Africa AHEAD

Applied Health Education and Development

Biennial Report

January 2016 — December 2017

ACKNOWLEDGEMENT S

Acknowledgements:

The 2016 –2017 Biennial Report

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Front Cover:
Photo:
One of thousands of model hygienic kitchens that CHC members are constructing in Zimbabwe

For more information visit the website:

www.africaahead.com

For registration of Community Health Clubs

www.chcahead.org

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REGISTRATION
Africa AHEAD is registered in the following countries:

South Africa	Non Profit Sect. 21:2005/040379/08
United Kingdom	British Charity No: 1151795
USA	Not for Profit 501c(3) 38-3862007
Zimbabwe	Private Voluntary Organisation 19/2014
Rwanda	International NGO registered 177/DGI&E/13

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ACRONYMS

AA	Africa AHEAD
ACF	Action Contre la Faim
AHEAD	Applied Health Education and Development
ASOC	Affaires Socialles
BMGF	Bill & Melinda Gates Foundation
CBEHPP	Community-Based Environmental Health Promotion Programme
CBF	Community Based Facilitators
CD	Country Director
CEO	Chief Executive Officer
CSIU	Civil Society in Development
CHC	Community Health Club
CoN	Children of the Nation
cRCT	Cluster Randomised Control Trial
DAPP	Danish Aid people to people
DFID	Department for International Development (UK-Aid)
DRC	Democratic Republic of Congo
EHD	Environmental Health Department (in MoH)
EHO	Environmental Health Officer
EHT	Environmental Health Technician
FAN	Food, Agriculture & Nutrition
IPA	innovations for Poverty Action
MDGs	Millennium Development Goals
MoH	Ministry of Health
OFDA	Office for Foreign Disaster Assistance
PHO	Polish Humanitarian Organisation
PPP	Private Public Partnerships
PUT Z	Pensioners Union Trust of Zimbabwe
RCT	Randomised Control Trial
SDG	Sustainable Development Goals
SIDA	Swedish International Development Aid
ToT	Training of Trainers
UFW	Upgraded Family Well (Self-Supply for rural water)
USAID	United States Aid

FOREWORD

Chairman: Prof. Richard Carter

Africa AHEAD recognises that households and communities which may be poor in terms of financial and physical assets can nevertheless make improvements to their environments, livelihoods, and health and hygiene practices. These behaviour changes may ultimately contribute to numerous health, educational and economic benefits.

The Community Health Club (CHC) model embodies a number of features which make it effective in bringing about such behaviour changes in households and communities. It is a structured approach offering highly practical and useable knowledge, set in a context of positive peer pressure and the pride of individual achievement. Knowledge alone is rarely enough to alter behaviour, but knowledge acquired in an enjoyable social setting, and in which the members undertake agreed actions related to their new-found knowledge, is a different matter. The sense of pride felt by members on graduating from their structured programme of participative learning reinforces their learning and self-help actions.

One of the most surprising aspects about the CHC model is its effectiveness in many very different contexts – rural and urban, relatively secure and decidedly insecure places. The combination of learning, structure, belonging, peer pressure and pride of achievement has shown itself to be a winning formula.

Africa AHEAD, like many non-Government organisations, relies heavily on project-by-project funding for its ability to work. When funding is available, the work progresses; when there is a lull in funding, activity diminishes. At the time of writing, Africa AHEAD is in such a nadir. We are taking this opportunity to consolidate the achievements already made over many years, ensure that our governance arrangements are of the highest standard, work on our goals for the coming years, and set up the necessary funding strategy to achieve those goals.

One of Africa AHEAD's challenges in the last two years has been the publication in a reputable academic journal of an experimental trial (a randomised controlled trial or RCT) from the national programme in Rwanda, which, on the face of it, showed little in terms of behavioural outcomes and no health impacts. That this was disappointing is an understatement. But the evident flaws in the trial and the fact that its findings strikingly contradicted those of our own rigorous monitoring meant that we had to draft two papers for publication responding to the trial. These are under review at the time of writing. On the positive side, this experience is helping to inform wider international thinking about how to generate rigorous evidence about 'what works' in complex settings, and how researchers, practitioners and others can better collaborate in that important endeavour.

Bringing about beneficial behaviour changes among cash-poor households and communities is challenging. Many organisations and programmes try to achieve this in ad hoc and unsystematic ways. The CHC approach is well-thought through, systematic, built on many years of experience, and effective. In short, it works.

It is therefore a privilege for me to support and serve Africa AHEAD as the chair of its UK board of trustees.

BOARD OF TRUSTEES

Enhancing our credibility &

Ensuring good accountability

UNITED KINGDOM TRUSTEES

Prof. Sandy Cairncross, our Founding Chairman since 2013 hands over to Prof. Richard Carter as Chairman, whilst continuing as a Trustee. Lyle Aitkin, our Director of Finance and Richard Bennison, Secretary to the Board both retired after three years (2013-2016) of dedicated service. In their place we warmly welcome Oliver Cumming and Michael Mills.

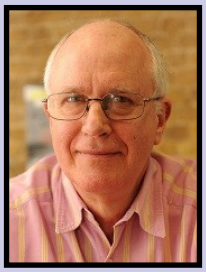
Outgoing Founding Chairman
Prof. Sandy Cairncross
2013-2017

Incoming Chairman
Prof. Richard Carter
Chairman 2017

Outgoing Secretary
Richard Bennison
(2013 — 2016)

Incoming Secretary
Michael Mills
(2016 - current)

Prof. Barbara Evans
Water Institute,
Leeds University



Kevin Laue, Human Right Lawyer and Founding Trustee of Zimbabwe AHEAD

Oliver Cumming,
Assistant Prof, London School of Hygiene & Tropical Medicine

EAST AFRICA ADVISORS

Zachary Bigirimana, Regional Representative since 2014, became an Advisor in 2017 as did Eugene Rutagarama and Kevin James who is our EA Finance Advisor.

Zachery Bigirimana

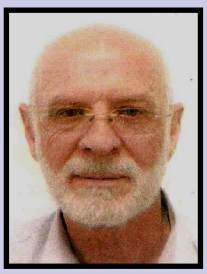
Eugene Rutargarama

SOUTHERN AFRICAN ADVISORS

in Zimbabwe the local Advisory Board is chaired by Janette Heatherton with local Advisors Jaap Kuiper, Molly Smo and Graham Cheater. This year we also welcome Sally Whitaker.

