A.H.E.A.D.

Applied Health Education and Development

Annual Report
April 2013 - March 2014

The 2013 –2014 Annual Report
was prepared by
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Regis Matimati
Andrew Muringaniza
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www.africaahead.com
Zimbabwe AHEAD

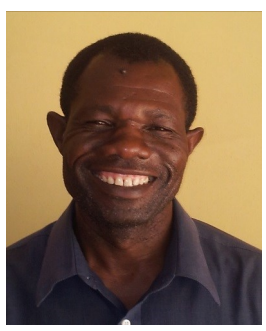
March 2014

2013 Staff Zimbabwe AHEAD

Janette Hetherton
Administrator (part time)

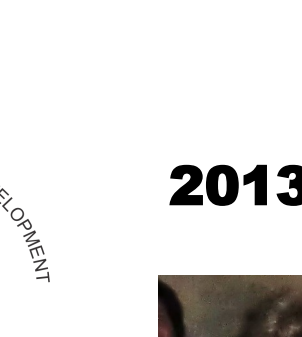
Dr. Juliet Waterkeyn
Executive Director (part time)
1999 - 2014

Regis Matimati
Acting Director
2008 ongoing



Andrew Muringaniza, (1999 ongoing)
Programme Manager

Innocent Marivo. 2008-2013
Admin & Finance Manager



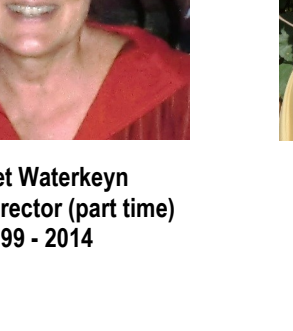
Patricia Determan
M+E Officer USAID
2013 (one year)

Rangandu Mushipe
Project Manager
Chipinge

Morgan Haiza (2008-2013)
Project Manger, EU
Bindura

Moses Matondo (2011-
Project Manager
Gutu & Mberengwa

Nyasha Chinyamutangira
Admin Officer



Project Officers: Sipiwe Mpofu

Canaan Mukusha USAID

Fanuel Chihota EU / ACF

Tenda Ndachengedzwa

Patience Muserepwa
Finance Officer

Project Officers: Mercy Jamba

Tendai Saunyama

Felistus Mutimukulu

Leeroy Maliseni

Staff in 2013

2013 was the year in which we reached our highest staff compliment ever, with 29 employees in two major projects, headed up Regis Matimati as Director of Programmes, ably assisted by Andrew Muringaniza as Programme Manager for USAID Programme and Moses Matondo managing the ACF programme taking over from Cecilia Chinhengo who sadly died prematurely from cancer in March 2013. Project Mangers for the EU funded urban WASH Programme were Morgan Haiza in Bindura and Rangandu Chipise in Chipinge. Project Officers not pictured above, are Brighton Ngirazi, Leeroy Maliseni, Muchisi Marange, Shingirai Marufu, Sipiwe Mpofu, Tamuka Betserai, Winston Muzhanye, and Wiston Usavi. **Logistics**: Alois Chidembo, Charles Makahwi, Hamilton Orphan.

As the Executive Director, Dr Juliet Waterkeyn, was appointed CEO of Africa AHEAD –UK in 2013. Since then she has been gradually delegating authority to Regis Matimati as Acting Director, providing about 50% support in 2013. Innocent Marivo, Elizabeth Chimbetete, and Nyasha Chinyamutangira left the organisation during the year and Patience Muserepwa is now the Finance Officer. Accountability has been strengthened with the part–time assistance of Janette Heatherton as Administrator and Ruth Evans remains as internal auditor. We expect to attract many of the officers back in 2014 when new projects start. Our strength is in the commitment of our staff and we work hard to develop a sense that Zim AHEAD is a family.

ZIMBABWE AHEAD, 2013

Anthony Waterkeyn, Chairman

This past year has been a momentous year for our organisation as it celebrates 20 YEARS since the very first Community Health Club was established in Makoni District in Manicaland. This was part of an early pilot project to determine whether our innovative CHC approach would achieve holistic development and the empowerment of women. Over the intervening years we have received a loud, clear and extremely positive response from countless rural communities, not only here in Zimbabwe but also from many countries across East, West and Southern Africa (as well as from Vietnam and Haiti where CHCs are also flourishing). Rural and urban communities across all of these diverse countries have wholeheartedly responded to the CHC approach that has impacted so positively on their families health and socio-economic well-being.

We also celebrate this past year as the best year ever for ZimAHEAD. It has been a truly remarkable year in which over 1,000 new CHCs were established with direct funding from USAID and ACF. We had a total compliment of 29 staff supporting this achievement (the largest number of staff ever) and yet managed to keep our per capita unit costs to **under US$ 5 per beneficiary** (***actual US$4.42***)

As ***Africa AHEAD*** we have now signed a joint MoU with the Permanent Secretary of MoHCC who have requested our support with the implementation of their national Community-Based Environmental Health Promotion Programme (CBEHPP). With this MoU in hand we are now in final stages of achieving the long-sought PVO status that will strengthen our international linkages and exposure as well as increase our potential funding sources. This combination of AfricaAHEAD (international with HQ in UK) and ZimAHEAD as 'local partner' will significantly enhance the potential for our growth within the WASH sector in the SADC region and beyond.

