THE EUROPEAN SOCIETY OF MEDICINE
Medical Research Archives, Volume 14 Issue 4

RESEARCH ARTICLE

# Preventing Disease in Primary Health: Harnessing Group Consensus through Ubuntu in Zimbabwe and Communitarianism in Vietnam

**Juliet Waterkeyn**[1]

[1] PhD, London School of Hygiene and Tropical Medicine

OPEN ACCESS

**PUBLISHED**
30 April 2026

**CITATION**
Waterkeyn, J. 2026. Preventing Disease in Primary Health: Harnessing Group Consensus through Ubuntu in Zimbabwe and Communitarianism in Vietnam. Medical Research Archives, [online] 14(4).



**ISSN**
2375-1924

## ABSTRACT

For the past fifty years, the dominant paradigm in public health has been the Health Belief Model of knowledge transfer, using an individualistic appeal to 'beneficiaries' with the expectation that community members are able to undertake change through solo decision-making. However, most subsistence societies are organised along communitarian lines with an emphasis on group consensus rather than individual decision making. Technology transfer has often failed to achieve long term sustainability, using top-down transfer of information to achieve change. Since 1995, the Community Health Club Model of community mobilisation has been successfully introducing the idea that instead of approaching individuals in a community, a dedicated group is formatted which is mandated to make communal decisions so alleviating the need for individual choice. This paper argues that a communitarian ethic — known as 'Ubuntu in Africa — may explain the success of health clubs, and account for the long-term sustainable development in rural communities. Using health promotion as an entry point this is a group approach which can rekindle a culture of mutual reciprocity in a collective mobilisation strategy. Practical group activities related to hygiene, water, sanitation, agriculture and women's empowerment through skills transfer have achieved remarkable success in a variety of contexts across 13 countries in Africa and two countries in Asia. Policy recognition of this community mobilisation approach in both Rwanda and Zimbabwe demonstrates the potential for the institutionalisation of the Community Health Club model into other African countries particularly in fragile states. In addition, there is also compelling evidence that health clubs in Vietnam can improve hygiene and sanitation with reduction of diarrhoeal disease, showing the model may also be successfully replicated to other countries of Asia. This approach may provide a bridge for the prevention of many diseases in primary health because it reinforces cultural values of group consensus.

## Introduction

Public health interventions have long grappled with the challenge of hygiene behaviour change and the need for community 'buy-in' to new ideas to ensure sustainability particularly in water supply, sanitation and hygiene (WASH) programmes.[1] For the past half-century, the dominant paradigm in the WASH Sector in developing countries has been to use the 'Health Belief Model' which attempts to persuade individuals of the reason *why* they would benefit from the recommended new practice. The underlying assumption in the Health Belief paradigm is that the beneficiaries of such programmes are autonomous decision-makers and assumes that people act on knowledge based on scientific evidence. This ethnocentric rationale reflects the cultural norm prevalent in the global North, whereby health promotion campaigns routinely place emphasis on individual responsibility for personal action.[2] Our hypothesis in this paper is that this unconscious assumption that individuals ***can*** make their own choices, is often the root cause for the lack of community response in developing countries.

### INDIVIDUALISM

In developed countries of the global North – commonly referred to as the 'West' – the need for personal achievement is routinely developed from childhood through the educational system which is modelled on cultural ideals largely enshrined in the 'protestant work ethic' identified by Max Weber in which success of the individual is paramount.[3] The universal educational system in the North, has from an early age encouraged children to distinguish themselves individually, to compete for personal recognition, and to pursue advancement as a solitary achievement – academic accolades are based on their own individual excellence and are achieved through competition, ambition, and the drive to succeed — even at another's expense.[4] Such 'need to achieve' produces a linear world view where progress (continually improving standard of living) is accepted as the primary objective of life. Each generation aspires to build on the previous generation and in the North, there is little fear of change.