Janette Hetherton,
Chairperson for AA/Zim
Trustee on UK Board

Dr. Jaap Kuiper



Graham Cheater

Smolly Moyo

Sally Whittaker

ORGANOGRAM

Africa AHEAD Personnel 2016/17

CHIEF EXECUTIVE OFFICER

Dr. Juliet Waterkeyn
Outgoing CEO

Anthony Waterkeyn
Incoming CEO

DIRECTOR OF FINANCE

Advisor on Advocacy
Roger Short

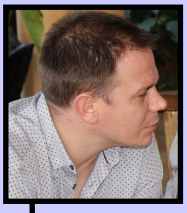
Outgoing Director
of Finance Lyle Aitkin

COUNTRY DIRECTORS

Rwanda
Joseph Katabarwa

Zimbabwe
Regis Matimati

FINANCE SUPERVISORS



Rwanda
Kevin James

United Kingdom
Alison Chambers

South Africa
Birgit Rosner

RWANDA: PROGRAMME MANAGERS

Amans Ntakarutimana, DRC

Fausca Uwingbire, Rwanda

COUNTRY FINANCE OFFICERS

Rwanda
Jeanne Gasengayire

Finance Zimbabwe
Patience Muserepwa

Admin Zimbabwe
Nyengeterai Katsiru

RWANDA PROJECT OFFICERS

Emanuel Bwimana,

Mercie Mberire,

Vincent Habimana

ZIMBABWE PROGRAMME MANAGERS

Andrew Muringaniza

Spiwe Mpofu

Canaan Makusha, Mercy Jambo, Moses Matondo, Agrippa Chigono, Felistus Mutimukulu, Lloyd Chasinda, Rangandu Mushipe, Kudza Nyamukapa

CEO'S OVERVIEW

January 2016 — December 2017

Anthony Waterkeyn

Chief Executive Officer

As Juliet retires as CEO at the end of 2017 and I take up the reins, I am delighted and challenged by the prospect of ensuring that our joint endeavours over many years in establishing Africa AHEAD (AA), will continue and flourish. I would especially like to acknowledge Juliet's personal inspiration of the Community Health Club (CHC) concept in Zimbabwe some 22 years ago. As founding CEO, Juliet has devoted a phenomenal amount of time and effort, mostly voluntary, to develop the theory around this approach whilst at the same time mentoring our local in-country teams.

These efforts have resulted in the launch of AA in several countries, most recently in UK, which is no mean feat when one considers our extremely lean administrative budget. We estimate that these efforts since 1997 have resulted in establishing 3,466 CHCs across 11 countries with positive impact on the lives of over 2,2 million people living in some of the poorest countries in Africa and beyond. This figure does not include the countless other CHCs that have been implemented through other organisations or governments (e.g. in Rwanda where CHCs have been taken to scale nationally).

Yet despite these obvious achievements, these past two years have been challenging; we have become a shadow of what we were just a couple of years ago when we had around 40 operational staff (30 in Zimbabwe and 10 in Rwanda). With the BMGF funding coming to an end in Rwanda last year and with minimal investment in Zimbabwe due to the ongoing pariah status of the country, we have had to downsize our staff complement considerably. However, it is important to point out that we have all along been able to maintain an exceptionally loyal core group of staff who have remained with us through good times and bad; and those who have been laid off are more than ready to re-engage with us whenever we secure funding for projects.

The other point to highlight is that we have been able to maintain in many cases, our quite exceptional cost-effectiveness at achieving sustainable Hygiene Behaviour Change at under US$ 5 per person while at same time increasing the scope of the CHC approach to address a whole raft of the new Sustainable Development goals (SDGs) in an holistic and integrated manner (refer to *page 13* for a case study). As we go forward we want to maintain our dynamic and innovative edge to disseminate an expanded CHC-SDG approach.

I would especially like to thank Prof. Sandy Cairncross, our founding Board Chairman since 2013, who in November 2017 handed over the baton of Chairmanship to Prof. Richard Carter while thankfully confirming that he is keen to stay on the Board. Our Board of Trustees have been resolute in ensuring that we have regular quarterly Board Meetings and their loyalty and strong encouragement has enabled AA to weather a number of storms whilst encouraging us to continue despite minimal funding to cover our core costs.

I remain optimistic that the CHC model will steadily become better understood and appreciated, especially within the current context of the Sustainable Development Goals (SDGs) by which a far more integrated and cross-sectoral approach to holistic development is gaining ground. We will consolidate our presence with a dedicated management and administrative team in our new head office located in Cambridge, while our two regional hubs in Zimbabwe and Rwanda will continue to expand their role and capacity to disseminate CHCs into neighbouring countries and beyond.

RESEARCH AND MONITORING

Summary of activities 2016—2017

Dr. Juliet Waterkeyn

Dr. Juliet Waterkeyn with a community based facilitator, Sibusiso Charamba in Chipinge Zimbabwe sitting on outside sofa moulded in clay in one of the many model homesteads. Note the VIP latrine and Tippy tap behind and see the decorated kitchen (front cover and page 10)

In view of the urgent need to document the more theoretical side of our organisation as we seek to defend and refine our 'product', am grateful to be able to hand over the management to Anthony (my long time partner in life and a career in 'development') enabling me to concentrate on the modifying the training for different contexts as we replicate and scale up the CHC model, whilst monitoring CHCs more effectively so as to advance knowledge of how to achieve and sustain hygiene behaviour change at low cost.

With Prof. Cairncross also standing down after 5 years at the helm, I would like to thank him for giving me such great moral support over the years, starting off as supervisor for my PhD research of the CHC Model and then becoming our first Chairman when we started Africa AHEAD in the UK in 2013. After 5 years I feel we have barely laid the foundations, but it has been exhilarating and I am sure the new combination of Prof. Carter as Chairman and Anthony as CEO, will enable us to come out of the ground as Africa AHEAD.