Another landmark this past year has been the publication of the **National Water Policy of Zimbabwe** (March 2013) that calls for CHCs to be established in every village and rural institution throughout the country. Meanwhile the Gates Foundation is currently carrying out an **Evaluation of CHCs in Rwanda** in order to determine the health and socio-economic impact of our CHC methodology. The timing for this Gates-funded Evaluation of CHCs is extremely exciting for us as an organisation because it comes at a time when the many fatal weaknesses in the alternative CLTS/CATS/ZimCATS approach (that has been championed by UNICEF and others for many years) are finally being exposed. Recent Evaluations of CLTS in Asia and Africa have indicated an almost zero health impact and a 92% failure rate (PLAN, 2014). These are clearly alarming and hugely disappointing outcomes for the narrow CLTS model that has been seen as the so-called 'magic bullet' by many within the WASH sector. But at least this negative outcome should stimulate increasing interest in our own far more holistic CHC model that is likely to 'go viral' when the results from the Randomised Control Trials of the CHC model come out from Rwanda later next year!

Finally within the broader global context, the past few years have been extremely thought-provoking for the WASH sector at large as a result of two hugely important ongoing areas of research, both of which have huge significance for the CHC approach:-

(i) ***Environmental Enteric Dysfunction*** (EED) otherwise known as Environmental Enteropathy, causes devastating stunting across the Developing World and is very much WASH related. EED occurs within the first 1,000 days of a child's life (including the 9 months in its mother's womb). In Africa it is estimated that as much as 40% of total population suffers the life-threatening and performance-limiting impact of stunting. Our twenty years of CHC experience leads us to firmly believe that the CHC approach can offer a very practical and low-cost means to address this devastating challenge at scale. We therefore intend to specifically focus on addressing EED in the years ahead and hope to collaborate closely with the SHINE programme (that is carrying out groundbreaking EED research right here in Zimbabwe).

(ii) ***Climate Resilience*** (CR): we already know that our well proven phase-two FAN Clubs (Food, Agriculture & Nutrition Clubs) provide a low-cost and extremely practical solution to address CR in most rural areas across Africa. We intend to expand this already very successful area of our work by engaging with a broader spectrum of development partners outside the WASH sector and beyond Zimbabwe's borders into the greater SADC region at large.

The future thus looks increasingly bright for CHCs and Zim AHEAD, despite the dire economic situation that Zimbabwe continues to endure. I want to most sincerely thank and congratulate all of our staff who contributed to such a remarkably productive past twelve months of highly successful operations.

20 years of Community Health Clubs in Zimbabwe

Dr Juliet Waterkeyn, Co-Founder & Director

Senior Management:

Regis Matimati, Director of programmes, with Juliet and Anthony Waterkeyn, the Founders of Zim AHEAD at the UNC Conference in USA, October 2013.

This year we are celebrate 20 years since 1994 when we first tried out my original concept of starting a Community Health Club to galvanise women into taking action to improve their own health and hygiene in their homes. I would like to pay a tribute to all those in Zimbabwe who have given their time and energy that has led to the Community Health Club approach being adopted nationally in Zimbabwe but is now being replicated in many other countries in Africa. A review of '20 years of Community Health Clubs' is being published this year to mark the event.

Permit me to reminisce on those early days, when as young development practitioners, Anthony and I were feeling our way in water and sanitation projects to incorporate an element of hygiene promotion. As a woman working in the villages I had a gut feeling that a kind of sociable 'club' would appeal to rural and largely semi-literate women struggling to ensure their family not only survived but prospered. I also related to the need for mothers to have a sense of achievement in their daily activities, so that we mothers can excel at what we spend most of our life doing, caring for our children. From my work with women's groups in Kenyan villages with WaterAid and KWAHO, I saw that mothers do not always understand why children get sick nor realise how much can be done to prevent so many diseases at little cost and with no reference to anyone else.

When I returned to my home country in Zimbabwe from Kenya in 1991, I was determined to put these ideas into practice and approached the Ministry of Health to see if they were interested. They had support from WHO to develop a participatory training kit and so, setting up my Studio AHEAD consultancy for the development of appropriate training materials, I created what were to become the core of the training material which was to be used throughout Zimbabwe. PHAST training, was in 1993 considered the most effective way to ensure 'participatory hygiene and sanitation transformation' of knowledge and good practice. However I was sceptical that PHAST was comprehensive enough to really address all the aspects of public health and I expanded the training to include all preventable disease, such as malaria, bilharzia, skin disease and worms—all of which can affect the development and survival of children.