### COMMUNITARIANISM

By contrast to the Northern paradigm, in the global South (Sub-Saharan Africa, Caribbean, South America, India and Southeast Asia), the fundamental belief is that a person's individual advancement should not disrupt communal harmony. A high proportion of subsistence communities still retain a cyclical world view which endorses the repetition of cultural beliefs and practices which stretch back historically to pre-colonial values and religion. Individual competitiveness is fundamentally at odds with communitarian ethics traditionally found within such subsistence societies. One such philosophic world view which sustained pre-colonial rural societies is the ethic of *Ubuntu* which is still found in various forms in traditional societies throughout sub-Saharan Africa. This communitarianism world view is reflected in the many derivations of the word *Ubuntu,* which denotes a human '*muntu*'. Thus, we find *Unhu* or *Hunhu* in Zimbabwe and Zambia, '*uMunthu*' in Malawi, *Botho* in Tswana, *Vumuntu* in Mozambique, *Bumuntu* in Tanzania, *Umuntu* in Kenyan Kikiyu, *Bomoto* in Democratic Republic of Congo and *Gimuntu* in Angola[5].

Having been popularised by President Nelson Mandela of South Africa, *Ubuntu* is the most commonly used term internationally for all derivatives. The ethic of *Ubuntu* is described in the South African isiXhosa saying, '*Umuntu, ngumuntu, ngabantu*' meaning a person can only be a true human through the connection with other people[6]. People who behave selfishly profiting at another's expense, can be denigrated as *akabuntu* which infers they are subhuman. With such a coherent culture of *Ubuntu* stretching throughout sub-Saharan Africa, some African academics such as Morove (2009) are challenging the basis upon which the international development norms have been perhaps subconsciously based[7].

> *"When Westerners discuss the urgent need for Africans to embrace modernity and its inherent propensity for change, they usually mean that Africans should rid themselves of a communal morality in favour of one that is individualistic. In most western accounts, the age of enlightenment, characterised by individualism is portrayed as being the greatest contributor to the contemporary phenomenon of capitalist economic development."*

### HOW THE ETHIC OF UBUNTU TRANSLATES INTO BEHAVIOUR

In most of Africa, a communitarian concern for the harmony of the whole society at the expense of individual advancement is taught to children through stories and idiomatic sayings which teach personal humility[8]. *Ubuntu* is shown in the deference of minors towards the elderly and those in authority. Children do not voice opinions; few adults will volunteer their views unless invited. Thus, even a well-educated adult will defer to an illiterate village leader.[9] This is the opposite to northern socialisation whereby children are explicitly taught to be original and question authority. Such reticence to think for oneself in Africa often frustrates the well-educated and is sometimes mistaken by foreigners as diffidence or indifference.

The communitarian ethic is most apparent in the sharing of food. People in a rural gathering will go hungry rather than consume food in front of others without sharing. By contrast a foreigner seldom has any reservation about eating from their own personal lunchbox in front of others without sharing their sandwich. In the home throughout Africa, all members of the family share a common dish. Eating out of one dish with one's hands throughout the global south is the custom. For Northern foreigners this eating with hands is derided because it risks the spread of germs through contamination of food by others.

### HOW DOES VILLAGE LIFE REMAIN UNCHANGED?

Those that are curious and want more out of life usually leave the village and migrate to towns. Those that are left are conservative. Within this group there is often a subconscious 'levelling mechanism' which tends to ensure that everyone in the village remains at a similar standard of living. This 'tall poppy syndrome' often prevents individuals from adopting new ideas. Individuals may not want to put on 'airs and graces' or draw attention to their

wealth or achievement in case they attract covertness, jealousy and resentment. The flat stratification pyramid of the 'have's' and 'have-nots' particularly in rural Africa favours more harmony in the village in contrast to the highly stratified caste system of India. This is not to say that no one gets rich, but that when they do progress, they tend to leave the village. This cultural norm of 'comfort in sameness' explains the villager' apparent resistance to change. Unlike in the North, this dynamic does not favour the 'trickle down' of diffusion of innovation. Instead, a group approach is needed whereby everyone in the village maintains the same level, they learn together and move up the ladder together. It takes longer but is more cost-effective.

