AFRICA AHEAD

Applied Health Education and Development (AHEAD) for
Scaling up through Institutionalisation & Integration for Sustainabily

The 5x5 Challenge

Reduction of 5 diseases in <5's in 5 million families in 5 countries at < US$ 5 pp

A Five Year Strategy: 2014 – 2018

List of Acronyms:

AHEAD	Applied Health Education and Development
CBF	Community-Based Facilitator
CBEHPP	Community Based Environmental Health Promotion Programme
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHC	Community Health Club
CHW	Community Health Worker
DAPP	Danish Aid People to People
DFID	Department for International Development
DoP	Director of Programmes
DoAP	Director or Advocacy and Partnerships
EC	European Commission
EHD	Environmental Health Department (or Desk) within MoH
EHTs	Environmental Health Technicians
EHOs	Environmental Health Officers
EI	Effective Interventions
EU	European Union
FAO	Food and Agriculture Organisation
ISIS	Integration, Sustainability & Institutionalisation at Scale
IWRM	Integrated Water Resources Management
LSHTM	London School of Hygiene and Tropical Medicine
MDGs	Millennium Development Goals
MoH	Ministry of Health
MoHCW	Ministry of Health and Child Welfare (Zimbabwe)
MoHS	Ministry of Health & Sanitation (Sierra Leone)
NGO	Non-Governmental Organisation
OBE	Order of the British Empire
PO	Project Officer
SMART	Specific Measurable Achievable Relevant Time Bound
SHCs	School Health Clubs
UNC	University of North Carolina
VHW	Village Health Worker
VLOMM	Village Level Operation Management and Maintenance
WASH	Water Sanitation and Hygiene
ZOD	Zero Open Defecation

For more detailed information and publications: www.africaahead.com

Please contact us directly:

Chief Executive Officer ***Juliet Waterkeyn*** ***juliet@africaahead.com***

Director of Programmes ***Anthony Waterkeyn*** ***anthony@africaahead.com***

Director of Advocacy & Partnerships ***Roger Short*** ***roger@africaahead.com***

The words of Nelson Mandela
1st democratic President of South Africa (1996)

"The legacy of oppression weighs heavily on women.

As long as they are looked down upon,
human rights will lack substance.

As long as outmoded ways of thinking prevent women from
making a meaningful contribution to society,
progress will be slow.

As long as the nation refuses to acknowledge the equal role of
more than half of itself,
A nation is doomed to failure."

On the 15th December 2013, Nelson Mandela was laid to rest, and in his honour we pledge the next 5 years of work to further his vision in our effort to assist at least 5 million families in Africa out of the 'prison of poverty'

Health Promotion is the process of enabling people to exert control over the determinants of health and thereby improve their health. **(Ottawa Charter, 1986)**

Community Health Clubs create common unity of knowledge
understanding and practice, empowering women in particular
to manage their hygiene and livelihood with confidence,
so ensuring the healthy development of the family

Support Africa AHEAD to make this vision a reality

The Purpose

The purpose of this prospectus is to outline our vision and offer 'partners in development' an exciting opportunity to contribute to raising living standards through this challenging, yet achievable programme. As a modest NGO we do not, obviously, intend to work alone but, just as we have been doing in the recent past with minimal resources, we know we can play a catalytic role in seeding programmes that support Local Government and Ministry of Health to achieve sustainable and holistic solutions towards preventing the five most common diseases that account for child morbidity and mortality as well as to promote holistic development outcomes at scale.

With the ongoing challenge of trying to address the basic needs of Africa's population still living in absolute poverty and also to meet the alarming shortfall of MDG targets in the majority of countries across Sub-Saharan Africa (SSA), National Governments, with support from Development Partners, would be wise to adopt behaviour-change approaches that have been proven to be effective, integrated and sustainable. Africa AHEAD's first-hand experience of introducing the **Community Health Club (CHC)** model into many countries gives us the confidence to believe that this exciting *5x5 Challenge* can indeed be taken to scale in a practical and cost-effective manner.

Africa AHEAD provides technical assistance and mentoring support to Ministries of Health through their respective Environmental Health Departments (EHD) to scale up their existing efforts in environmental health promotion and to implement the CHC model through **Village Health Workers**, where they exist, or through **Community Based Facilitators**.

What is the 5x5 Challenge?

The ***5 x 5 Challenge*** aims to improve the wellbeing and livelihood of over **5** million families in Africa over the next **5** years (2014-2018) by significantly decreasing the main causes of morbidity and mortality due to the **5** critical diseases in children under **5** years of age at less than US$ **5** per person. Given our recent first-hand experience in Rwanda, Zimbabwe & Vietnam, we know this to be entirely feasible when using the Community Health Club (CHC) Model of development.