When IPA published the results of their RCT in Rwanda, concluding CHC *'had no effect on any main outcomes. Neither did it achieve the broader aims of the CBEHPP campaign, including zero open defecation and at least 80% hygienic latrine coverage'* [1] - and therefore did not merit being scaled up - those of us who had seen strong community response in Rwanda could not stand by without mounting a challenge. It is by no means the first scientific research to have identified little to report in recent years[6], and as in other cases there seemed to have been a disconnect between the RCT quantitative measurement of CHCs and an ability to interpret reality on the ground. For a small NGO such as ours to challenge the findings of an RCT (a method considered by scientists as a gold standard in research), is comparable to a young David taking on the giant Goliath — in this case the BMGF which funded the trial *(page 13).* Our monitoring data indicated that the trialists had *pre*judged issues before the facts were in. We have now submitted two papers [2,3] for publication *(see pages 14 & 15)* providing more context in an effort to establish the truth. The 3rd national CBEHPP Scale-up Workshop that was hosted by Ministry of Health (MoH) in Kigali (May 2017) enabled other INGOs to present their CHC results that proved comparable to our own, indicating significant uptake of hygiene in CHCs, with World Vision reporting an increase of 60,680 latrines in over 720 CHCs in their areas[5] whilst WaterAid had similar positive outcomes. It was also gratifying that the (MoH) in Rwanda was not deflected from their national CBEHP Programme that is expanding into other sectors in an Integrated Nutrition-WASH (INWA) programme in 20 districts across Rwanda (supported by UNICEF & USAID).

The closure of our work in Rwanda, was more than compensated by a huge surge of activity in Zimbabwe during the second half of 2016, where the long-awaited USAID funded project got going in two districts of Chimanimani and Chipinge in partnership with DAPP, with another team working in Gutu and Mberengwa in partnership with ACF (also funded by USAID/OFDA). During this 2 year period we had a total budget of US$970,873 with 15 staff in Zimbabwe. We supported a total number of 212 CHCs involving 143,046 people from as little as US$2.2 per person in some projects with an average of US$6.52 *(page 8).* The extraordinary efforts being made by the health club members in beautifying their homes through an ingenious technique of polished clay ornamentation, which enables even the poorest of homes to shine and achieve levels of hygiene, needs to be seen to be believed *(front cover, page 11).* We really need to spotlight the extraordinary levels of hygiene being achieved by CHCs in Zimbabwe which provide such a delightful example of how CHCs can work within a more integrated approach that incorporates at least eight of the Sustainable Development Goals, empowering women and decreasing poverty, as well as improving hygiene and health.

CHC COUNTRIES

6 **Beneficiaries by Country**

'Direct Beneficiaries' refers to all those in a family benefitting from improved home hygiene as a result of one of them being a CHC member.

A 'CHC member' is the representative from the family who attends the weekly CHC sessions and transfers their knowledge home.

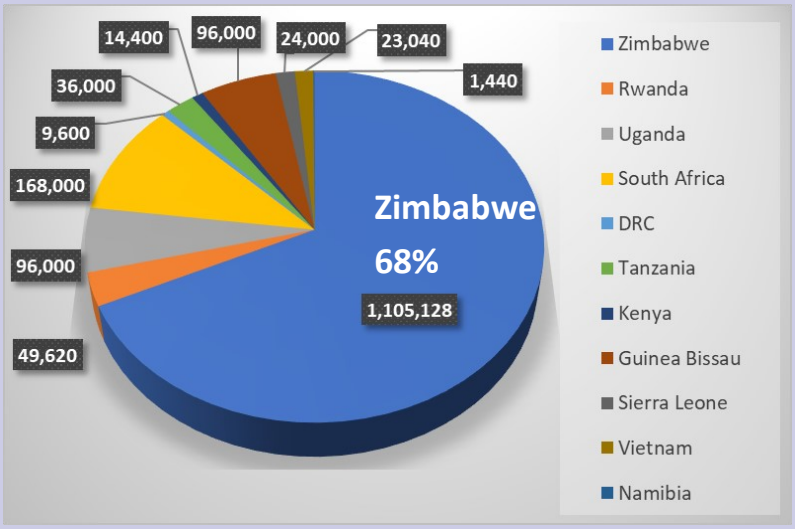
TOTAL REACHED TO-DATE

BY AFRICA AHEAD DIRECTLY

- **2,227,152 Direct Beneficiaries**
- **372,192 CHC Members**
- **3,466 Community Health Clubs**

The CHC number for Rwanda only includes our direct implementation in Rusizi district: in reality around 8 million will have benefitted from CHCs which were started by MoH and other NGOs in almost 15,000 villages throughout the country in the national CBEHP Programme.

Percentage of direct beneficiaries by country: 1995-2017



Estimated number of beneficiaries from CHC by country: 1995-2017

COUNTRY	Number of CHCs	Members	Beneficiaries	%
Zimbabwe	2,340	184,188	1,105,128	68%
Rwanda*	150	9,924	49,620	3%
Uganda	200	16,000	96,000	6%
South Africa	350	28,000	168,000	10%
DRC	20	1,600	9,600	0.8%
Tanzania	75	6,000	36,000	2%
Kenya	30	2,400	14,400	1%
Guinea Bissau	200	16,000	96,000	6%
Sierra Leone	50	4,000	24,000	2%
Vietnam	48	3,840	23,040	1%
Namibia	3	240	1,440	0.2%
TOTAL	3,466	371,192	2,227,152	100%

DEMOCRATIC REPUBLIC OF CONGO: Africa AHEAD in partnership with Tearfund & Oxfam (funded by DFID) introduced CHCs on a pilot basis into DRC. By the end of 2016, the response from the community and MoH was positive and the CHC model is appreciated in DRC with the local authorities requesting AA to scale up in South Kivu province.

RWANDA: Gates Foundation extended the project in Rusizi District for a final six months until June 2017, ensuring all 150 villages had the same Classic CHC treatment, and that District competitions were held to identify best performing CHCs. Over 80% compliance of CHC households was achieved for six key indicators of safe hygiene behaviour *(pages 13-15).*

ZIMBABWE: Four main programmes were running in 6 districts:

1**. Gutu and Mberengwa Districts**: Through ACF/OFDA, AA trained 31 CHCs (3,750 members, 15,750 beneficiaries). 52 water-point user committees with 371 participants were also established for borehole maintenance. Also 6 School Health Clubs with 60 members and 64,110 beneficiaries *(page 9).* Swedish SIDA extended the programme for a further 10 months until October 2017 resulting in a further 30 CHCs (2,250 members; 9,450 beneficiaries) and 30 more boreholes rehabilitated *(page 10).*

2**. Chipinge and Chimanimani Districts:** DAPP/USAID enabled us to provide support to 4,500 households (22,680 people) in 6 wards to increase dietary diversity and adoption of improved nutrition practices through Food Agriculture and Nutrition (FAN) Clubs resulting in 80 boreholes being rehabilitated with 474 nutrition gardens; 343 self-funded latrines and 168 subsidized latrines. In total 49 water points were constructed (21 over target). Water testing was done in 13 boreholes. The project ended in July 2017 *(page 8).*

3. Makoni District A small pilot project in partnership with SKAT (Secretariat to RWSN) took place in 2017 to demonstrate the effectiveness of achieving 'Self Supply' through CHCs. Achievements included 60 wells rehabilitated with the rope and washer pumps in 25 CHCs with 1,500 members and 6,300 people benefitting from improved drinking water and hygiene.