NEGATIVE IMPACTS OF UBUNTU

Some manifestations of *Ubuntu* can impact negatively on progress in community health and gender equity[10]. For example, the apportionment of food whereby men eat the best morsels of meat, and women and children take what little remains. In traditional African culture women have no rights to own land and are treated as minors, owing full obedience to their husband or another male upon his death. The old ways of *Ubuntu* clash with modern values in the ongoing urbanisation as the rural peasant class moves to town, and much of the old way is vanishing. Previous research of the author shows that although the concept of *Ubuntu* is still understood, it is becoming increasingly irrelevant to the younger generation[11]. A middle way is needed which combines *Ubuntu* behaviour which honours harmony of the village, but which gives way when it threatens to retard improvements to standard of living by ignoring modern scientific knowledge.

## Methodology

BACKGROUND TO THE WASH SECTOR

How has hygiene behaviour change been attempted un the past? Typically, to achieve non-risk behaviour change in order to prevent common diseases such as diarrhoea, cholera and malaria, public health initiatives would be held with a one-off *ad hoc* public meeting to inform a crowd (often gathered for another purpose) of the issue and how to prevent it. Alternatively, with a more targeted approach, a non-governmental organisation (NGO) might employ health promotors to go house-to-house tutoring each person individually. Importantly, both *ad hoc* gathering and door-to-door approaches are based on a top-down process of knowledge transfer whereby the benefactor is a passive recipient. Such face-to-face meetings with the community are usually one-off events with little follow up and no attempt to create a dedicated group for decision-making. People are expected to make up their own minds and with the new knowledge and respond rationally by changing their behaviour.

After a couple of decades of using this 'Health Belief' [12] model in the 70s and 80s many in the Water Sanitation and Hygiene (WASH) Sector concluded that health education was largely ineffective in inducing behaviour change[13]. In the 1990s, a more 'participatory approach' known as PHAST (Participatory Hygiene and Sanitation Transfer) was developed to try and empower community to take responsibility for their own water projects. PHAST, at its best, involved seven public planning meetings, but even with this extended training there was only marginal response by the community[14]. In the 2000's, the WASH Sector was beginning to despair that *anything* could make the community embrace hygiene and sanitation. In desperation some adopted a promotional approach inspired by the success of commercial advertising which tried to appeal to status to trigger change. Social Marketing rejected the need to supply a rationale for change. Marginal change was achieved in a few targeted behaviours such as handwashing[15], but the method failed to address the wide number of changes needed to prevent diarrhoea which was the ultimate objective. From 2005, the more draconian Community Led Total Sanitation (CLTS) method [16] became popular. Despite being clearly 'akabuntu' by African norms, community leaders were shamed into achieving 'Open Defecation Free' areas using the tactic of public humiliation. Although CLTS should have been recognised as inappropriate for conservative African villagers few in the WASH Sector challenged the ethics of such a method.[17]

DESCRIPTION OF THE CHC MODEL

The Classic CHC Model differs in a number of ways from the different WASH methodologies described above, primarily because of the recognition of the need to format a *specific membership* and develop a *set of accepted norms and values* as a *pre-requisite* in order to achieve sustainable behaviour change.[18] The approach of Africa AHEAD was to build on the strengths of PHAST with its empowerment of the community using participatory activities within a more structured group called a Community Health Club (CHC ).[19] The rationale for this approach was that 'community health' is a public good and by its very definition cannot be achieved through individual action alone. Diseases that spread through a shared environments — such as diarrhoea, cholera, malaria, tuberculosis, Covid 19 and trachoma require universal conformity if the spread is to be controlled. Within the WASH Sector the main concern is sanitation because one household's latrine is insufficient to prevent the spread of diarrhoea by flies, if the neighbours continue open defecation.

The CHC training provided 24 two-hour hygiene promotion sessions once a week for six months, by which time the community were well prepared *before* any material inputs were provided by a donor. This resulted in a deep appreciation of the need to manage water supplies and a strong demand for sanitation and high levels of safe hygiene.[20] This method could be called a 'model' for hygiene behaviour change because it could reasonably predict strong community response providing it was properly done (the Classic model).[22]

When Community Health Clubs (CHCs) were introduced in Zimbabwe, they drew large membership, often of up to 100 members with an average of 70 in each CHC. Research showed that the reason for this popularity is that CHC provided a forum for group learning which is highly valued in Africa particularly in areas of low literacy. In the past three decades, CHCs have been introduced into

at least 13 countries in Africa, and a few countries in Asia, of which Vietnam was the most thoroughly researched.[22]

This paper compares two such CHC interventions, in Zimbabwe and Vietnam, and will attempt to make a case that the communitarian values of *Ubuntu* in Zimbabwe and the Buddhist philosophy of *Interbeing* [23] which emphasise interconnectedness and mutual responsibility of the sangha (community) is a culturally appropriate method of community mobilisation in Asia. We show evidence to suggest that a similar concept inherent in *Ubuntu* maybe found in many other cultures where subsistence communities rely on mutual assistance.