Why support this 5x5 Challenge through Africa AHEAD?

We believe our CHC Model should appeal to development investors for the following reasons:

- **Value for money:** very low cost per beneficiary (<US$5)
- **Sustainability:** Health Clubs build capacity of communities to manage themselves over time
- **Economies of scale:** Large numbers of beneficiaries reduce the per capita cost of training inputs
- **Measurable:** CHC achievements can be accurately monitored and progress is tracked in "real time"
- **Localised:** Implementation is achieved by training & capacity building local VHWs & CBFs
- **Transparent:** management of development investments by professional fund managers
- **Integrated:** development that achieves holistic health and socio-economic outcomes
- **Low admin costs:** A "flat organisation": minimal micro management through expatriates

The 5x 5 Challenge

S.M.A.R.T. TARGETS:

✓ **Specific:**

The reduction of 5 critical diseases in at least 5 million families with children under 5, at less than US$ 5 per person, in 5 years.

The five diseases are: Diarrhoeal diseases including cholera, Malaria, Bilharzia, Intestinal worms and skin diseases. Controlling these critical diseases will contribute substantially to improving child survival and reduce stunting and minimize early deaths and morbidity of under 5's.

✓ **Measurable:**

With a fixed target group within a defined number of CHCs, communities themselves actively monitor observable proxy indicators of non-risk hygiene behaviours that are proven to reduce the above targeted diseases using our standard monitoring tool, the CHC Household Inventory, collected using cell phone technology for data collation.

✓ **Achievable:**

We are aiming for 5 million beneficiaries. With an average of 6 people in a family, an average CHC with 75 members will reach 450 people. Therefore in 5 years we need 11,111 CHCs, which is 2,222 CHCs per annum, divided between 5 countries is only 444 CHCs per annum per country.

We know this is practically possible because we are aiming for half was achieved in Zimbabwe in just 5 districts where over 1,000 CHCs have been established by Zimbabwe AHEAD with only 30 local staff.

✓ **Relevant:**

This objective is clearly in line with the MDG target No 7 and will reflect government priorities of the partner countries focusing on disease and poverty reduction

✓ **Time Bound:**

The target is to be achieved within 5 years by 2018.

About Africa AHEAD

Africa AHEAD is a UK registered charity (No: 1151795) that brings together experience of over twenty-five years in successful delivery of community-driven development solutions throughout Africa, particularly in the areas of:

- Public health and disease control
- Hygiene and sanitation
- Community-based water management
- Food security, nutrition and livelihoods
- Empowerment of women

Our programmes show that hygiene and sanitation can be an effective, non-divisive & ethical "entry point" which enables communities to build their own capacity through increasing social capital & knowledge.

Community Health Club activities build positive peer pressure and social cohesion over time so that we can expect the number with safe drinking water and improved sanitation to significantly improve through self-supply that is sustained and expanded.

The Board of Trustees

To ensure good governance and transparency as well as to garner greater visibility and confidence for potential development investors and supporters, Africa AHEAD has attracted an influential and internationally respected Board of Trustees.

Prof. Sandy Cairncross Chairman (OBE)

The Founding Chairman of Africa AHEAD is Prof. Sandy Cairncross, one of the leading academics from the London School of Hygiene and Tropical Medicine, who recently received an OBE for his outstanding contribution towards alleviation of tropical diseases. Richard Bennison, retired CEO of KPMG-UK, is Secretary to the Board.

Richard Bennison Secretary

The Trustees are all well reputed leaders in development: Prof Jamie Bartram, Head of the Institute of Water, University of North Carolina; Prof. Richard Carter, formally Professor at Cranfield University; Dr. Darren Saywell, currently heading PLAN International's WASH sector in Washington; and Barbara Evans who heads up the WASH programme at the University of Leeds and is a leading light in the Joint Monitoring Programme.

Prof Jamie Bartram

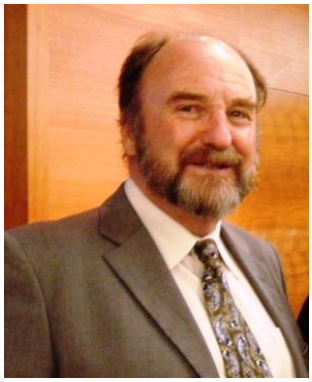
Prof Richard Carter

Dr. Darren Saywell

Barbara Evans

Meet our Senior Management

Chief Executive Officer
Dr Juliet Waterkeyn



Director of Programmes
Anthony Waterkeyn

Director of Advocacy
Roger Short

Chief Finance Officer
Lyle Aitkin

The Executive Directors of Africa AHEAD are Dr. Juliet Waterkeyn (CEO), Anthony Waterkeyn, Director of Programmes (DoP) who are the founders of the organisation. Roger Short is Director of Advocacy and Partnerships (DoAP), and brings his experience of community driven Integrated Water Resource Management (IWRM) programmes in Southern Africa (DANIDA). James Broadley is the Chief Finance Officer (CFO), and Janette Heatherton is the Administrator. Our country teams have long practical experience enabling Africa AHEAD to provide genuine community driven development, with a high level of transparency and vocational commitment.