4. Mutasa District: For the first time AA works in Mutasa District providing support to two local NGOs to start 10 CHCs, with 13 nutrition gardens including 500 households *(page.12)*

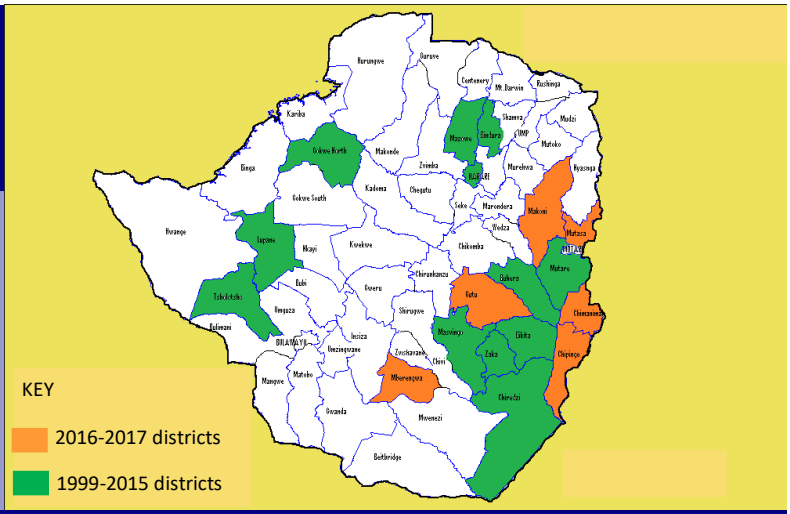
ZIMBABWE

8 **Summary of Impact 2016 & 2017**

MAIN ACHIEVEMENTS

- **264 CHC formed**
- **19,200 CHC Members**
- **148,856 Direct Beneficiaries**
- **US$ 4.2 per Direct Beneficiary**

Distribution of project districts in Zimbabwe where Africa AHEAD has started CHCs directly (1999 - 2017)



By 2017 we had reached 1,150,128 people in Zimbabwe (68% of total beneficiaries)

Direct Implementation by Africa AHEAD / Zimbabwe AHEAD in Zimbabwe: 2016-2017

Year	Partner	District	CHCs	CHC /SHC members	Direct Beneficiaries*	Budget in USD	Funder	Cost /direct beneficiary
2016 - 2017	DAPP	** Chipinge	37	2,497	12,692	553,075	USAID	US$ 24.38
		**Chimanimani	43	2,903	9,998			
2016	PT	Mutasa	10	500	2,100	9,000	CISU	US$ 4.2
2016 - 2017	ACF	Gutu	30	1,844	4,876	177,230	OFDA	US$ 2.2
		Mberengwa	31	3,750	15,750			
		School Clubs	6	660	64,100			
2017 - 2018	ACF	Gutu	30	2250	9,450	180,447	SIDA	US$ 19.09
2017	SKAT	Makoni	25	1500	6,300	35,000	D & D	US$ 5.55
Totals		**6 District**	**212**	**19,130**	**143,056**	**965,073**		**US$ 11.08**

* Household size in Zimbabwe has shrunk to 4.2 from 5 in recent years making less beneficiaries per CHC
** Chipinge & Chimanimani overall budget included borehole rehabilitation and school latrines

Consultancies providing training by Zimbabwe team to NGOs regionally

Year	Partner	District	Country	Trainers trained	CHC	CHC members	Direct Beneficiaires	Cost of training
2016	PHO	Pibor	South Sudan	28	20*	2,000**	10,000***	7,805
2016	CoN	Lilongwe	Malawi	42	38	3,800	19,000	8,316
	2	**2**	**2**	**70**	**58**	**5,800**	**29,000**	**16,121**

* conservative estimate of one CHC per trainer trained ** estimated at 100 CHC members per CHC *** estimated at 5 family members per CHC member

Totals	8 District	CHC	CHC members	Beneficiaries	Cost US$	Average cost per beneficiary = US$ 6.52 *
		264	19,200	148,856	970,873	

* Cost per beneficiary is calculated by dividing number of direct beneficiaries by the total cost of implementing the programme including administration and core costs

ACRONYMS :

ACF *Action Contre la Faim*
CISU *Civil Society in Development*
CoN *Children of the Nation*
D&D *Drink and Donate*
DAPP *Danish Aid people to people*
PHO *Polish Humanitarian Organisation*
PUTZ *Pensioners Union Trust of Zimbabwe*
SIDA *Swedish International Development Aid*

Partner: DAPP
Funder: USAID
Dates: Sept 2016 – August 2017
Area: Chipinge & Chimanimani
Budget: US$ 553, 075
Number of CHCs: 80
Number of CHC members: 5,400
Number of beneficiaries: 13,440
Number of staff: 9

The two year USAID funded Community WASH project in partnership with DAPP ended in August 2017 in Chipinge and Chimanimani Districts.

PROGRAMME GOAL

- To implement community led approaches to secure safe WASH practices within 3,200 Households in 6 wards of Chipinge and Chimanimani Districts
- Increase dietary diversity and adoption of improved nutrition practices by 3,200 Households.
- Improve the water conservation and environmental preservation efforts of 3,200 farmers in 6 wards of the 2 districts.