The author was responsible for the design of the CHC programme in both Zimbabwe and Vietnam,[24] thus both conformed to a 'classic' CHC intervention as originally conceived. Previous publications have described the 'Classic' CHC method of community development in detail.[25] In brief, once a CHC is introduced into a village through the village leadership the aim is that it should include at least 80% of all households within walking distance of the CHC venue (usually under a large shady tree). Upon setting up a club, members – which tend to consist mainly of women – vote to form their own executive committee, which should be gender balanced. The meetings are held once a week for at least two hours. Each member has a membership card listing the 24 topics that they will cover and at each session their card is signed upon attendance. Topics includes all preventable diseases in the area as well as the practical and cost-effective ways within their means in which they can combat such disease. At each session a participatory activity is done using illustrated cards that prompt discussion[26] so getting women to gain confidence in speaking out. Every week there are recommended practices which all the members endorse as a group. These recommendations require small incremental changes: for example: during the period of one week, households will all cover their drinking water properly; the next week they learn how to make a wash hand facility. The ultimate challenge is the building of a latrine.[27] Individual understanding is not the yardstick and there are no tests of personal levels of knowledge. If the member simply attends all meetings, they will receive a certificate.

DATA COLLECTION

In both Zimbabwe and Vietnam, a similar method of data collection and analysis was done by the author on the impact of the intervention in terms of hygiene and sanitation behaviour change and disease reduction. This has been previously described where more detailed analysis can be found.[28]

In Zimbabwe a case / control study was done in Makoni District where 382 CHC households from 25 randomly selected CHCs were compared to 113 non-CHC households in 25 control villages which had been matched with the intervention for literacy and economic level. A Household Inventory, with a spot check of 17 observable indicators related to safe water hygiene and sanitation was taken before the training and then six months after the end of training. Secondary data on disease prevalence was collected from eight Health Centres purposely selected in areas where CHCs were operating at different levels of saturation.

In North Vietnam the same Household Inventory tool was adapted to the local context. In one district of Ha Tinh a base line survey was done of 7,187 untrained households and post intervention survey conducted in 900 households from 12 CHCs and 300 non CHC households.

Both sets of data were analysed by the author using SPSS and standard test of chi square used to compare. Secondary data which tracked reported cases of diarrhoeal disease was collected from eight clinics in CHC areas and five control clinics in non CHC districts.

SOURCES OF BIAS AND CONFOUNDING.

In Vietnam there could have been some confounding as the CHC training was not the only health promotion programme but to minimise this overlap, only indicators which were unique to CHCs were used. The post intervention survey also included some non-CHC members due to shortage of CHC members which would dilute the level of response recorded. Interviewer bias could be present in both countries as the same Ministry of Health enumerators were those who also conducted the training. However, some spot checks were done by the author to triangulate findings.

## Results

1. ZIMBABWE

**Empirical Evidence of hygiene behaviour change and disease reduction**

In Makoni District, 265 CHCs were established between 1999 and 2001, enrolling over 11,000 members and reaching approximately 63,700 beneficiaries. Observable hygiene improvements included 80% adoption of the use individual cups and plates, construction of latrines, pot racks, rubbish pits and establishment of handwashing facilities and nutrition gardens.[29] Reported diarrhoeal cases at health centres declined by over 1,200 cases in the five years following the start-up and operation of CHCs, so demonstrating significant disease control of malaria, bilharzia, as well as skin and eye disease and reduction of intestinal helminths.[30]

2. VIETNAM

A pilot CHC programme in Vietnam in 2010 took place in Ha Tinh where 48 CHCs, with 2,929 members, were estimated to benefit 13,258 people [13]. This district recorded an outstanding uptake in sanitation which resulted in Zero Open Defecation (ZOD) being achieved within five months of which half the households constructed permanent latrines – this was a higher achievement even than in Zimbabwe.