Country Teams

ZIMBABWE

Regis Matimati
Country Director

Andrew Muringaniza
Project Manager

RWANDA

Joseph Katabarwa
Technical Advisor

Amans Ntakarutimana
Programme Director

Our Vision

To build capacity among mothers and their families through the development of a 'Common-unity' of knowledge, understanding and purpose, thereby strengthening communities and promoting self-reliance to effectively control most preventable diseases and to substantially improve their food security, nutrition and income generating potential through informed decision making and skills training.

Our Core Values: SISI

Sustainability: by increasing the capacity of communities to become **self-reliant**, managing their own family health and hygiene

Integration: of health + hygiene + water + nutrition + livelihood initiatives

Scalability which enables every village in the country to be reached.

Institutionalisation: of the CHC Model as a national programme through the combined resources of the Ministries of Health, Education and Local Government

Our Mission

To enable Government Ministries, Agencies, and NGOs to roll out the Community Health Club Model in developing countries so as to reduce poverty, gender discrimination, ignorance and disease through an approach that is **Integrated** and can be **Institutionalised** through government departments to ensure such development is **Sustainable** and **Scalable.**

Our Aim: By 2018, to have improved the health, well-being and livelihoods of over 5 million families (25 million beneficiaries) in Africa.

Our Philosophy: The empowerment of women

Our belief is that no matter how poor they are, people control their own development and that until all women, men and children know the importance of, and routinely practise good hygiene, unnecessary suffering due to preventable disease cannot be eradicated.

A woman on her own is often powerless, but as a group, women can become a significant force for development. We believe every mother, however poor or uneducated, will do whatever she can to enable her children to prosper.[i] Therefore health promotion is an ideal entry point into all development, because it is non-divisive and merely provides a forum for exchange of information and ideas and enables a process of women's empowerment through shared learning and developing social capital and support systems. Therefore, as our name and logo suggest, we promote **Applied Health Education and Development (A.H.E.A.D).**

What are Community Health Clubs?

CHCs are community-based organisations (CBOs) open to men and women of all ages, incomes and educational levels dedicated to managing their own health through safe hygiene

The clubs have no political or religious affiliations and are formed specifically for improving public health in their community. To ensure that communicable disease can be effectively controlled, we aim for a critical mass of 80% of the households within a village to be represented. A CHC usually consists of between 50-100 dedicated members, mainly women, meeting weekly in order to learn how to ensure safe hygiene practices within their family and village. Health Clubs have their own executive committee (voted annually), a constitution and bank account and are trained by voluntary **Village Health Workers** or **Community-Based Facilitators** drawn from the local population. Community Health in its broadest sense includes mental and spiritual well-being, which comes from empowerment and through a sense of purpose, achievement, common-unity and material and physical security. We recognize that development is a process. There are four main stages as identified in the following sections.

Graduation day: members who have completed 20 sessions (shown on their green membership cards) receive certificates.

The 4 Stages of Development through a Community Health Club

An immaculate kitchen in a mud hut with shelves of polished moulded clay and protected drinking water.

A model home with a beautifully protected Upgraded Family Well with latrine, hand-wash facility & pot-rack.

Maintenance of hand-pumps is critical and training is done for village mechanics as part of a CHC.

Stage 1: Health Promotion is the entry point. A two-hour session is held every week at a regular time and venue decided upon by the members. The CHC members participate in activities that are designed to engage and entertain them as well as provide a forum for debate and full involvement of each member in the decision making process using visual aids specifically designed for the area. Those who complete all 20 - 24 sessions are publicly recognized with an attendance certificate at a graduation ceremony.

Behaviour Change: The Community Health Clubs are not just talk shops. Each week there is a recommended practice (homework) to ensure prevention of the disease under discussion. Members pledge to make small changes in their own homestead before the next meeting the following week – dig a refuse pit, make a dish rack, cover drinking water, make a tippy-tap & wash hands in a more hygienic manner, build a model kitchen etc. Such recommended practices seldom require much financial outlay but are just a matter of changing habits and reorganisation.