ACHIEVEMENTS

Target	Goal	Achieved in first 3 months	Achieved in 2 years
FAN (CHC) Clubs started	64	72	80 (125%)
Borehole Rehabilitation	65	69	72 (110%)
Water quality Testing	65	14	65 (100%)
Construction water pan	140	6	140 (100%)
School latrine blocks	8	4	8 (100%)
Self supplied latrines	343	204	385 (112%)
Subsidized latrine	168	85	168 (100%)
Nutrition Gardens	310	474	472 (152%)
Ward cluster meetings	6	6	6 (100%)
Exchange visit	1	1	1 (100%)

Above: *Andrew Muringaniza, Programme Manager and CHC trainer since 1999.*

Above: *One of builders trained to repair boreholes and build latrines receives his certificate*

Above: *Jira borehole in ward 20, Mumera village before and after headworks repaired*

ZIMBABWE

10 **Addressing undernutrition and WASH needs of 'El-nino induced drought'**

Partner: ACF
Funders: USAID / OFDA
Date: 2016 – September 2017
Location: Gutu & Mberengwa
Budget: US$ 177,230
Number of CHCs: 61
Number of CHC members: 3,750
Number of beneficiaries: 15,750
Indirect beneficiaries: 64,110

GOAL: To protect the lives of children in drought affected populations in Gutu and Mberengwa districts through provision of timely integrated WASH and Nutrition interventions.

Obituary:
We acknowledge with great sadness the demise of Rangandu Mushipe (left) Project Officer on this programme, who was sadly swept away in flash floods and never found December 2016.

SPECIFIC OBJECTIVES

1. To improve access to adequate safe water for 12,500 drought affected people, school children and patients in Gutu and Mberengwa.

2. Guarantee access to prevention, screening and treatment of acute malnutrition, through reinforcement of community mobilization and support to health services.

Achievements in the first 3 months (2016)	Target	Achieved by end of 2 years
School Health Clubs / Sanitation	6	6 (100%)
FAN (CHC) Clubs started	50	52 (104%)
Borehole Rehabilitation	50	52 (104%)
Water quality Testing	50	48 (96%)
Construction water pan	140	140 (100%)
Water containers distributed	1,000	1,000 (100%)
Water Point User committees	50	52 (104%)
Village Pump minder trained	50	49 (98%)

Above: *husband and wife both gain their certificates together in CHC, encouraging gender equity.*
Below: *Delight in a king size pumpkin!*

ZIMBABWE

Safe Water, hygiene & Sanitation in Gutu District

11

The Swedish Development Agency project took over from USAID in support of 5 wards in Gutu District, resulting in 30 new community health clubs, 5 new boreholes at clinics and schools whilst 25 other boreholes were rehabilitated by our team which included an engineer.

Partner: ACF
Funder: Swedish SIDA
Date: 2017—Jan 2018
Location: Gutu
Number of CHC: 30
Number of CHC Members: 2,250
Beneficiaries: 9,450
Boreholes: 30
Budget: US$180,447.32
Staff: 7
Manager: Andrew Muringaniza

Above: *An outside sitting area in the shade, rivals those of a safari lodge.*

Above: *another design of clay sofa.*

Above: *Immaculate bedroom, and (below) a home -made 'tippy tap' facility easily used even by small kids.*

Above: *A simple mud hut on the outside is transformed inside*
Below: *moulded clay benches and shelving for individual plates for the whole family and well-stored drinking water .*

'Model Homes' in all CHCs involve very little expense but lots of extra work. Many CHC women mould and polish clay to furnish the inside of their mud huts, making an extraordinary artform of their simple kitchens, bedrooms and outside sitting areas reaching a high standard of cleanliness and comfort. These homes need to be seen to be believed!

ZIMBABWE

12 Self-Supply in Makoni District

Partner: Skat Foundation
(Rural Water Supply Network)
Funder: Drink & Donate (Switzerland)
Year: 2017
Location: Wards: 5,6,7,19,20
District: Makoni District
Budget: US$ 35,000
Number of CHC: 25
Number of CHC Members: 2,500

***Above left**: Rope and Washer hand pump* ***Right:** Self funded VIP latrine*

PROJECT GOAL: To stimulate the Self-Supply of Upgraded Family Wells with locally made rope & washer pumps and VIP latrines for safe water supply to 960 beneficiaries.

TARGETS:

- 14 Environmental Health Technicians trained in Community-based management of safe water
- 30 masons trained in digging and lining of wells
- 60 wells newly constructed in the first 6 months providing water to over 240 households

***Above:** Country Director, Regis Matimati addressing community in Makoni*

Communities used the trained masons and well-diggers paying for their own well construction. Targeted subsidies were given to vulnerable households (child headed households, the very poor and disabled community members) as demonstration units so other community members could copy the design.

Africa AHEAD provided training through the full participation of the community, to refresh the demand for safe water by promoting safe water chain knowledge within the communities. We trained well-diggers and masons, involved local private partners in rural water supply including water supply project management. All households were involved in a CHC and the levels of response were high resulting in many latrines being constructed without subsidy.

Water quality monitoring at base line showed that 51% (23 / 45) had fecal coliform contamination but within a year all wells were protected and polluted wells were treated with water purification chemicals.

ZIMBABWE

Mutasa Community Development Project

Partner: Pensioners Trust (Zim)
Funder: CISU/Denmark
Date: December 2017
Location: Mutasa
Number of CHC: 10
Number of CHC Members: 500
Beneficiaries: 2,100
Budget: US$ 9,000
Staff: 3
Regis, Andrew, Patience

PROJECT GOAL:

To improve water and sanitation and producing vegetables and small livestock to ensure 3 meals a day for the households.

TARGETS:

- 500 households in 4 wards of Mutasa District
- 50 facilitators for nutrition gardens
- 13 garden committees
- 14 members of the SRRC Management Committee
- 5 NGO organizations strengthening their partnership coopera-

Meeting the Sustainable Development Goals: an example of an holistic programme of integrated development using health promotion as an entry point to poverty alleviation

Ten Local health clubs in collaboration with local and district health officials, use participatory teaching methods to encourage the building of improved latrines and homestead improvements to support better health. The CHC members who are all farmers are growing a range of new crops such as beans, sweet potatoes, finger millet, wheat and indigenous vegetables with soil improvement using introduction of earth worms. The households ensure food security by processing vegetables for future use and they have improved in chicken production. They have all started 'savings and loans clubs' and there is a strong sense of ownership as they are all run by the women which has strengthened their independence and empowering. Teaching skills for income generating activities is an integrated element in training and educational activities. The local authorities have shown great support for the project by giving more land for the communal gardens.

Left:

One of 219 CHC trained in AA programmes in the past 2 years.