Using the same hygiene indicators as in Zimbabwe, nine of 17 indicators exceeded 80% uptake, including safe drinking water which increased from 35% to 90% of households.

Government records at Health Centres in CHC areas recorded striking disease reduction: diarrhoea,

dysentery, and food poisoning cases dropped from 171 to 17 in CHC areas, while control areas showed little change.

Qualitative interviews confirmed high satisfaction with the approach, with all government officials rating the success of CHCs highly. The popularity of CHCs in Vietnam was attributed to voluntary participation, communal organization, and improved relationships within villages.

## Discussion

ZIMBABWE: NUTRITION GARDENS AND THE CHIEF'S PLOT

Even as 85% of Zimbabweans today identify as Christian, the traditional values of *Ubuntu* continue to shape social life through informal practices of solidarity, extended kinship obligations, and communal rituals. Within CHCs, *Ubuntu* resurfaces in collective learning, peer accountability, and gendered empowerment. The secret of the health club success is that CHCs provide an institutional forum for *Ubuntu* to thrive, enabling communities to reclaim collective identity in the face of individualising pressures.

CHCs reintroduced the concept of the communal nutrition garden, which echoes the historical 'chief's plot' whereby communal land was farmed jointly to provide food for the marginalized, widows, orphans, and travellers. This practice embodied *Ubuntu's* ethic of care: no one should go hungry if the community as a whole has the means to provide. By reviving this tradition, CHCs translate *Ubuntu* into practical action. Nutrition gardens improve dietary diversity and food security, while reinforcing the principle that health is a collective responsibility. Members work together, share harvests, and ensure that vulnerable household's benefit. In this way, CHCs bridge ancestral practices with contemporary public health, creating higher response levels because interventions feel culturally authentic. Similarly, the deep pits needed for latrines are dug by groups of women CHC members who take turns to assist all in the village ensuring that those who are unable to dig a latrine are supported by other members. In most CHCs a savings and loan scheme is initiated by members themselves which enables a fund for sanitation. Each week at least one household is able to build a latrine by drawing on the common savings collected by small donations from all members.[31]

This finding is further corroborated by extensive research carried out by UNICEF where it was reported that 75% of all 158 urban CHCs in 13 towns had progressed to a mature stage, meaning they had ongoing projects and bank accounts. Furthermore, 80% of the CHCs which were established between 2013-2015 were found to be still active in 2018, suggesting long term sustainability of such CHC.[32] Another international review on water sanitation and hygiene projects using CHC, notes that although not the *primary* objective of the project, 10 of 25 studies also reported '*qualitative evidence of impact on social capital and collective action*' which can be taken as the equivalent of *Ubuntu*.[33]

VIETNAM: MEETING HOUSES AND COLLECTIVE COMMUNICATION

In North Vietnam, the Indochinese Communist Party, founded by Ho Chi Minh in 1930, grounded in Marxist–Leninist ideology led to the suppression of individual enterprise, the closure of monasteries, and persecution of religious orders. While Buddhist practice was curtailed, communitarian structures were reinforced through socialist organization — village committees, women's unions, and collective halls. After the Vietnamese – American War (1955–1975), there was a resurgence of engaged Buddhism, particularly through Thích Nhất Hạnh's philosophy of Interbeing. Today in Vietnam there exists an inclusiveness akin to *Ubuntu* which involves the whole village. No household can miss out on information; participation is universal. This is ensured because all gatherings in meeting house are broadcast by loudspeaker to the entire community. This practice reflects the collectivist ethic of working with the whole, rather than the northern "trickle-down" model where information filters unevenly and individuals are expected to act in isolation through personal effort. The philosophy within Buddhism recognises that well-being is inseparable from community solidarity, and that decisions must be shared openly with all. CHCs align naturally with Buddhism and the Vietnamese culture generally, ensuring that health promotion is embraced collectively, in recognition that each person's welfare affects the others.