Stage 2: Safe Drinking Water & Sanitation

When health club members appreciate how germs are transmitted they usually make an effort to protect themselves. Once convinced as a group, ***positive*** peer pressure ensures that sanitation becomes a priority need and CHC members help each other to meet 'their' new hygiene standards. They dig wells and latrines through 'self-supply' without any support from outside funds. Village level operation, management and maintenance (VLOMM) of water facilities (e.g. gravity, piped, pumped) is a natural responsibility of the CHC committee, who are responsible for ensuring the use and sustainability of WASH facilities in the village.

A communal Nutrition garden where each woman has 5 beds of vegetables; Chipinge, Zimbabwe. 2009.

Above: *This CHC in Zimbabwe has constructed its own meeting place with demo facilities for members to copy - note the pot rack in foreground.*
Below: *Women show their 1st intake of toddlers to use the shelter as a playschool in 2014.*

Stage 3: Food Agriculture & Nutrition (FAN

When all high-risk habits have been replaced by improved hygiene practices and basic facilities are available for safe drinking water & sanitation, mothers are then encouraged to turn to an equally important aspect of child survival – a balanced diet. With stunting being such a major concern across so much of Africa, as a direct result of poor absorption of nutrients, there is urgent need for mothers to better understand how to protect their young children and to build up their immunity and strength. CHC members start either individual or communal nutrition gardens, which also help to support vulnerable families in the village. Preservation through drying of the vegetables is done in each home, so that a balanced diet can be maintained all year round.

Stage 4: Empowerment of women

Such is the importance attributed to CHC gatherings that some even construct permanent meeting shelters and also use the shady new venue for play schools for their toddlers. Other clubs have started income generating projects such as soap making, oil pressing, sewing and food preservation. Yet others decide to start saving and loan schemes to enable members to buy what they need to keep up their hygiene standards. The CHC becomes a safety net for mothers.

Meeting the MDGs on Gender:

The CHC addresses MDG 1: women's empowerment through income generation, nutrition, employment and access to, and control, over resources such as land and water as well as MDG 3 targets as defined by WHO;

"Maternal deaths and pregnancy-related conditions cannot be eliminated without the empowerment of women. Maternal mortality is the number one cause of death for adolescents 15–19 years old and in many countries, sexual and reproductive health services tend to focus exclusively on married women and ignore the needs of adolescents and unmarried women."

In the post MDG period after 2015, we intend to focus on a 'Rights Based' approach in all development and gender equity will continue to be the hallmark of the CHC Model.

Our History

Africa AHEAD was founded by Dr. Juliet Waterkeyn and Anthony Waterkeyn (a husband and wife team) who have been working in the WASH Sector since 1984, and who first initiated the concept of the Community Health Club Approach. To replicate a successful field trial of the CHC concept, they co-founded Zimbabwe AHEAD, an indigenous NGO registered in 1999. This organisation continues as our flag ship in Zimbabwe, conducting large scale CHC programmes and training numerous other NGOs. In 2005 the same team established a consultancy in Cape Town, South Africa, as a Not-for-Profit Company to provide regional training to replicate the CHC Approach throughout Africa. However, as demand for CHC training steadily built up, there was need for a better constituted organisation to institutionalise CHC Programmes in other countries while ensuring quality control and sustainability for this proven development model. For this reason, the three organisations: Zimbabwe AHEAD, Africa AHEAD-South Africa and Africa AHEAD-Rwanda were absorbed into the UK Charity, Africa AHEAD-UK in April, 2013. In addition, Africa AHEAD is currently also in the process of being registered in the USA.

Proven track-record in Zimbabwe (1999 – 2013)

Andrew Muringaniza, since 1999 Programme Officer responsible for many successful CHC projects

Since 1999, Zim AHEAD has started over 2,000 CHCs ***directly in Zimbabwe*** with over 850,000 beneficiaries at an average cost of well under US$ 5 per beneficiary, in partnership with DFID, DANIDA, Oak Foundation, FAO, USAID, NZ AID, LEAD, Oxfam, Mercy Corps, ACF, DAPP and many others. Our advocacy has influenced over 25 other NGOs who have used the CHC Model. In 2013 CHCs were adopted as the national policy in Zimbabwe (See p.14).

