Applied Health Education Agriculture & Development (AHEAD)

Putting women at the heart of development

5 Year Strategy: 2020 – 2025

A Prospectus for Partners in Development

List of Acronyms:

AHEAD	Applied Health Education and Development
CBF	Community-Based Facilitator
CBEHPP	Community Based Environmental Health Promotion Programme
CHC	Community Health Club
CHW	Community Health Worker
EHD	Environmental Health Department (or Desk) within MoH
EHTs	Environmental Health Technicians
EHOs	Environmental Health Officers
FAO	Food and Agriculture Organisation
MoH	Ministry of Health
NGO	Non-Governmental Organisation
SDG	Sustainable Development Goals
SMART	Specific Measurable Achievable Relevant Time Bound
VHW	Village Health Worker
WASH	Water Sanitation and Hygiene
ZOD	Zero Open Defecation

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

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Contents

Our Inspiration

"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."

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

Our Model of Development

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

Our '5 x 5' Target

500,000 women
5 SDG targets
5 countries
5 years
5 US$ pp

About Africa AHEAD

Africa AHEAD brings together the experience a team of dedicated professionals with long experience of the successful delivery of women-led development solutions, particularly in the following sectors:

- Gender issues and empowerment of women
- Public health and disease control
- Water, hygiene and sanitation
- Community-based management
- Food security, nutrition
- Skills and livelihoods

Our Vision

To build capacity among mothers and their families through the development of a 'Common-unity' of knowledge, understanding and purpose, thereby creating functional 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, thereby ending poverty by 2030.

Our Core Values

To enable Government Ministries, Agencies, and NGOs to institute the holistic and **Integrated** Applied Health Education and Development (AHEAD) Approach, reducing ignorance, poverty, gender imbalance and disease.

Our Aim

Meeting 5 SDG goals for 500,000 women in 5 years:

1. Organise CHC to empower women (SDG 5)
2. Enable women to prevent disease (SDG 3)
3. And ensure safe water & sanitation (SDG 6)
4. With Nutrition gardens to prevent malnutrition (SDG 2)
5. Plus skills for women's to earn money (SDG 8)

In this way we aim to end ***absolute*** poverty in Community Health Clubs by 2030

The 5x 5 Challenge with S.M.A.R.T. TARGETS:

Specific:

Reduce 5 diseases affecting <5's

- **Diarrhoeal disease** by good hygiene, safe drinking water and sanitation practices
- **Environmental Enteropathy** by promoting clean environment and improved child care
- **Malaria:** by promoting use of insecticide treated nets and control of breeding sites
- **Intestinal parasites** through improved sanitation facilities and good personal hygiene
- **Covid 19**: Responsible behaviour and good personal hygiene

Measurable:

Using our standard monitoring tool, the CHC Household Inventory, collected using cell phones for data collation we monitor the level of compliance to 10 categories of recommended practices.

Achievable:

We are set targets which are achievable based on the aiming for 500 CHCs in 5 new countries those that have already been achieved by Zimbabwe AHEAD as a small NGO over each of the past 20 years.

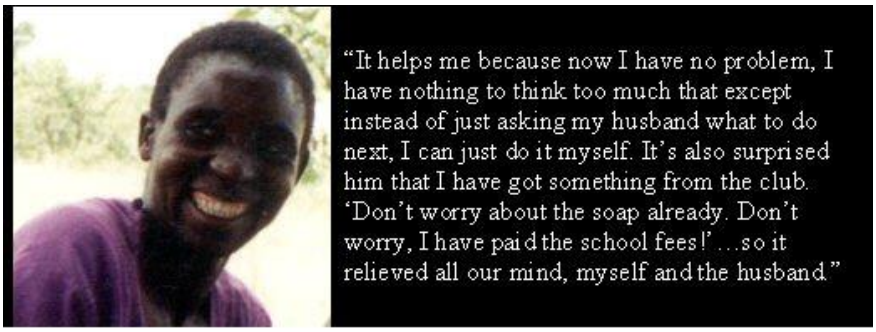
Relevant:

The '5x5' Strategy is based on the United Nations Sustainable Development Goals to eliminate poverty by 2030, and works within government policies to ensure all training is locally relevant

Time Bound:

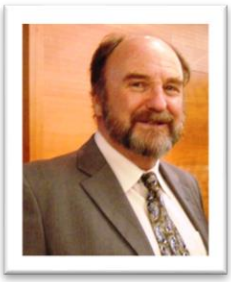
The targets are to be achieved between 2020 and 2025.