In 1994, Unicef funded me to try out the first trial of a few Community Health Clubs in Makoni District and Caleb Mwaramba was the first EHT in Zimbabwe to test the method. The response he received was overwhelming, and women in their hundreds flocked to clubs in Ruwombe. We thought it was the personal charisma of a trainer, then we found the same huge community response when we tried out the same CHC recipe in three other wards in Makoni District. Morgan Haiza, Evos Makoni and Silas Gwengwe had the same overwhelming response. Some cynics thought it was because the graduating members got T shirts as a reward, but even when we did away with all rewards and subsidies, the people still joined health clubs in droves, and many sceptics could not believe we could attract over 100 people each week for six months of sessions. On the strength of this success we attracted funding from DFID, Danida and Oak Foundation to scale up the approach and in 1999, Anthony and myself founded Zimbabwe AHEAD Organisation, dedicated to replication of the CHC Approach. George Nhunhama, Head of the NCU at the time, was our first Chairman and has continued ever since as our founding Trustee, acting as Director in my many absences from Zimbabwe since 2000.

Between 1999 and 2001, we demonstrated the cost effectiveness of what CHCs could do, and set a new benchmark for achieving behaviour change which is often used in the literature, (Waterkeyn & Cairncross, 2005) achieving an average of 47% change in a range of behaviours including total sanitation coverage. We had 400 CHCs in three districts by 2001 (32 in Tsholotosho, 85 in Gutu and 285 in Makoni in 20 wards). Sadly, at this point external funding dried up and this promising start was derailed for the next 6 years while Zimbabwe nosedived into an economic nightmare. However, the CHC model had shown the way, and with my own PhD research, publishing a peer reviewed paper with Prof Sandy Cairncross, Head of the Department at the London School of Hygiene and Tropical Medicine promoted the findings in Zimbabwe and was starting to be recognised internationally.

George Nhunhama, Acting Director 2002-10
Founding Chairman 1999-2010, Current Trustee.

Josephine Mutandiro, District Coordinator 1999-2012
Spent 40 years in community development d. 2012.

Andrew Muringanisa Programme Manager
Longest serving & dedicated ZA officer

Morgan Haisa, Project Manager 2005-2013
One of the first EHTs to start CHCs

In Zimbabwe we were only able to keep the process alive thanks to the dedication of Josephine Mutandiro and Andrew Muringanisa who carried the torch through the dark times, often voluntarily giving their time and energy until we began to get funding again in 2007.

District Coordinator, Josephine Mutadiro, 2002-2005 celebrating with trainers at a graduation ceremony in Makoni District, 2005.

With support from New Zealand High Commission and FAO, we ran livelihood programmes which enabled CHCs to start nutrition gardens, keep bees and cultivate and use herbs.

Makoni had 1,000 communal nutrition gardens, 4,000 individual gardens and 5,000 bee keepers and in the height of recession we helped the 10 CHCs build a training centre near Rusape where ZA was based. The fact that cholera largely passed by this district was attributed by the PEHO to the density and strength of the many CHCs.

When Anthony took over from me as Director in 2008 he secured funding from Mercy Corps and moved Zim AHEAD back to Harare. By partnering with other International NGOs such as OXFAM we managed to keep our organisation alive. However, the next few years saw mainly emergency funding which allowed for little capacity building of the organisation.

With British Lottery Funding / EU funding through Mercy Corps, Zim AHEAD started 126 CHCs in Manicaland, with 10,706 members, in Chipinge, Chiredezi and Buhera. Throughout this time we kept monitoring the results and accumulated increasing evidence not only of the cost-effectiveness of the approach but also that it could be used in an emergency context to combat cholera, and in urban areas to support municipality and tackle the ever increase public health threat of lack of safe water, sanitation and disposal of solid waste in Zimbabwe's towns. Our CHCs cleaned up Chiredzi Town in 2010, Masvingo Town 2011, Mutare in 2012, and Chipinge urban and Bindura in 2013. 'Seeing is believing' and more and more NGOs were beginning to adopt our style of community mobilisation.

In 2012, DFID's Protracted Relief Programme (PRPII) commissioned Zim AHEAD to train 22 local and international NGOs in the country. This training enabled the CHC process to spread, although there were some challenges. There was no follow up so the outcomes were unrecorded and we still do not know exactly the numbers who benefitted from the many CHCs which were started by other NGOs. Apart from Zim AHEAD records, there is little institutional memory of the extent and location of these organised communities. Opportunities to use organised communities have been wasted and the numerous NGOs are operating in isolation from the Ministry of Health and therefore cannot not hope to scale up effectively despite the strength of the CHC training. We are still battling to grow the organisation to match the strength of our ideas, but at last we have done two large programme that were worthy of the scale that can be achieved with CHCs. In 2011– 2012, Action Contra la Faim (ACF) had the vision to try for a blanket coverage of CHC members in 10 wards in Gutu and Mberengwa. The results were the highest ever achieved by the CHC Model. In one year alone, 83.5% of the households in 457 CHCs had been formed in 427 villages with 17,578 members and 73,827 beneficiaries. Unsubsidized VIP Latrine construction increased by 24% with 90% compliance of 11 recommended hygiene practices.