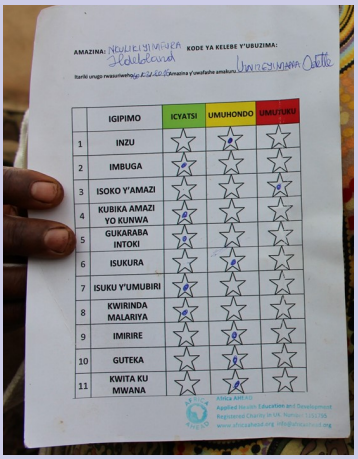
CHC Members receive certificates for full attendance (left) at 'Graduation Ceremonies'.

These certificates are the only incentive to attend the sessions.

RWANDA

Overview of monitoring in Rwanda 2016 - 2017

Funder: Bill & Melinda Gates Foundation
Partner: Ministry of Health
Location: Rusizi District
Dates: Oct. 2016 - April 2017
Number of CHC: 150
Number of CHC Members:
Beneficiaries: 45,000



Dates	# Months during/before/ after training	Survey name	Team	# Households Surveyed	Villages surveyed
May–Aug 2013	**6-12 before**	**Baseline[2]**	**IPA**	**8734 [3]**	**150 villages**
Oct-Nov 2013	3 before	Baseline	MoH/AA	5745/6866	50 classic CHCs
Feb—June 2014 Intervention in 50 Classic					
Apr-May 2014	3 mths in project	Midline	MoH/AA	424/4056	30 classic CHCs
Dec 2014	6 after project	End-line	MoH/AA	738/4056	24 classic CHCs
Sept – Dec 2015	**15 after**	**End-line[1]**	**IPA**	**7934 [4]**	**150 villages**
Apr-May 2016	23 after	post-inter	MoH/AA	408/4056	50 classic CHCs
Feb-Mar 2017	34 after	Final	MoH/AA	604/4056	23 classic CHCs

Above: *Summary of data collection by MoH/AA & IPA during the cRCT intervention in Rusizi District; 2013-2017*

During 2016 we once again modified the Household Inventory so that each household could be given instant feed back on their level for each of the ten indicators, using a traffic light score of red (below standard), yellow (incomplete) and green (safe) *(See picture above)*. We developed a smartphone 'App' to collect the Household Inventory by using an open-source tool known as Open Data Kit (ODK). When BMGF funding ended in July 2016, the programme stalled for 3 months until a final tranche to complete activities was received in October 2016 upon which 3 coordinators were posted to Rusizi District to ensure all CHCs engaged in the Model Home Competitions and were registered on the new 'chcahead.org' website. Meanwhile 100 new Community Workers were trained for the 100 'Control / Lite village' CHCs and 24 sessions were completed by June 2017. A final data collection took place in Feb/March 2017 after which only three AA staff remained until June 2017.

In December 2017 a final workshop was held to provide feed back to District Authority and EHOs on the results of our monitoring data, showing the 7 intermediate outcomes selected for the RCT had increased significantly 34 months after the end of the training, with all achieving >70% compliance ($p<0.001$ for each indicator). However Africa AHEAD could not respond to the District Council's request to remain in Rusizi and scale up to the 150 villages without CHC due to lack of funds.

As the RCT findings from Rusizi District were published with little context to explain reasons for the disappointing findings, our group has submitted the following paper for publication providing background to the programme so as to enable lessons to be leant from the intervention.

Monitoring hygiene behaviour change in Community Health Clubs: supplying the context and process neglected by an external Evaluation

Waterkeyn Juliet[1], Waterkeyn Anthony[2], Pantoglou Julia[3], Uwingabire Fausca[4], Ntakarutimana Amans[5], Mbirira Marcie[6], Katabarwa Joseph[7], Bigirimana Zachery[8], Cumming Oliver[9], Cairncross Sandy[10], Carter Richard[11]

Submitted to BMC Public Health Journal (Feb 2018)

ABSTRACT

A cluster Randomised Controlled Trial (cRCT) of a Community Health Club (CHC) intervention in Rwanda claimed little impact on hygiene behaviour change, whilst asserting that *all* intervention villages had received the intended per-protocol treatment. As little context was supplied to substantiate reasons for this perceived failure we provide an analysis of the process to examine the extent and reasons why the intervention was compromised in relation to the research protocol.

Methods

We assessed *community response* to the intervention using membership records of CHC members to ascertain spread of the intervention. We analysed the *expected inputs* to the CHC model against the research protocol, and through focus group discussions and key informant interviews examined the *external determinants* affecting delivery and response to the intervention.

Results

Although *spread* was below the target of 80%, with only 58.4% of the total households of 50 villages enrolled due to time constraints, the response from the *community* was high, with a mean of 80 *members registered* per CHC, with 41% *average attendance* of all sessions and 51% *mean completion rate* of the training. With numerous implementation challenges which were not explained by the cRCT, *expected inputs* showed only 54% fidelity to protocol whilst *external determinants* seriously jeopardised the delivery of the intervention which resulted in only 10% of the CHCs receiving the per-protocol,

Our findings raise concerns about the effectiveness of cRCTs, as performed in Rusizi District, to evaluate the CHC Model. We find coherent explanations for the perceived lack of health impact which were not adequately considered by the trialists, as well as strong evidence of community response which continued three years after the trial concluded, suggesting premature conclusions. Despite the negative findings of the cRCT, the Rwandan government is expanding the scope and the reach of Community Health Clubs to all villages in Rwanda.

Above: *Africa AHEAD Regional Representative Zachery Bigirimana, with the Secretary General of Ministry of Health , facilitating at the 3rd CBEHPP Scale-up Workshop, where both IPA and Africa AHEAD presented results of the Rusizi Intervention, showing markedly different results (26th May 2017).*

Measuring hygiene behaviour change in Community Health Clubs: methodological questions arising from a cluster-randomised controlled trial in Rwanda.

Cairncross S.,[1] Waterkeyn J.,[2] Ntakarutimana A.,[3] Waterkeyn A.,[2] Uwingabire F.,[4] Pantoglou J.,[5] Katabarwa J.,[6] Bigirimana Z.,[6] Cumming O.,[1] & Carter RC.[2]

Submitted to Journal of Water, Sanitation and Hygiene for Development (Feb 2018)

When the results of the Randomised Control Trial[1] were presented, those who had been involved in the intervention were surprised as the findings did not tally with experience on the ground. The group then prepared the following paper which was submitted to BMC in Feb 2017 for publication (currently under review)

ABSTRACT

Aims

To account for divergence in findings between data generated by monitoring of 150 Community Health Clubs and the findings of a cluster-Randomised Controlled Trial (cRCT) in Rusizi district (Rwanda) (2013-2015), we conducted a comparative analysis of methods used in the two sets of data.

