, complementary platforms,

"The implementation of Amalima's water, sanitation, and hygiene component in the four districts of Matabeleland was welcomed by the participating communities, and led to remarkable improvements in the accessibility and efficiency of health services. The project activities were clearly relevant and effective in meeting community needs and expectations, and left the communities satisfied. These particular efforts resulted in positive behavior change where the outcomes were readily incorporated in participants' daily lives. Prospects for the sustainability of improved household hygiene after the main phase of project implementation are quite high, since the communities have realized that these practices strongly contribute to improved primary health for their family members."

- Amalima's final performance evaluation

and the engagement of men resulted in positive changes, and key learnings from the study and from implementation were shared with the government of Zimbabwe and partners to inform future programming. In the Amalima final performance evaluation, all WASH FGDs committed to sustaining the improvements made by creating more CHCs and constructing additional household sanitation facilities using VSL and IGA activities to achieve open-defecation-free status in all participating villages. Sustaining community engagement and behavior change longer term may require some additional support and follow-up. Supporting the Government of Zimbabwe in providing "refresher sessions" on hygiene promotion as well as support on emerging threats, such as COVID-19, may help in achieving long-term success. The CHC model strengthened emergency preparedness and is now serving as a resource during the COVID-19 pandemic. Also, having a trusted network of club members and trained CBFs ahead of the pandemic allowed for the rapid dissemination of key messages through the CHCs and building Tippy Taps at business centers.

To learn more about the milestones, approaches, and studies gathered from the program's seven years of implementation, visit the Amalima learning site at www.cnfa.org/amalima.

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²⁰ idem

²¹ Cameron, L., Olivia, S., & Shah, M. (2015). Initial Conditions Matter: Social Capital and Participatory Development. *SSRN Electronic Journal*. doi: 10.2139/ssrn.2704614