The following year (2013), whilst ACF provided subsidies for the vulnerable households without latrines, Zim AHEAD went on to start 52 School Health Clubs in the same area, so as to ensure generations to come will maintain the standards their parents now practice. After three years trying to meet compliance stands for direct funding, USAID finally funded Zim AHEAD directly to carry out a one year Cholera Mitigation program which reached 470 villages in Chimanimani, Chipinge and Mutare. In one year, therefore, our organisation was coordinating approximately 1**,000 Community Health Clubs** with a total of only 30 dedicated staff. This must be a world record!

The original vision of cost-effective sustainable development lives on under the invaluable leadership of Regis Matimati, who has been standing in as Acting Director and building up the visibility of the organisation with his strong advocacy skills. He is suitably supported by Programme Manager, Andrew Muringaniza (the longest serving employee with Zim AHEAD for 15 years) who heads the field team. I attribute our success in the past few years to Andrew's ability to make things work in the field. He wins 'Worker of the Year 2013' for his quiet organisation and infinite patience in the field, achieving all targets despite the hurdles of the past year. As I prepare to stand down as Executive Director, I plan to hand over to Regis Matimati, and would like to thank all my staff, past and present for the enormous contribution they have made to demonstrating the CHC model of development in the field. We all share the same vision which I entrust to the next generation of Zim AHEAD staff to work with Government towards promoting a 'Culture of Health' in Zimbabwe.

Together we have started over 2000 CHCs in Zimbabwe, and improved the lives of well over one million people in 20 years through our small NGO.

EXECUTIVE SUMMARY
Regis Matimati

2013 has been the most productive year to date in ZimAHEAD's existence, with two major programmes district wide in Chipinge, Mutare, Chimanamani and Mutare with two smaller projects in the towns of Bindura and Chipinge. In total this amounts to 54 wards in all. In the rural areas, we have been conducting health promotion in 429 villages, with 80% coverage in Gutu wards, and 87% in Mberengwa.

Our Annual Budget was also the highest it has ever been at close to a million USD and our latest audit gave us a clean bill of health, which should encourage future partners. The USAID project was particularly important as we were directly funded for the first time since 2002 and this has given us the ability to approach donors directly rather than the sub contracting of projects which do little to grow the organization as they are typically short on capacity building elements so critical to sustaining core staff and keeping the office running between projects. ACF was particularly generous and supported our finance and non finance staff and in-house grant management. It is only a pity that USAID / OFDA completed their short emergency funding and were are unable to expand in these projects, as without exception the local authorities have been delighted with our outputs. The target in the ACF Programme were ambitious by any standards with 100% coverage of all villages but we achieved outstanding results which were highlighted internationally at the Water & Health Conference in North Carolina, where Africa AHEAD presented Papers in October 2013. This project has generated much interest internationally and we feel that in the field we have made an impact out of all proportion to our size as a NGO.

2013 saw an all time high for the number of beneficiaries we reached this past year thanks to proper funding at scale. With a small staff of only 12 Project Officers we started up a total of 883 Community Health Clubs and 73 School Health Clubs in 12 months. This amounts to 44,444 CHC members which equates to 171,445 direct beneficiaries. With our target to meet one million beneficiaries in 5 years we have achieved 17% in one year.

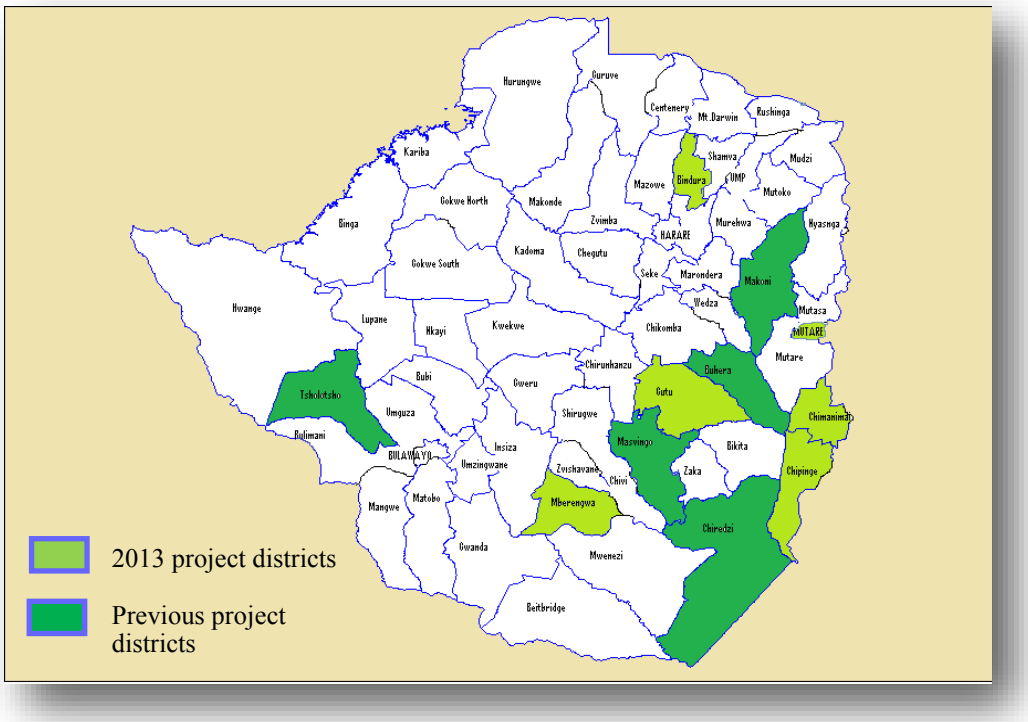
Zim AHEAD became more visible nationally as we made sure we were well represented at all national level WASH, Nutrition, Urban Rehabilitation, Education and Agriculture Networking Technical Working Groups. Various Cluster meetings were attended to keep the organization visible to network in order to build and strengthen partnerships. We continue to work closely with the Ministry of Health and Child Welfare, who have requested us to spearhead a national training for the Community Health Club approach, if funding can be found. To this end we have signed a MoU with MoHCW and are actively seeking such support to roll out our programme now that the CHC Model has been adopted in the National Water Policy (March 2013). All projects were well supported from Head Office. Staff meetings where conducted as planned to receive updates and reports as well as to issue out project and program logistics. Team leaders periodically came to the Head Office for such coordination meetings. I was able to visit the project sites to keep posted on goings on and to have a hands on feel of the programme as well as network with the stakeholders.