Methods

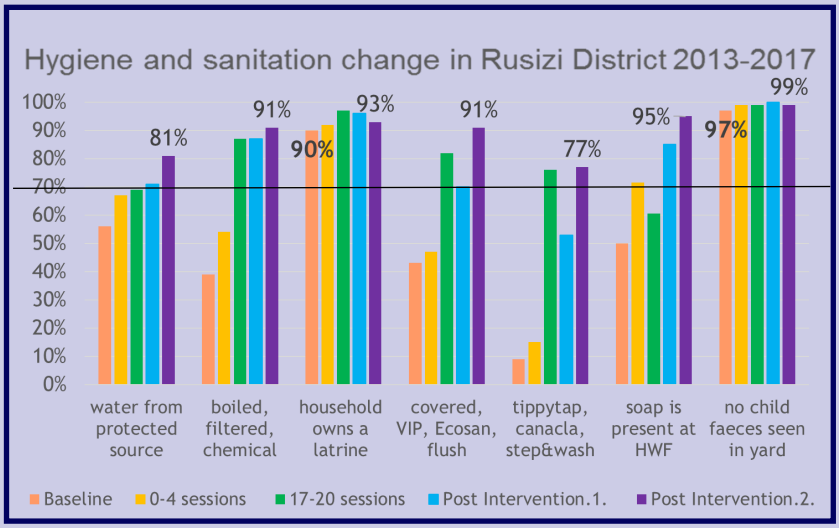
We selected seven intermediate outcomes from monitoring data to match those used by the trialists and assessed the two methods in terms of *Scope*, *Choice and Definition of Indicators*, *Methods of Data Collection* and *Timing and Intermediate Outcomes*.

Results

Whilst cRCT found no significant difference 18 months after the end of the intervention, monitoring data in 50 randomly sampled CHC households showed all seven intermediate outcomes had increased significantly 34 months after the end of the training, with all >70% compliance ($p<0.001$ for each indicator).

Conclusion

Poor understanding of the context, questionable selection and definition of indicators and use of long recall periods all lead us to question the findings of the Rusizi cRCT. The published conclusion on the failure of CHCs to reduce diarrhoea appears to be premature and adds to a growing body of evidence which questions the reliability of RCTs to correctly ascertain the impact of complex development inter-



Left:

Summary of the results of the five rounds of data collections of the monitoring of CHC in Rusizi District by AA and Ministry of Health (2013-2017 showing 70% uptake of all 7 indicators by CHC households, 34 months after the end of their hygiene training.

DR CONGO

*The **Community Health Club (CHC)** approach for was piloted in DRC in 2015 to identify if the CHC Model could add value to the National 'Ecole e Village Assaini Programme' in terms of sustainable hygiene behaviour change, Value for Money, effectiveness and sustainability.*

Partner: Tearfund
Funder: DFID
Dates: Jan — March 2016
Area: Dem. Rep Congo, South Kivu
Dates: Oct 2014—Sept 2015
CHCs: 20
Beneficiaries: 18,959
Total Cost: US$ 51,280

The training had taken place between October 2014 and September 2015. In January 2016, Our Project Manager Amans Ntakarutima visited the CHC to follow up on activities, and was requested by the District Health Director of Fizi Health zone to scale up to other villages in South Kivu as they had noticed there had been no cholera since the introduction of CHC. However, Tearfund is now able to implement the CHC model without our assistance and we consider that we have successfully disseminated the CHC concept into this influential INGO.

Tearfund's WASH Coordinator for DRC, Nathanael Hollands, stated:

"The CHC approach encourages partnerships and collaboration amongst club members, strengthening the social fabric where it may not historically be present. Thus making a social capital helping to build community cohesion and self development in post conflict communities",

With no clean water and no bathrooms, Fikiri, CHC Member explains, "*After nine years of refuge, we had no house, no bathroom or toilet, but with the different teachings we received from the Community Health Club (CHC) we acquired an advantage to gain skills so we can build our own toilet for our families".*

***Above:** CHC member, Fikiri , a 42 year old teacher, testifies how the training helps his family.*

IN DEPTH RESEARCH

A case-control study and a cross-sectional study was conducted in Rwanda and DRC respectively during the period of 2014-2015 by Amans Ntalakatrutima, our Programme Manager, who is using this research for his PhD. The purpose was to investigate the potential contribution of the CHC approach to reduce hygiene related diseases and malnutrition (environmental and practice related). The findings were shared at a regional conference in Burundi[2], where much interest was raised by his demonstration of how hygiene behaviour change had been achieved in each country. He found that between April and September 2015, the coverage of latrines had increased from 20% to 49%, handwashing facilities had increased from 6% to 12%, pot-racks from 9% to 48%, clean yards from 7% to 51%, clean environment from 1% to 63%, and the use of mosquito nets from 21% to 57%. Reported cases in nearby clinic showed a decline in malaria from over 1,200 cases to 650 cases, and reported cases of simple diarrhoea dropped from 850 to 650 in the same period. This adds more evidence of the efficacy of the CHC particularly in the most challenging contexts.

CHALLENGE

18 Our '5 x 5' Target

5 years
5 million people
5 countries
5 diseases
5 dollars p/p

Which diseases?

Those responsible for most child mortality / morbidity

- Diarrhoea
- Malnutrition
- Malaria
- Bilharzia
- Worms

Between 2019 –2023, we intend to persevere with our '**5 X 5 Strategic Plan'** that we devised back in 2013 : we are almost half way there having improved the lives of 2.2 million people to date.

How will we do this?