How did the Community Health Club help you?



Our Team





Chairwoman (AA)
Dr. Juliet Waterkeyn

Executive Director (AA)
Regis Matimati (Zim)

Director of Advocacy (AAA)
Anthony Waterkeyn (S.A)

AAA Programme Manager
Siphiwe Mpofu (Zim)

Monitoring
Julia Pantoglu (Germany)

Our History

Zimbabwe AHEAD, a local Non Governmental Organisation was founded in 1999, to replicate and scale up the Community Health Club Approach which was first piloted in Zimbabwe in 1995. In 2013 the organisation changed its name to Africa AHEAD and registered as a UK registered Charity. Five years later it relocated back to Zimbabwe which is now the main Head Quarters, headed by Executive Director Regis Matimati, with a team of over 30 staff implementing 12 projects (2020). Since its foundation Zim AHEAD/Africa AHEAD has started 2,883 CHC with 217,206 members and 1.9 million beneficiaries training over 30 local and international NGOs in Zimbabwe.

In 2005, the co-founders Dr. Juliet and Anthony Waterkeyn set up a separate consultancy based in South Africa for replication the CHC Approach *internationally*, providing regional training with a group of associated colleagues based in various countries. They have been responsible for starting 1,236 Community Health Clubs with 81,900 members and estimated 426,000 beneficiaries between 2002 and 2015, working with many international partners in 8 countries. Our Associates are skilled trainers in the art of starting Community Health Clubs and can provide consultancy training for other NGOs who wish to replicate this model, training virtually online and in situ

Our Associates






Zachary Bigirimana
Uganda

Joseph Katabarwa
Tanzania

Justin Otai
Uganda

Fausca Uwingabire
Rwanda

Dr. Monique Oliff
Kenya

Marcie Mbirira
Rwanda

Our Core Principle: Mainstreaming the 'Women in Development Approach'

The Empowerment of Women

Whilst one women by herself may often be powerless to control her life, women in an organised group (such as a CHC) can become a very powerful force for development.

We believe every mother, however poor or uneducated, will do whatever she can to enable her children to prosper.

This is why we use health promotion as the non-contentious entry point into a process of development, providing a vital forum for the exchange of information and ideas which results in women's empowerment through shared learning and developing social capital and ensuring adequate skills, coping mechanisms and support systems.

- Enabling understanding of how many common diseases are caused
- Ensuring improvement of home hygiene so as to prevent these diseases
- Providing technical assistance to improve drinking water quality
- Galvanising action to build latrines and hand washing facilities
- Providing opportunities for skills training for income generation
- Providing literacy and numeracy training for women
- Training women in finance and management of projects

Our philosophy of development is based on the principle that people themselves are the agents of their own development. Whilst men particularly in Africa tend to control most of the means of production, community health clubs enable a process of self-improvement for women to build confidence and self-efficacy and ensure gender equity and end to indignity in their own homes.

Since 1995, we have been using Community Health Clubs to mobilise the whole community, both men and women, into dynamic action-oriented groups to improve hygiene and sanitation in the home and ensure a functional village that can manage its own public health.