Staffing had its ups and downs this year: as we rose to giddy heights at the beginning of the year, our two major projects came to an end simultaneously in October, so from 30 staff we dropped back to our pre 2010 team by the end of the year. It is still an unfortunate reality that funding for Zimbabwe is scarce. Our organization still lacks the ability to sustain staff between projects as we are totally donor reliant. We had an ambition of starting a Training Centre as a means of bridging the gap left between projects, but these dreams were undermined by the reality of the situation in our sector in the current economic climate. We moved offices in Harare yet again at the end of the year as the landlady wanted the previous premises back. We are now even more well-housed at 1, Thurso Ave, Eastlea, with plenty of space to expand. We closed offices in Mutare and Masvingo at the end of the projects there.

We reshuffled our Finance and Administrative department at the end of 2013, and put in place more checks and balances to ensure the highest levels of transparency as we continue to increase our capacity to implement large scale projects. We now have separated the Finance from the Admin Department and with the resignation of Innocent Marivo, who left after 5 years in October 2013, we are delighted to welcome Janette Heatherton as part-time Administrator as well as Patience Muserupwa as Finance Officer. As Programmes come to an end our past partners IMC, ACF, Oxfam and Mercy Corps, have been exceptionally generous this year to the extent we have been donated 11 4x4 vehicles, in various stages of repair and of which we can retain 6 vehicles and 11 motorbikes for future projects. Zim AHEAD donated water testing kits and motor cycles to Chipinge and Chimanimani Districts' Environmental Health Departments, as the USAID project wound up. This support was much appreciated and we are welcome to continue working in all districts, where the reputation of Zim AHEAD stands high.

SUMMARY OF PROJECTS

Number of Districts	7
Community Based Facilitiators	430
School Based Facilitators	73
Numbr of Rural wards	54
Number of Villages	429
Number of Households	36,723
CHC Households	40,493
Community Health Clubs	883
School Health Clubs	73
CHC Membership	44,444
Total Direct Beneficiarles	171,445



RURAL	CBF	SBF	Ward	Village	H/hold	CHC Hhold	% coverage	CHC	SHC	M/ship	beneficiaries
Gutu	70	30	5	192	8,274	6,640	80	214	30	7,963	33,444
Mberengwa	84	23	6	237	8,208	7,221	87	243	23	9,615	40,383
Chimanimani	84	-	5	87	10,489	7,187	68	111	-	7187	30,185
Chipinge	150	-	10	164	42,585	14,795	35	235	-	14,795	62,139
Total Rural	388	53	26	429	16,482	35,843	68%	803	53	39,560	166,151

URBAN	CBF	SBF	Ward	H/hold	CHC Hhold	% coverage	CHC	SHC	M/ship	beneficiaries
Mutare Town	12	-	8	22712	1702	7.5	22	-	1702	7148
Chipinge Town	30	10	8	6,857	1,650	4.1	41	10	2,144	6,930
Bindura Town	17	10	12	11,172	1,298	11	17	10	1,038	5,294
Total Urban	42	20	28	20,241	4650	7.50%	80	20	4,884	5294

44,444 Community Health Club members trained in 2013

Project	Partner	Value
EU Water Facility	ACF	500.172
Urban WASH-Unicef	GAA	117.000
Urban WASH-Unicef	ACF	134.000
USAID Manicaland	MOHCC	500.000
TOTAL		1,251,172