Josephine Mutandiro, Zim AHEAD Co-ordinator (2000-d.2010) - inspirational community motivator for CHCs

1999 -2001	**DANIDA** 285 Community Health Clubs in Makoni District in Manicaland
	DFID 120 CHCs in Tsholotsho and Gutu: IRWSS programme
2002-2004	**LEAD/FAO** over 5,000 nutrition gardens in Makoni with > 60,000 beneficiaries
2008-2010	**Mercy Corps/EU/BLF** Manicaland: 134 FAN Clubs 65,000 beneficiaries
2008/9	**Oxfam** 50 CHCs, cholera mitigation in Mutare Town: 55,000 beneficiaries
2009:	**DFID/IWSD** PRP II: trained 22 NGOs in the CHC Approach
2010:	**OFDA/Oxfam**: Chiredzi 180 Urban Health Clubs and 85 SHCs, 1,300 latrines
	OFDA/Oxfam Masvingo rural: 121 CHCs: 82 boreholes rehabilitated
	OCHA/Oxfam Masvingo town: 9 Urban Health Clubs and 10 School Health Clubs
2011-13:	**ACF/ EC** Gutu and Mberengwa: 450 CHCs and 50 SHCs: 250, 000 beneficiaries
2012-2013:	**USAID** Manicaland: 480 CHCs: 105,000 beneficiaries, 7,770 self-supply latrines

REPLICATION OF THE CHC MODEL

Africa AHEAD has, within the past decade of consultancy activities, supported the uptake of around 1,000 CHCs in a number of countries (see Fig. 1 below) with an estimated 600,000 beneficiaries. However the real impact is the catalyst these pilot projects have had on those countries where the CHC Model is being taken to scale by governments and NGOs resulting in an estimated 2.6. Million beneficiaries' to-date particularly in Zimbabwe and Rwanda.

2002	Sierra Leone	**CARE** International	50	rural CHCs in Moslem villages
2003	Uganda	**CARE** International	150	CHCs in IDP camps: 11,400 latrines[ii]
2007	Guinea Bissau	**Effective Intervention**	120	rural CHCs in Moslem villages
2003	Albania	**Caritas**	10	peri-urban CHCs (first in Europe)
2008	South Africa	**Municipality**	400	urban CHCs[iii] & rural pilot in Kwa Zulu Natal[iv]
2010	Vietnam	**DANIDA**	200	rural CHCs in 3 districts[v]
2012	Rwanda	**Gates Foundation**	150	rural CHCs in a randomized Control Trial

Fig 1: 1,000 CHCs started by Africa AHEAD since Year 2000 *Training in CHCs in Sierra Leone, 2002.*

RANDOMISED CONTROL TRIAL IN RWANDA

Following research at LSHTM (Waterkeyn and Cairncross, 2005)[vi] the model is being increasingly recognised by a broad spectrum of leading agencies (WHO, UNDP, World Bank[vii], DFID, LSHTM, WaterAid, DANIDA et al) as being one of the very few approaches able to deliver significant, sustainable and verifiable community development at low cost per beneficiary.[viii] With their interest in identifying *innovative* and *sustainable* solutions that can be *up-scaled*, the Gates Foundation is currently supporting a Randomised Control Trial to accurately determine the health and socio-economic impact of CHCs in Rusizi district in Rwanda that is being conducted by Innovations for Poverty Action (IPA). Preliminary results will be available at the end of 2015.

SCALING UP THROUGH INSTITUTIONALISATION

The strength of the CHC Model is that it can readily be scaled up into a national programme which can be rolled out to every village in the country through the existing out-reach structures of the Ministry of Health. **Environmental Health Officers & Village Health Workers,** who are already employed within the MoH structure, are trained in the CHC model in order to optimise their current duties to enable the community to better manage and take responsibility for their own health. Two countries in Africa have already opted to roll this out: Rwanda in 2011 and Zimbabwe in 2013.

RWANDA: The Community-Based Environmental Health Promotion Programme (CBEHPP)

Rwanda is one of only 5 countries in Africa set to achieve the UN Millennium Development Goals in Water & Sanitation by 2015. Through advocacy of WSP-World Bank, Africa AHEAD and UNICEF, this go-ahead country rapidly accepted the efficacy and cultural sensitivity of the CHC Model of holistic preventative health which has now been **institutionalised through the Ministry of Health into their Community-Based Environmental Health Promotion Programme (CBEHPP) which has resulted in all 14,800 villages in Rwanda having CHCs** to manage health and hygiene related issues. CBEHPP (incorporating the CHC Model), is now being implemented by over 15 International NGOs, Development Partners & Agencies. Africa AHEAD provides on-going support to this national programme as well as Monitoring the classic CHC programme in Rusizi District to enable the model to be properly monitored and evaluated by the Gates Foundation (2012-2016).

ZIMBABWE:

Although Zimbabwe was the country where the CHC Model first originated, most of the implementation has been done at project level. Zimbabwe AHEAD alone with 30 staff, has started over 2,000 rural and School Health Clubs in 8 districts, as well as urban CHCs in six towns across the country[ix].