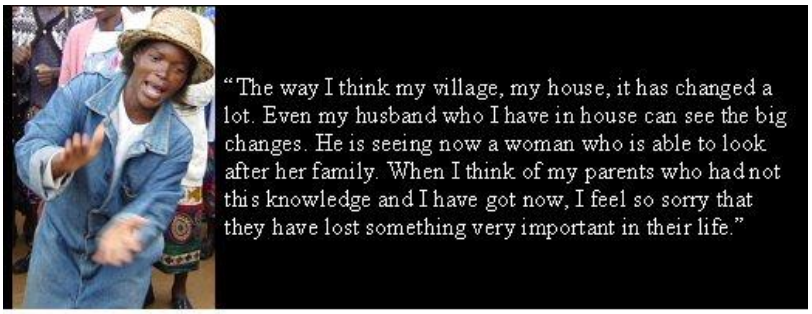
In 25 years, AHEAD has started
over 4,119 CHCs
training over 300,000 members

"Teach the women and you teach the nation"

Julius Nyerere,
1st President of Tanzania

Mrs Josephine Mutandiro, (left) Coordinator at Zimbabwe AHEAD, (1999-2007) was one of the first 'liberated women' of her generation in Zimbabwe who inspired countless women through Community Health Clubs which she said was one of the best ways she had come across in her long career as a field worker to empower women.

Empowering women



- To make informed decisions
- Improving husbands' respect
- Enabling discussion on previously taboo subjects
- With domestic equity between men and women
- To find their voices through public speaking
- As leaders of Community Health Clubs
- With own projects independent of men

Awareness raising at community level to address

- Gender inequity in theory and in practice
- Gender stereotyping
- Prejudices in language and folk law
- traditional gender roles on control of resources
- traditional ownership of land and title deeds
- Rights of women and children
- Domestic abuse and protection of vulnerable

Practical means to poverty eradication

- Land ownership
- Management of resources
- Literacy and numeracy
- Financial Management
- Skill training
- Income generation

Year 1: Women's Empowerment through Community Health Clubs (CHCs)

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

Training: *Community Health Club Members problem solves with visual aids in a PHAST training in Sierra Leone.*

Graduation day: *members who have completed 24 sessions (shown on their green membership cards) receive certificates.*

The first stage of the AHEAD MODEL sets out to ensure that males and females are equal players with Gender Equity in all aspects of the Community Health Club in terms of

1. **Social Equity**: no discrimination by gender
2. **Protection** from domestic abuse/violence
3. **Political Equity**: women leadership of CHC
4. **Training Equity**: women on a par with men
5. **Financial Equity:** women control production

Community Health Clubs (CHCs) avoid political or religious affiliations and are formed specifically for controlling public health and promoting welfare in their area. CHCs usually consist 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, headed by a woman with a majority of officers being women. They also have a constitution and bank account

3 YEAR 2: EQUITY THROUGH HEALTH EDUCATION (Safe Hygiene)

Before joining a Community Health Club ……. and after becoming a CHC member

DIGNITY AND COMPETENCY AS A MOTHER AND WIFE… a model home of which a woman can be proud.

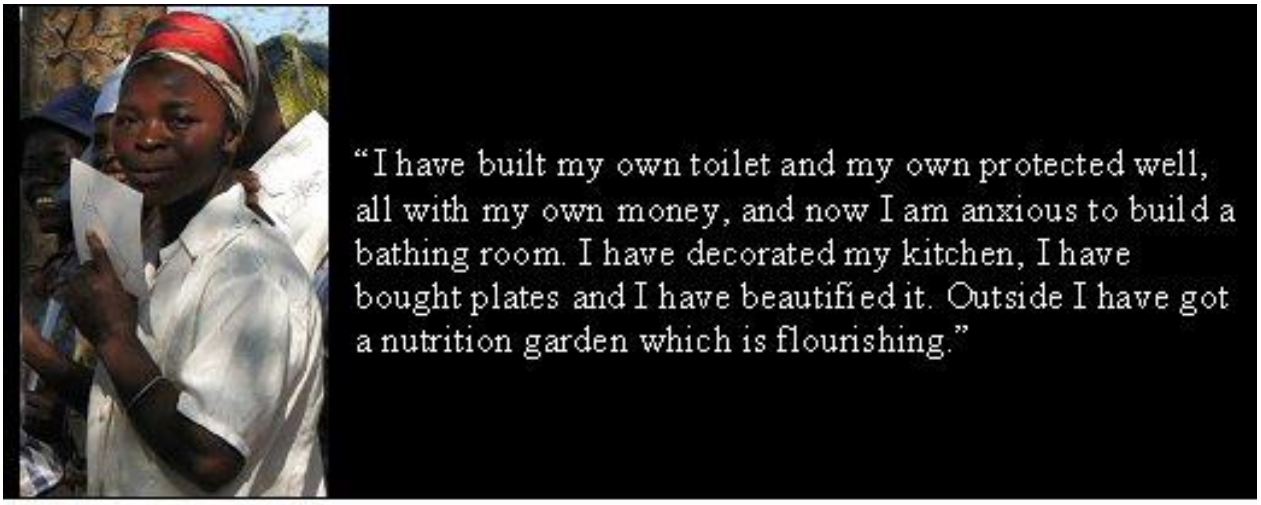
High standard of home hygiene:

Each week in the CHC session 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

CHC recommended practices seldom require much financial outlay but is just a matter of changing habits and re-organisation.

A typical Community Health club member

- Has a refuse pit and recycles waste
- makes a dish rack to keep pots clean
- Cover drinking water
- Has handwashing facilities
- Wash hands regularly with soap
- Has a model kitchen (see above)
- Has a comfortable place to relax
- Is respected by her husband
- With children who flourish



YEAR 3: WASH SECTOR: Safe Water & Sanitation

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

A ventilated Improved pit latrine, complete with pipe, lined pit, plastered walls and a cement hand washing facility made by the CHC members as an income generating project.

Safe Drinking Water

The CHC members are encouraged to dig their own wells through 'self-supply' without any support from outside funds. Village level operation, management and maintenance (VLOMM) of water facilities (e.g. gravity, piped, pumped etc.) is a natural responsibility of the CHC committee, who are responsible for ensuring the use and sustainability of WASH facilities in the village.

CHC Women make themselves sitting areas with chairs moulded out of mud – a hallmark of being in a CHC.

Safe Sanitation

When health club members really grasp how germs are transmitted and cause disease they usually make an effort to protect themselves by improving their hygiene. Once the group subscribes to safe sanitation, ***positive*** peer pressure ensures that zero open defecation is a priority in every home and CHC members help each other to meet their new hygiene standards. If they can't afford to build a latrine they can at the very least use cat sanitation (burial of faeces) which is the first step in the sanitation ladder.

Sitting on a par with their husband – an observable indicator of their self-worth and self-confidence.

YEAR 4: Food Agriculture & Nutrition (FAN)

A communal nutrition garden where each woman has 5 seedbeds for growing vegetables using crop rotation and organic fertiliser. Chipinge, Zimbabwe. 2009.

One of many women master farmers– showing her crop of comfrey, one of 30 herbs grown and used as a medicinal herb in CHCs.

Food Agriculture & Nutrition (FAN)

With stunting being such a major concern across so much of Africa, 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 growing a range of vegetables and herbs in either individual or communal nutrition gardens, which also helps to support vulnerable families in the village.

Women in FAN clubs have kept their families going in times of extreme economic collapse due to food growing within the CHC. One women reported she had even managed to build onto her home from the sale of tomatoes in a time of rampant inflation.

Women in the FAN Club learn to dry and preserve surplus food so that a balanced diet can be maintained all year round.

Sale of surplice produce enables women to provide for their families as well as ensure that they have a balanced diet. This also enables circulation of currency within the village.

Control over their own income enables women to support more of their children to attend school, so one consequence of this income is that more girl children remain at school when it is a mother's choice.

Husbands report more respect for women who can also contribute to family income.