171,445 direct beneficiaries in one year

Improvement of Water and Sanitation and Health Promotion in Schools

Partner: Action Contre la Faim
Funder: EC
Period: February 2012 – January 2014:
Objective: Improve WASH in Schools
Donor: EC
Partner: Action Contre La Faim
Date to start and finish: Feb 2013 - Jan 2014

Number of Wards: [11]
Gutu: 5, 6, 7, 19, 23
Mberengwa: 24: 23, 25, 26, 27, 36

Number of School Health Clubs (SHCs): 53

Number of SHC members: 3,101
Gutu: 1,712,
Mberengwa: 1,389

Number of beneficiaries: 15,825

Total Project cost US$ 500 172.00.
Cost of SHC Project: US$246,000
Cost per indirect beneficiary: 15.54
Cost per SCH Member: US$79

Hand washing facilities outside every classroom: pupils learn the habit of hand washing at Cheninga School, in Ward 27 , Gutu district -one of 53 school with School Health Clubs

The EC-WF collaboration with ACF entered into the last year long second phase of the programme with the aim of improving WASH in 53 schools in the 5 project wards of Gutu and 6 wards of Mberengwa districts. This called for a reduction of field staff from 11 to 4 project officers as there was less work in the field.

53 School Based facilitators were drawn from 53 schools (23 in Mberengwa and 30 in Gutu, (25 males and 28 females) and trained in PHHE to roll out the School Health Clubs.

School Health Clubs were formed and established at all 53 schools in Mberengwa and Gutu with a membership of 3,101 school children and impacting on 15,825 households. The pupils attended weekly sessions of public health training using the same curriculum that has been used the previous year with their parents in the Community Health Club in their village
(see next page)

One of 53 School Health Clubs show their certificates at their graduation.

Pupils of a School Health Club make health stories with cards

Graduations

Upon completion of their session each member was awarded a certificate (see above) and the schools were presented with a wheel barrow and two hard brooms for participating in the program. In Gutu 1,633 and in Mberengwa 1,488 members of SHCs completed sessions. A floating trophy was also awarded to the winning school in each ward in the School Hygiene competitions, to ensure the sustainability of the concept of hygiene in schools.

Attendance and Gender: The percentage completion of training in CHCs is slightly lower at 82% as compared to SHCs at 98% due to the compulsory attendance at schools. As reflected in the CHCs the SHCs were predominantly female, as 62% were girls in Gutu (1,024); whilst in Mberengwa it was 59.4% (899) of registered members. This is encouraging because in the African culture the burden of health and hygiene activities rests mainly on women so it is appropriate that the there are so many girls in the School Health Clubs (SHCs).

Sustainability of the project is also ensured in the fact Government played a major role through the activities of the Environmental Health Technicians within the selected wards, who have continued with the CHCs and SHCs, when Zim A.H.E.A.D exited.

Zero Open Defecation: Communities Changing Practices

An observation by Regis Matimati, Director of Programmes

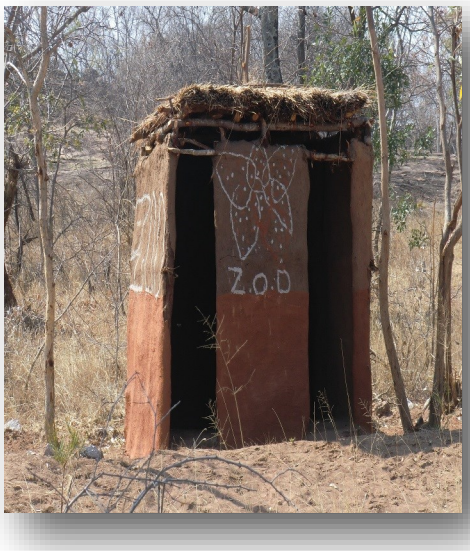
The ACF project was in two year stages: Year 1 Community Health clubs, and Year 2 School Health Clubs

Stage 1: 2012: Community Health Clubs

In 2012 ZimAHEAD started participatory health and hygiene promotion in 11 wards of Gutu and Mberengwa districts of Zimbabwe with funding from the European Union in partnership with ACF. An intensive blanket coverage approach was adopted to rope in the participation of every household in the target wards. Villagers were enrolled into 457Community Health Clubs led by 154 Community Based Facilitators and 11 ZimAHEAD Project Officers.

Of the 17,578 households enrolled, 4,482 had toilets at baseline (25%) and the rest of the households practiced open defecation. The public health promotion sessions conducted in the following 6 months resulted in households building 4,559 toilets and an additional 3,212 pits being dug as work in progress. Upon completion of the dug pits, this would leave the communities with 12,253 toilets (70% of the households with toilets). From a baseline of 25% coverage to an end line of 70% after 6 months of sanitation promotion is phenomenal. Thousands of temporary toilets were constructed and a village walk conducted by the villagers found there was no open defecation practices in the villages weeks after the sanitation sessions began. Prizes like shovels, picks and hoes were won by the best villages to promote and sustain the construction of sanitary facilities.