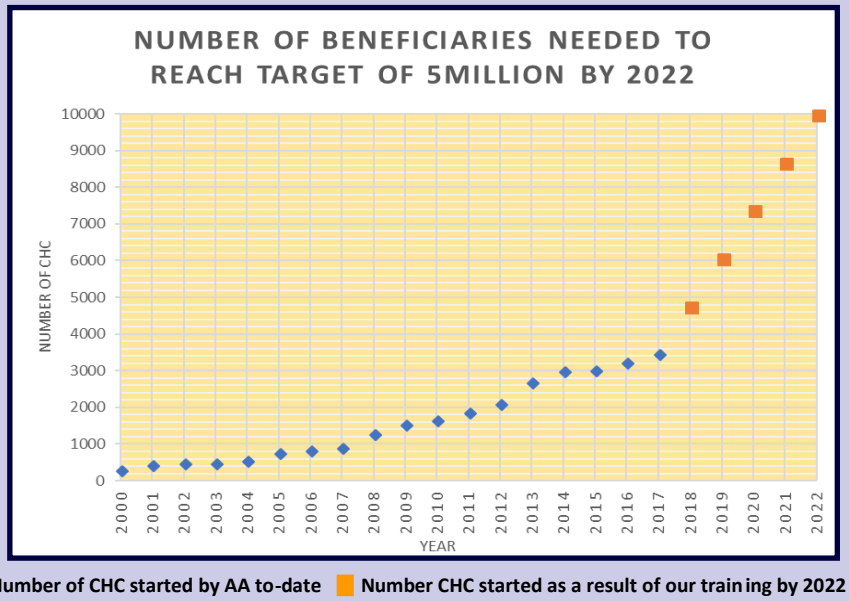
1. Though direct implementation
2. Through training other NGOs
3. Through national policy

To benefit 5 million people

We need to reach 1 million households

We can do this by starting 10,000 CHCs

- CHC started already 3,466
- Remaining CHC target 6,534
- CHCs every year x 5 1,306
- 261 CHCs in 5 countries per year



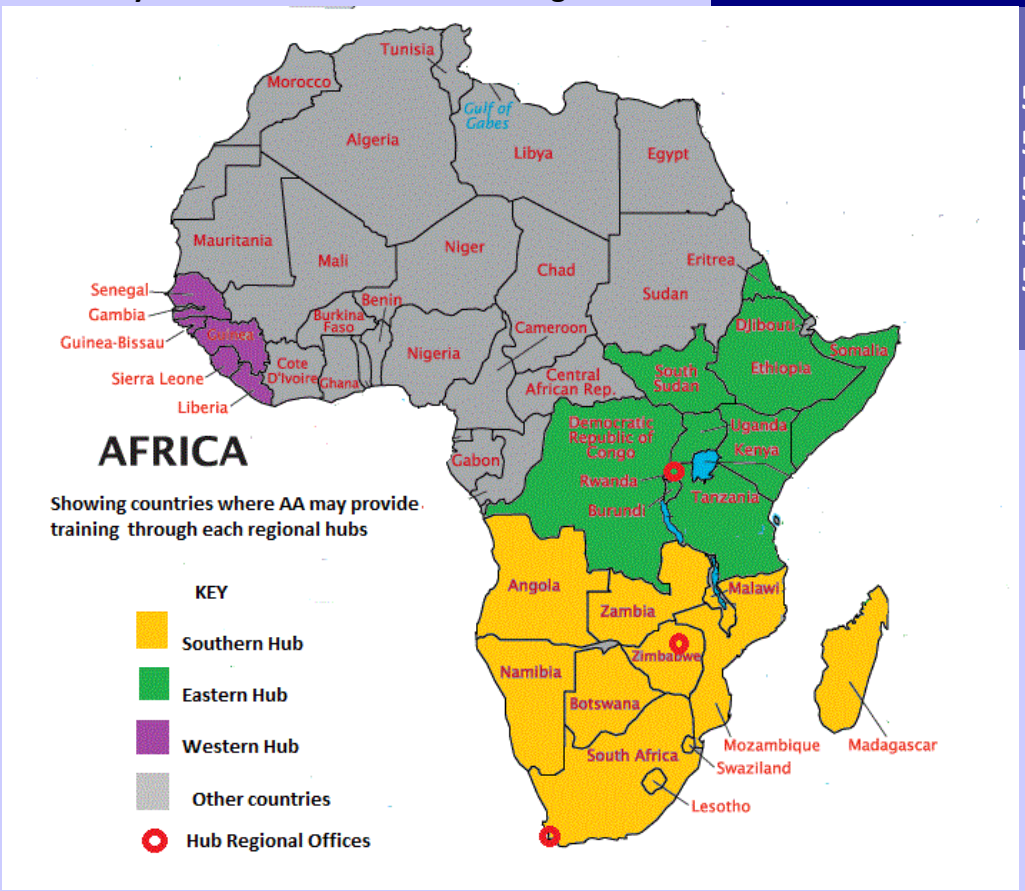
Is this ambitious target possible?

The increase of CHCs from 2000-2017 reflects only our own direct implementation. To increase our impact we intend to train other NGOs and their CHC beneficiaries will be included in this count as indirect beneficiaries, as they are achieved as a result of our training and monitoring.

FUTURE CHALLENGE

Targeted countries from our two Regional Hubs

Map of Africa showing countries targeted by our two hubs in Harare and Kigali.



'5 x 5'

5 years
5 million
5 countries
5 Diseases
5 dollars p/p

The Way Forward

Rwanda has provided us with a very good example of how the CHC model can be taken to scale if it is introduced into policy by an enabling government. We intend to promote the Rwandan model of CBEHPP in 5 other countries through MoH / EHD by developing Roadmaps (similar to the Rwandan CBEHPP Roadmap) so as to disseminate the CHC approach at national scale.

To reach maximum number through policy it makes sense to target the most populous countries. For this reason in the next year we will aim to increase dissemination of CHCs into Democratic Republic of Congo and Ethiopia, from our hub in Rwanda, and from our hub in Zimbabwe, we'll target Zambia and Mozambique.

To ensure AA has sufficient capacity to achieve this 5 x 5 target we have identified the following key areas that require urgent capacity building:

Our Five Pillars

1. Strengthen Management and Administrative capacity in UK
2. Develop a detailed 5-year Strategy and Business Plan to raise funds
3. Demonstration of the CHC Approach to 5 new countries
4. Continue Programme Implementation in our two Regional Hubs (Zimbabwe & Rwanda)
5. Ensure our CHC Training Materials & Monitoring Tools become 'open-source'

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CHC Registry website: www.chcahead.com

Publications by Africa AHEAD on the CHC Model: www.africaahead.org/documentation/

Videos of CHC in action: www.africaahead.org/zimbabwe/videos-on-zimbabwe-chc/