A school health club presenting a hygiene drama, Zimbabwe

An urban health club in Mutare, Zimbabwe conducts a clean-up of refuse during the cholera outbreak of 2008

Through the PRP II funded by DFID in 2009-12, Zim AHEAD trained 25 Implementing Partners; there are now numerous CHCs in many districts of Zimbabwe run by various NGOs, although there are no accurate records of the numbers benefitting. **In March, 2013, the Zimbabwe National Water Policy states that every village and rural institution in Zimbabwe should have a functional health club.**

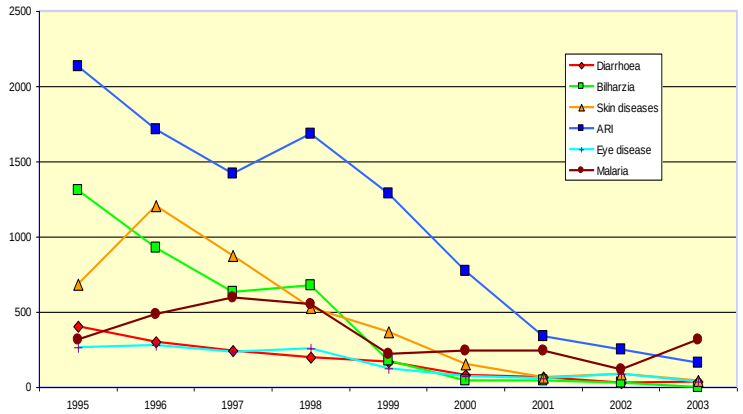
HOW can we reduce disease?

WHO and UNICEF estimate that around 88% of child mortality and morbidity can be prevented through improved hygiene behaviour, safe drinking water and improved sanitation. Stunting is a considerable burden in Africa with as much as 46% of the population affected in some countries. This is caused not only by poor nutrition, but also by poor hygiene resulting in diarrhoea and stunting of toddlers. Recent research[x] indicates that stunting can be caused by Environmental Enteropathy (reduced ingestion of nutrients) as a result of high faecal intake of toddlers growing up in poor sanitary environment.

We aim to reduce:

1. **Diarrhoeal disease** by ensuring good hygiene, safe drinking water and sanitation practices
2. **Environmental Enteropathy** by promoting clean environment and improved child care
3. **Malaria:** by promoting use of insecticide treated nets and control of breeding sites
4. **Intestinal parasites** through treatment with improved sanitation and personal hygiene
5. **Eye and skin diseases**: improved sanitation and good personal hygiene

Fig 2: Reduction of 5 Diseases in Ruombwe Ward, Makoni District 2005.[xi]



Case Study: Prevention of child deaths by early treatment seeking

Early referral at a Health Centre is important in order to prevent death due to untreated dehydration, pneumonia, malaria, bilharzia, intestinal parasites, HIV status and unsafe deliveries. Many lives are saved through CHCs, as members are informed as to how to recognise when treatment is essential. The efficacy of the CHC Model for achieving sustainable hygiene behaviour change was demonstrated during the cholera epidemic that swept through Zimbabwe in 2008/9, with over 100,000 cases nationwide that killed over 4,500 people. Makoni District, which had the highest density of CHCs in Zimbabwe at the time, remained largely unaffected by cholera and this was attributed to the ability of the CHC households to take preventive measures as well to clearly recognise symptoms and to seek early treatment, thus saving thousands of lives. Centers for Disease Control and Prevention noted: *"Those who survived cholera had more often received information from a village health worker/community mobilizer—52 (47%)—in contrast to those who died—18 (33%) p=0.059.'* (Morof, 2009)[1]."

CHC COUNTRIES: PRESENT AND POTENTIAL

The countries we are targeting in order to disseminate the CHC Model are all within the category of the lowest 20 on the UN's global Human Development Index.