The involvement of traditional leaders was noted as key as they set example for community participation. Villages proudly stuck ZOD notices at strategic places in their villages to commemorate the achievement of Zero Open Defecation. Months later, more and more toilets are still being dug and constructed. The fire was lit and community members are policing each other as they ride the sanitation ladder.



Communities can improve their health with minimum stimuli from external stakeholders. They built their toilets on self supply. They have improved their own sanitation coverage. They just need support to change their mind set from donor dependency to self supply initiatives. Community Health Clubs proved to be a vehicle to this change in behaviour.

At a cost of $3,65 per beneficiary per year, water and sanitation related diseases were reduced and a whole lot of other changes in general health and hygiene practices changed significantly. Stage 2 in 2013 was to establish School Health Clubs (see next page)

Upon completion of sessions, *Action Contre la Faim* together with the Ministry of Health and Child Welfare continued to oversee the CHCs though the focus had shifted to Income generating activities (IGAs).

Above: ZOD means Zero Open Defecation, and this local variant of ODF has become a Slogan - painted on the wall of this latrine!

A Meeting place of a Community Health Club in Mberengwa.

Woman show the large ground map and each members is seated next to their own household

The stones indicate what type of latrine they have, i.e. temporary (Mud) or permanent VIP Latrine .

This accountability results in Zero Open Defecation

CASE STUDY: Community Health Clubs deliver Hygiene + Total Sanitation @ $4.42

District	Wards	Villages	H/holds	CHCs	M/ship	Pot racks	Refuse pits	Unsubsized latrines	Tippy Taps
Gutu	5	192	8,274	214	7,963	5,979	5,946	4794	11,975
Mberengwa	6	237	8,208	243	9,615	7,000	6,720	2977	912
Totals	**11**	**429**	**16,482**	**457**	**17,578**	**12,979**	**12,666**	**7,771**	**21,101**
% h/holds						**79%**	**77%**	**47%**	**128%**

Blanket coverage:
This Community Health Club project was implemented by Zim AHEAD, in partnership with ACF in 429 villages, within 11 wards of Gutu and Mberengwa, Masvingo Province, Zimbabwe in 2012. The ambitious aim was to achieve blanket coverage, by getting every household within each village represented in a Community Health Club, in order to achieve complete common understanding and full community participation in the management of safe hygiene and sanitation to achieve Zero Open Defecation.

Within six months, this project had exceeded its target of 450 CHCs with a total of 457 Community Health Clubs (214 in Gutu and 243 in Mberengwa). By December 2012, at the end of the six month training, there were 17,578 members (7,963 in Gutu and 9,615 in Mberengwa). The membership exceeded expectations with 107% coverage meaning 7% of the households had more than one member in a CHC. 7% of the 429 villages had more than one CHC.

Gender:
The hygiene training in Community Health Clubs appeals mainly to women with 13,590 female members (6,170 in Gutu and 7,420 in Mberengwa), of which 75% completed all 20 sessions. Given the gender bias in African culture, it is always a challenge to attract men to the hygiene sessions. It was therefore considered an achievement to have 3,988 male members (1,793 in Gutu and 2,195 in Mberengwa), of which 31% achieved full attendance. Male involvement is demonstrated by their physical support in the construction of hygiene enabling facilities and latrines.

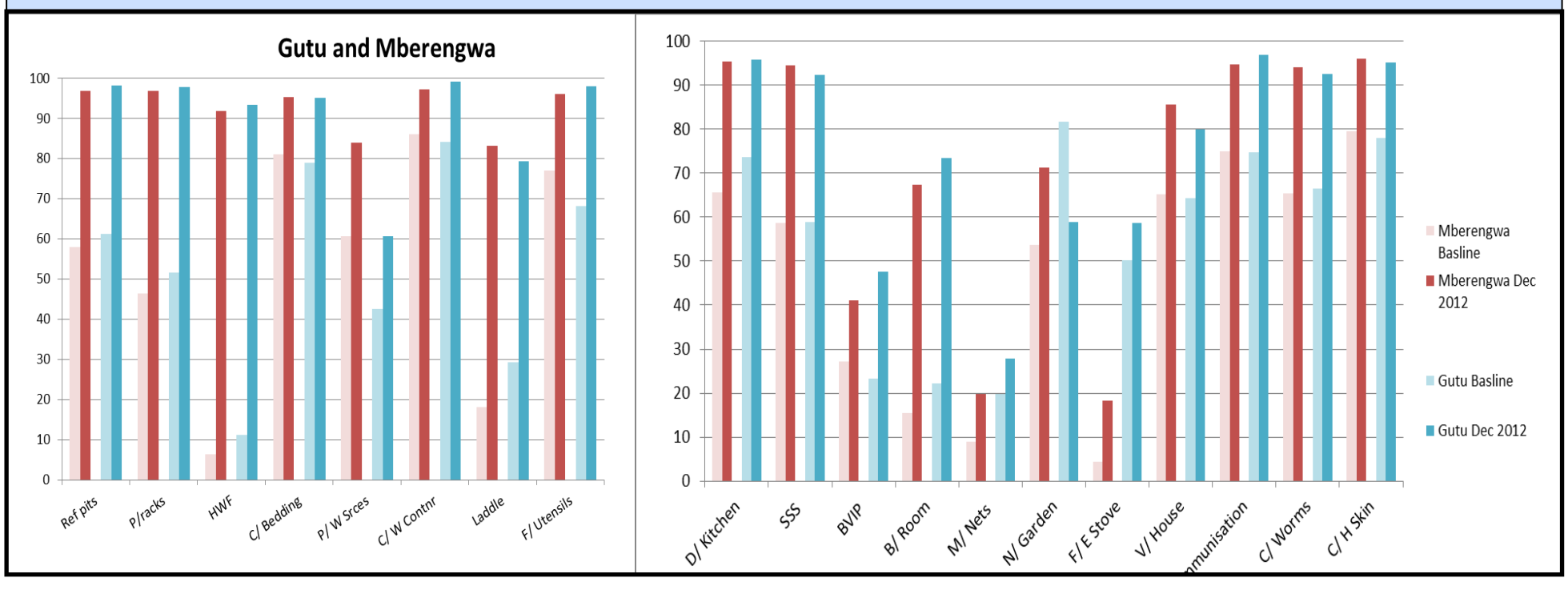
Value for Money:
This project supplied no inputs for water and sanitation, relying completely on positive peer pressure to galvanise households to upgrade at their own expense. With an estimated 82,410 beneficiaries (5 per household) and the total cost of the programme at US$ 363,961 the cost per beneficiary is estimated at **US$4.42**. Alternatively it can be estimated that the average cost per CHC is estimated at US$796 per annum, including all administrative and field costs.

