Does integrating savings, lending, and income-generating activities improve the uptake of latrines?

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INTRODUCTION

Community Health Clubs (CHCs) are a cost-effective and participatory-based approach that supports the uptake of key water, sanitation, and hygiene (WASH) behaviors.[1, 2]

Amalima, a USAID Bureau for Humanitarian Assistance (BHA)-funded Resilience Food Security Activity (2013-2020), selected this approach with the Zimbabwe Ministry of Health and Child Care (MoHCC) and in alignment with the Zimbabwe National Sanitation and Hygiene Policy.[3]

During implementation, latrine costs were identified as a barrier to improving sanitation. CHCs were encouraged to diversify into income-generating (IGA) and village savings and lending (VSL) activities, although not all decided to pursue this activity.

This poster presents findings from a qualitative study 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.

CONTEXT

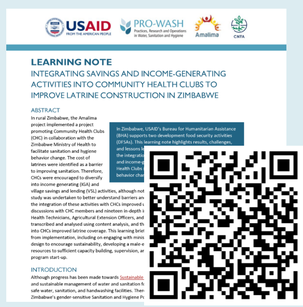
CHCs use a Participatory Health and Hygiene Education (PHHE) curriculum. Together, club members complete the modular curriculum over an average of six months, by meeting regularly with community-based facilitators and peers and undertaking hygiene improvements within the home. All club members must make these improvements to "graduate."

After completing the PHHE curriculum:

- CHC members participated in a guided session to discuss the CHC's plans and determined future activities, if any, including potential IGAs and VSL activities.
- Interested groups received training such as on constitution development, group fund development, loans and loan appraisal, recordkeeping, selecting, planning, and managing an IGA, along with ongoing support on the activity.
- No other financial or material resources were provided through Amalima.
- To date, 28% of CHCs have diversified into VSL activities and IGAs, referred to as **CHCs+**
- Routine monitoring data indicated that there was a notable difference between CHCs+ (with VSL/IGA) and standard CHCs (without VSL/IGAs):
  - **59% of CHCs+ members had latrines versus 32% of standard CHC members.**

Box 3

Learn more about Amalima and the integration of VLSAs into Community Health Clubs by visiting the FSN Network and downloading the Amalima learning note (left) and visiting the Amalima webpage (right).



METHODS

- The protocol and data collection tools were reviewed by the Amalima technical learning unit team, PRO-WASH, and IDEAL, and subsequently pre-tested during the enumerator training.
- Ten focus group discussions with CHC members (five with CHCs+ and five with standard CHCs) and 19 in-depth interviews with Community-Based Facilitators, Environmental Health Technicians, and Agricultural Extension Officers were conducted.
- Observations were held in a sample of households with CHC members who have diversified into VSL and IGA activities.
- Interviews were recorded in the Ndebele language and then transcribed directly into English for data analysis and reporting.
- Data were analyzed using content analysis.[4]

CHC members hold goats, which the whole group used to raise funds for building hygiene facilities in the members' homestead. *Photo Credit: Amalima*

Box 1

CHCs+ are CHCs that diversified into VSL and IGA activities

Standard CHCs are CHCs that had not diversified into VSL and IGA activities

Box 2

"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

FINDINGS

Do CHCs+ have an improved uptake of latrine construction compared to standard CHCs?

- Some CHCs+ 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.

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). 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 as a motivator.
- Shame, embarrassment, disgust, and the desire to have one's own latrine also encouraged latrine construction according to FGDs with standard CHC and CHC+ members, and in-depth interviews with Community-Based Facilitators.
- Social support was also cited as a supporting factor as "helping each other" in activities, such as brick molding, was an enabling factor.
- 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. However, there was a lack of water for brick-making, as districts were drought-prone and faced water shortages.

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 burden of constructing a latrine, particularly when it came to purchasing cement or paying builders.

CONCLUSIONS

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 studies and research.[5, 6]

However, hygiene promotion did not always remain a core component of groups' activities once they graduated and embarked on other VSL and IGA activities. Thus it is important to also consider hygiene promotion follow-up, refreshers and reminders. To our knowledge, this is the first study in Zimbabwe to document outcomes related to combining financial activities with CHCs.

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