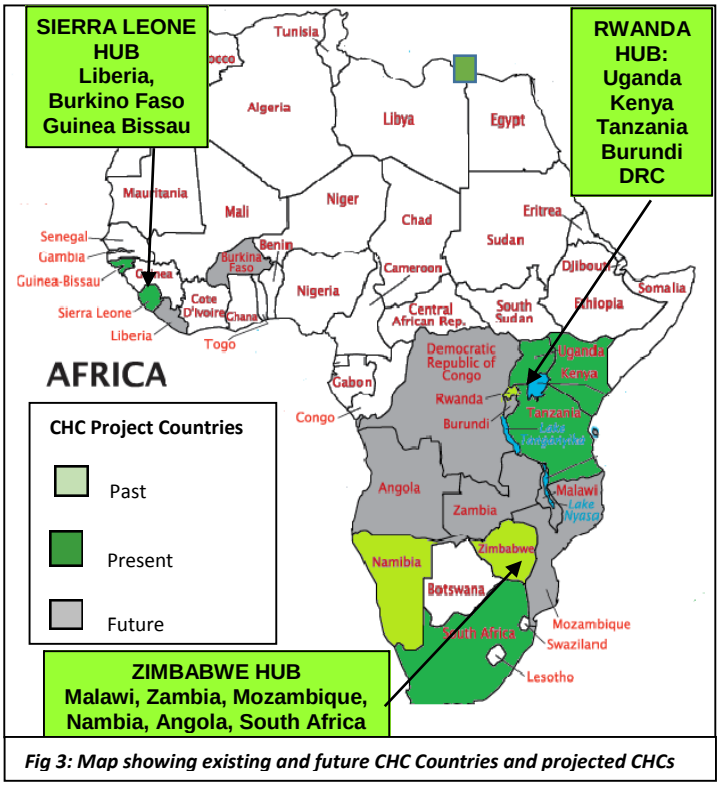


Fig 3: Map showing existing and future CHC Countries and projected CHCs

We will have three main hubs for administering and provision of training for the new CHC country programmes:

East Africa: Rwanda

Uganda, DRC, Burundi, Kenya, Tanzania

Southern Africa: Zimbabwe

Malawi, Zambia, Mozambique, South Africa, Namibia and Angola.

West Africa: Sierra Leone

Liberia, Guinea Bissau and Burkina Faso.

Current Proposals ready for submission:

- **SADC:** Borders along Zimbabwe in Mozambique and Zambia to contain cholera
- **Zimbabwe:** MoHCW requests Africa AHEAD to train all EHTs throughout Zimbabwe
- **Namibia:** CHC programme on Angolan border to prevent spread of cholera
- **Burundi:** MoH requests development of national programme and start up in 5 districts
- **Sierra Leone:** MoHS requests development of national training package and scale up
- **Burkina Faso:** WASH Consortium request start up demonstration project in one district
- **Liberia:** WASH Consortium requests piloting of CHCs
- **Kenya:** AA-UK requested by Leadership of two new Counties (Kericho & Siaya) for replication of Rwanda's CBEHPP (both urban and rural CHC model)
- **Zimbabwe + Rwanda:** CoMobi: Sustainable Agency for Community Wellness

If you are interested in the concept note or full proposal for any of the above or an adaptation for our own area, please contact us: juliet@africaahead.com

Country-level Programme Implementation

From experience, Africa AHEAD recognises that there are ***four*** stages for scaling up the CHC methodology at country level. These are:

Phase 1 : *Advocacy* and *Sensitisation* : government introductory workshops and look and learn tours to operational 'hub' countries with a small 'pilot project' established in the new country (<50) to understand the methodology.

Phase 2: *Demonstration projects.* Africa AHEAD works with key stakeholders and undertakes research and progresses through a collaborative learning process with local partners starting 50 -200 CHCs as a 'demonstration project' in the 'new country'.

Phase 3 : *Up-scaling*:The CHC Model is evaluated, approved and adopted for national roll-out. 'Large scale projects' with at least 200 and up to 1,000 CHCs per year.

Phase 4 : *Institutionalistion:* The CHC model is endorsed at the highest level and incorporated into government policy resulting in a 'national programme' through government structures coordinating all implementing partners - >1,000 CHCs/year.

	2014	2015	2016	2017	2018	Total CHC	Beneficiaries
Zimbabwe	**1000**	**2000**	**4000**	**8000**	**10,000**	25,000	6,250,000
South Africa	**10**	**50**	**100**	**200**	**1,000**	1,360	340,000
Namibia	**10**	**200**	**400**	**800**	**1,000**	2,410	602,500
Malawi	**20**	**200**	**400**	**800**	**1,000**	2,420	605,000
Zambia		**100**	**200**	**500**	**1,000**	1,800	450,000
Mozambique		**100**	**200**	**500**	**1,000**	1,800	450,000
		2650	5300	10800	15,000	34,790	8,697,500
Rwanda	**1000**	**2000**	**4000**	**8000**	**10,000**	25,000	6,250,000
Uganda	**60**	**120**	**400**	**1000**	**2,000**	3,580	895,000
DRC	**150**	**300**	**400**	**800**	**1,000**	2,650	662,500
Burundi		**100**	**400**	**800**	**1,000**	2,300	575,000
Tanzania		**100**	**400**	**800**	**1,000**	2,300	575,000
Kenya		**100**	**400**	**800**	**1,000**	2,300	575,000
		720	**6000**	**12200**	**16,000**	38,130	9,532,500
Sierra Leone	**20**	**100**	**400**	**800**	**1,000**	2,320	580,000
Liberia	**20**	**150**	**400**	**800**	**1,000**	2,370	592,500
Burkina Faso		**200**	**400**	**800**	**1,000**	2,400	600,000
	40	**450**	**1200**	**2400**	**3,000**	7,090	1,772,500
TOTAL						**80,010**	**20,002,500**

Fig 4: Scaling up CHCs in targeted countries over 5 years

Can we manage this scale of operation?