8 YEAR 5: A fully functional community responsible for its own development

***Left**: A CHC constructed its own meeting place with some demonstration facilities for members to emulate with pot rack in foreground. (Mberengwa, Zimbabwe. 2014)*

***Below:** The 1st intake of toddlers using the CHC venue for a play school (Mberengwa, Zimbabwe. 2014)*

Some CHC construct permanent meeting shelters, which can also be used for play schools for their toddlers.

Other CHC start income generating projects such as soap making, oil pressing, sewing and food production and preservation.

Many CHC start saving and loan schemes to enable members to buy what they need to keep up their hygiene standards.

The CHC has become a safety net for mothers.

After three years the village has become a fully functional society that can

1. Protect itself from public health threats
2. Has adequate and safe drinking water
3. Has open defecation free environment
4. Ensures the survival of mothers and children
5. Feeds itself through environmentally sound farming methods
6. Protects the environment from erosion and deforestation
7. Enables the youth to make a living in the village

New CHC Countries

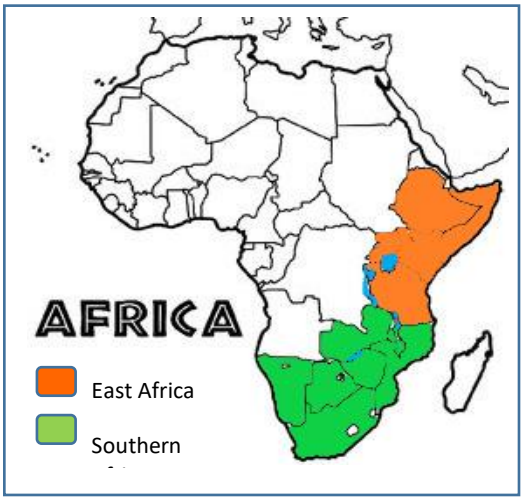
Two main hubs for administering and provision of training for new CHC country programmes:

East African Hub: Kenya

Kenya, Rwanda, Uganda, Tanzania, Ethiopia, Somalia, Somaliland.

Southern Africa Hub: Zimbabwe

Zimbabwe, Zambia, Malawi, Mozambique, Namibia, Botswana, South Africa



Map of Africa showing 2 Africa AHEAD Association Training hubs

Capacity for Implementation

Africa AHEAD Association does not claim to be able to implement at this scale ourselves but through our partners we can be the catalyst, enabling other organisations with existing presence in these countries to start at least CHC programmes.

At present we have interested partners in Zambia, Malawi, Kenya, Ethiopia, Somaliland in Africa as well as Mexico, Nepal and India, all looking for support to start a CHC programme.

Implementation can be done in three distinct ways:

1. By building capacity of Ministries of Health, we can enable their Environmental Health staff to rationalise their existing jobs, ensuring Village Health Workers are trained and equipped to be able to carry out their duties properly. Case Study: Rwanda

2. Through building capacity of local and international NGO enabling their staff to manage the programme and train Community-Based Facilitators. Case Study: Zimbabwe.

3. To implement ourselves directly in countries where we already have a presence (Zimbabwe & Rwanda)

Scale of Implementation

Africa AHEAD provides support through ***four*** stages for scaling up the CHC methodology from a pilot project in a country where CHCs have not been done before to a national programme managed by Government as in Rwanda.

The process can be charted as a progression through four stages:

Phase 1 : *Advocacy and Introduction*: Introductory workshop for all stakeholders interested in the CHC approach (using online training through Zoom.

Phase 2: *Replication and Adaptation:* Africa AHEAD works with partners in country to undertake research in a collaborative learning process assisting development of the manual and Toolkit for the specific context. Back stopping of partners during the start up of 20-50 CHCs as a 'demonstration project' in the 'new country'.

Phase 3 : *Scaling up and monitoring*: The CHC Model is monitored for quality control and evaluated by Africa AHEAD. Once approved it can be safely adopted for scaling up with at >50 - 200 CHCs per year and monitored closely with published research.

Phase 4 : *Evaluation and Institutionalistion:* The CHC model is endorced 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.