Together, the example of CHCs in both Zimbabwe and Vietnam show how CHCs succeed by aligning with cultural traditions of inclusivity and solidarity. This holistic vision of interconnectedness provides a spiritual and cultural foundation for collective health action, reinforcing the idea that individual well-being is inseparable from community solidarity and harmony with the wider web of life. These collectivist traditions in both Zimbabwe and Vietnam provided fertile ground for CHCs, resonating with the ethic of privileging community over individuality.

Both studies are examples of a positive drive for improving living standards, demonstrating that when public health interventions are rooted in local worldviews and values, they achieve higher response levels and better chance of sustainability. This shared ethic of inclusivity highlights a critical lesson: health promotion is most effective when it works with the whole community, not through trickle-down individualistic approaches.

POLICY IMPLICATIONS

Communitarian ethics are not peripheral cultural features but structural enablers of sustainability. Policy-makers should ensure that programmes which are introduced from outside of the country are not rooted in a northern paradigm of individualistic gain by the few but rather reflect local cultural values of inclusivity of the whole community. To accelerate uptake of hygiene practices CHCs should ideally be mainstreamed into national health systems enabling local communitarian practices such as *Ubuntu* or *Interbeing* to be encouraged by government and regenerated within state institutions, rather than adopting models of individuality which reflect norms of a secular Northern culture.

Recognition of the CHC model has reached the highest policy levels in two countries in Africa. In Zimbabwe, CHCs have been formally included as recommendations in both the Water Policy[34] and the Health Policy with the Minister calling for CHCs in every village in the country.[35] Whilst thousands of CHC are found throughout Zimbabwe, NGOs are largely uncoordinated by Ministry of Health. The coordination of all implementing partners *was* achieved in Rwanda in the Community Based Environmental Health Promotion Programme where all NGO partners were required to support the Ministry of Health to start CHCs in virtually all of nearly 15,000 villages countrywide[36] over a period of ten years from 2010 – 2020. In 2015, Rwanda was also (perhaps not coincidentally) one of only five countries in Africa to meet the United Nations Sustainable Development Goals (SDG) to halve the number without sanitation[37]. President Paul Kagame chairing the Kigali Declaration advocated that the CHC approach should be used to assist other fragile states in the same way that CHCs had helped to unite villages in Rwanda after the 1994 genocide, but this vision of CHCs throughout Africa has yet to be realised due to lack of advocacy and funds.[38]

GENERALISATION FOR WIDER APPLICATION

Positive case studies of CHCs have already been documented in some African countries—including Guinea Bissau, the Democratic Republic of Congo, Uganda, Rwanda, Sierra Leone and South Africa while smaller seed projects have been started in Namibia, Malawi, Tanzania, Kenya and South Sudan — as described in detail in the textbook on the CHC Approach[39]. These examples confirm that the CHC model is adaptable across diverse African contexts, where communitarian traditions provide fertile ground for collective health action.

Of interest for further research is whether the CHC pilot project in Vietnam can be replicated in other countries in Asia. Preliminarily findings in this study suggest there is much potential in this transfer of African CHC experience to Asia and indeed the Caribbean and South America. Worldwide subsistence societies understand the need to get together and help each other, and that their own survival depends on others in the community. It remains for those at the top of government who want to see authentic change starting from village level to enable CHC to be set up and supported.

## Conclusion

CHCs would be culturally appropriate in many other parts of Africa and Asia, where communitarian ethics still persist and may provide an adaptable model for bridging ancestral traditions with contemporary public health needs.

## Conflict of Interest

Although all effort has been made to report impartially, the author is the architect of the Community Health Club approach, and the founding Chairperson of Africa AHEAD.

## Funding

We acknowledge all funders of the programmes mentioned above, in particular DFID, DANIDA (Zimbabwe, South Africa and Vietnam), UNICEF (Zimbabwe and Rwanda), Gates Foundation (Rwanda).

## Acknowledgements

Ministry of Health teams in Zimbabwe, Rwanda and Vietnam

Zimbabwe AHEAD/ Africa AHEAD team of project managers and field staff

Village leaders, CHC Chairperson and executive committees, community-based facilitators.

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