We do not claim to be able to implement at this scale ourselves but we can be the catalyst, by working through Ministries of Health, using their Environmental Health staff and enabling them to rationalise their existing jobs, by ensuring they are trained and fully equipped to be able to carry out their duties properly. If provided with a motor cycle each field officer is capable of supervising as many as 20 Village Health Workers (VHWs) who start up and do the training for a CHC in their own villages. In countries that do not have EHO and VHW equivalents within the Ministry of Health, another option is to train Community-Based Facilitators to do the same job, supervised by Project Officers. This may seem an audacious prospect for a small NGO but is not far-fetched: it has been tried and tested and the CHC model can be reliably predicted to deliver this response. At scale, health promotion for safe hygiene and sanitation can be achieved at under US$5 per beneficiary[xii].

The Maths: Each VHW can facilitate 1 or 2 CHCs and each field officer can supervise up to 20 VHWs per year. If, for example, we trained all 800 EHTs in Zimbabwe (as has already been requested of Zim AHEAD by MoHCW) and they each only supervise 5 CHCs per year, this would total 4,000 CHCs in one year and in five years they would have trained 20,000 CHCs. With a conservative estimate of only 50 members per CHC this would result in > 1 million CHC Members. If we include their families who will also benefit from safe hygiene in the home, as beneficiaries (at an average of 5 per household) this is 5 million – half the entire population of Zimbabwe.

For a country to start a CHC programme, Ministry of Health needs the 4 'T's:

- **Trainers:** sufficient MoH EHTs and VHWs - or PO's and volunteer CBFs
- **Training Materials:** a national curriculum (CHC Manual and Tool kit of 350 visual aids)
- **Training:** standardised training for core trainers (EHOs) to roll out the training to CBFs
- **Transport:** EHD staff need motorcycles so they can monitor/mentor the programme

PHASE 1: AVOCACY & SENSITISATION (2014)

Experience over the past decade shows that the CHC Model is readily understood although a fair amount of explanation for top MoH and Local Government officials is usually required. This advocacy in a 'new CHC country' entails a series of visits to meet with senior officials within the Ministry of Health and Local Government. This usually results in high level deliberation and the commitment by the Minister to develop a Road Map to roll out a Community-Based Environmental Health Promotion Programme (CBEHPP), using the CHC Model as a vehicle for scale up. Advocacy efforts include provision of support for senior MoH officials to visit CHCs in Zimbabwe or Rwanda to witness for themselves the effectiveness of the CHC model. Africa AHEAD can assist MoH to

develop the full set of CHC Training materials necessary for a national programme as well as the training of a team of core CHC trainers for each country. There is already a training curriculum developed by Africa AHEAD for the three regions (East, West and Southern Africa) and only minor adaptations are needed to make the visuals aids culture specific for each new country. The start-up of a CHC programme depends on the political buy in, having a tool kit ready and printed and the required number of trainers available.

The following additional support is also provided by Africa AHEAD:

- Hosting of a portal online for all CHC programmes to record their own activities and measure their achievements by providing comparative data for their own officials and cross-learning of experience within countries and between countries: www.chcahead.org
- Management of the CHC Website for qualitative information and updates on Africa AHEAD: www.africaahead.com.
- CHC Training Seminars and presentations for government and NGOs
- Look & Learn Tours to visit programmes arranged for hands-on experience of the efficacy of the national CHC programmes.
- Research and programmes which can accommodate interns for 1st job experience,
- Monitoring, evaluation using cell phone for data collection[xiii]
- Papers published regularly to ensure that the CHC model remains dynamic in supporting the development sector at large.

CONCLUSION:

The CHC Model has been tried and tested and is ready for scaling up. There are demands from countries across Africa to implement large scale programmes and Africa AHEAD is ready to provide the advocacy and training for such a continent-wide drive to meet the MDG targets. What remains is financial support for the 5 x 5 Challenge. We seek partners with such a vision.

Poem by Riudo Chizikani - Community Based Facilitator, Ribatsira Club Ndadzingwa Village, Chimanimani, Zimbabwe

What is a Community?
It is a group of people
Understanding their situation
Changing for the better.
From here we have knowledge
From here we have confidence
From here we have knowledge
For the people to understand.

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[xiii] **Waterkeyn, J & Rosenfeld, J.** (2009) Monitoring Hygiene Behaviour Change Through Community Health Clubs. **WEDC Conference, Addis Ababa**

All the above publications can be found on www.africaahead.org/download_publications