Context

The country must be a low-middle income country where need exists and where implementing partners have committed to the CHC modle by completing Module 1, 2 & 3 through Africa AHEAD

A Community Health Club programme can be stated in most contexts:

- Long term development programmes or short emergency programmes
- Rural peri-urban or urban areas
- Christian, Hindu, Buddhist and Moslem
- Lower income countries or areas of poverty in middle income countries

Africa AHEAD Association Services

Africa AHEAD Association is not a funding organisation. We are able to assist in proposal writing to raise funds for a CHC Programme if is within our standards of implementation.

To fund raise we require an MoU of partnership with other organisations to co-implement.

We provide the following consultancy services:

- Advocacy meetings with senior government officials to explain the CHC model
- Write and design programmes and write proposals for fund raising.
- Assistance in the design and development of the CHC Training materials and manuals necessary for a national programme
- Pre-testing our existing Tool kit and make minor adaptations to our existing visuals aids to ensure they culture specific for each new country.
- Training of a team of core CHC trainers for each country
- Hosting an online registry for all CHC to record their own activities
- Provide monitoring tool to enable partners to measure their achievements
- Providing comparative data for cross-learning of experience between CHC programmes
- Online CHC Training Seminars and presentations for government and NGOs
- Arrange Look & Learn Tours to visit for hands-on experience of CHC programmes.
- Conduct monitoring and evaluations of partners CHC projects
- Accommodate interns for 1st job experience
- Monitoring Tool using cell phone for data collection[i]
- Publish regularly to ensure that the CHC model informs the development sector at large.

CONCLUSION

The CHC Model has been tried in a variety of contexts, and it is a low risk strategy, guaranteed to work if the standard quality of training is maintained. If funds permit CHC can be taken to scale and become a national programme. Africa AHEAD can provide the advocacy and training for such a drive to meet the SDG targets. We seek enthusiastic partners with a similar vision.

Annex: Supporting information

Fig.1: Number of CHCs, CHC members and beneficiaries form AHEAD projects in Zimbabwe 1999-2020.

Year	Partner	Donor	Area	CHCs	Members**	Beneficiaries
1999 -2004	Government	DANIDA/ FAO	Makoni Manicaland	285	19,950	99,750
1999 -2001	Government	DFID	Tsholotsho and Gutu	120	8,400	42,000
2008-2010	Mercy Corps	EU/BLF	Buhera, Chipinge, Chiredzi, Manicaland	134	12,998	65,000
2008/9	Oxfam		Mutare Town	50	11,000	55,000
2009	IWSD	DFID	National PRP	n/a	n/a	Unknown
2010:	Oxfam	OFDA	Chiredzi	265	18,550	92,750
	Oxfam	OFDA	Masvingo rural	121	1,470	42,350*
	Oxfam	OCHA	Masvingo town	19	1,330	6,650
2011-14	ACF	EC	Gutu & Mberengwa	500	35,000	250,000*
2012/13	Government	USAID	Manicaland	480	33,600	105,000
2012	GAA	Unicef	Bindura Town	25	1,750	44,033
2012-2013	ACF	Unicef	Chipinge Town	30	2,100	25,675
2012-2013	Direct	USAID/OFDA	Mutare, Chipinge, Chimanimani	215	15,050	75,250
2014	ADRA	Japanese	Gokwe North	4	280	112,500*
2014 - 2015	CNFA /IMC	USAID	Matebeleland	400	28,000	192,000*
	MSF	Belgium	Harare	16	1,440	7,200
	SNV	EU	Masvingo	120	8,400	180,000*
2016	DAPP	USAID	Chipinge Chimanimani	80	2,688	13,440
2016	ACF	USAID	Gutu & Mberengwa	30	3,000	64,110*
2017 - 2018	SKAT	Drink Donate	Makoni	25	2,750	13,800
2019	ACF	Unicef	Harare, Gwanda & Chipinge	95	6,650	400,000
2020	Direct	Unicef	Gutu, Mutare, Chipinge, Bulawayo	40	2,800	14,000
				2,883	217,206	1,900,508

Fig.2: Number of CHCs, CHC members and beneficiaries from partners projects internally 2002 - 2020.

Year	Partner	Country	CHCs	members	beneficiaries	Achievement
2002	**CARE**	S.Leone	50	3,500	35,000	CHCs Moslem villages
2003	**CARE**	Uganda	150	10,500	52,500	CHCs in IDP camps,
2007	**E.Interventions**	G. Bissau	120	8,400	42,000	CHC Moslem villages
2008	**C.Town Municipality**	South Africa	400	28,000	140,000	Urban CHCs
2009	**DANIDA**	K.Zulu Natal	10	700	3,500	rural CHCs
2010	**DANIDA**	Vietnam	200	14,000	70,000	rural CHCs 3 districts
2012/16	**Gates Foundation**	Rwanda	150	10,500	52,000	CHCs in RCT
2013	**ILF/Hilton Found**	Uganda	70	4,900	24,500	CHCs/ Borehole
2014/15	**Tearfund / DFID**	D.R.Congo	20	1,400	7,000	CHCs in South Kivu
2016	**Polish Humanitarian**	South Sudan	18	unknown	unknown	CHC
2016	**Children of the Nation**	Malawi	38	unknown	unknown	Lilongwe
2018	**CAWST/Seeds Hope**	Zambia	10	unknown	unknown	Ndola
2019	**12 NGOs**	Zimbabwe		unknown	unknown	
			1,236	**81,900**	**426,000**	

Africare, IMC,ADRA, Lutheran Development Services, Christian Aid, Medra, Apostolic Women, Empowerment Trust, IRC, DAPP, Mvuramanzi Trust, Practical Action.

Fig 3: Reduction of 5 Diseases in Ruombwe Ward, Makoni District 2005.

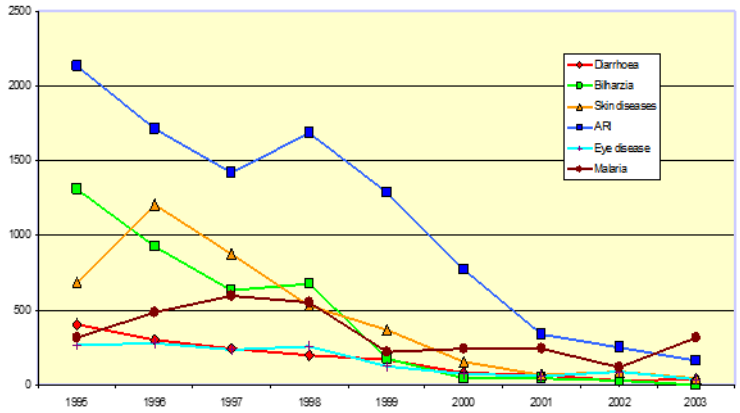


Fig 4: Projection of Scaling up CHCs in targeted countries which possible partners

		2021	2022	2023	2024	2025	Members	Beneficiaries
Zimbabwe	**AHEAD**	**100**	**200**	**300**	**400**	**500**	35,000	175,000
India	**SM Seghal**	**20**	**50**	**100**	**150**	**200**	14,000	70,000
Zambia	**OPAD**	**20**	**50**	**100**	**150**	**200**	14,000	70,000
Malawi	**Global Connections**	**20**	**50**	**100**	**150**	**200**	14,000	70,000
Kenya	**HPA & HLI**	**20**	**50**	**100**	**150**	**200**	14,000	70,000
Mexico	**SARAR**	**20**	**50**	**100**	**150**	**200**	14,000	70,000
Cumulative Total		**200**	**450**	**800**	**1150**	**1500**	**105,000**	**525 000**

GC Global Connections (Canada)
HLI Healthy Lives International (USA)
HPA Health Poverty Action (UK)
OPAD Organisation for Poverty Alleviation and Development (Sweden)

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

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