Compliance to recommended practices:
Of the 19 indicators used to assess compliance (See Fig. 1 below) 10 show over 80% compliance. Monitoring was conducted through the use of a household inventory kept at community level by the Community Health Club Executive Committees.

It was found that by project end, there were 21,101 new tippy taps. This means that in every single household there is at least one tippy tap for hand-washing, and 4,619 households have more than one tippy tap in their compound. 12,976 (79%) households have new pot racks, and 12,666 (77%) households have dug refuse pits. Most importantly 7,771 (47%) new hygienic latrines were constructed without any subsidy at all within the six months, an increase of 30%. Zero Open Defecation (otherwise known as ODF) has been achieved as the remaining households are practicing cat sanitation, whilst building their sanitation facilities. All this was achieved with 12 full time field workers, who trained and supervised 154 Community Based Facilitators.

Self-supply and self-monitoring through Community Health Clubs has ensured one of the highest community responses yet seen in Zimbabwe, and it is this success that can be rolled out with very little material inputs. An evaluation should be arranged to verify these claims.

Source: December 2012 Project Report Zimbabwe AHEAD/ACF, Cecilia Chinhengo



ABBREVIATIONS: Ref pits= refuse pits; p/racks= pot racks; HWF= Hand washing facility, C/Bedding= clean bedding; P?W source= Protected water source; F/Utensils = food utensils storage; D/Kitchen = decorated kitchen; SSS= salt sugar solution knowledge; BVIP= Blair ventilated Improved Pit latrine; B/Room= bathroom; M/Nets= mosquito nets in use; N/garden= Nutrition garden; F/E Stove= Fuel efficient stove; V/house= ventilated house; Immunisation; C/worms= Children without signs of worms; C/H Skin = children without skin disease.

Cholera Mitigation through Community Health Clubs

Donor: USAID / OFDA (direct funding)
Start and end Date: October 2012- September 2013

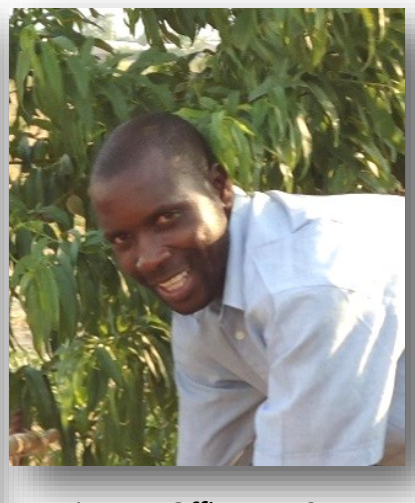
Districts: Mutare, Chimanimani and Chipinge
Project Manager: Spiwe Mpofu
Number of Project Wards : 23
Number Of CHCs : 408
Number of CHC Members: 23684
Cost of Project: US$ 506,316
Cost per Beneficiary: US$2.34

A Community Based facilitator in Chimanimani District conducts the weekly health sessions in one of the 408 CHCs which were formed in 2013 sponsored by USAID—OFDA.

Goal: To improve hygiene and sanitation practices and to sustainably reduce the risk of transmission of preventable communicable diseases and build resilience within communities by way of education and application.

Objective: To improve Hygiene and Sanitation practices through Health Knowledge and Sustainably reduce the risk of transmitted water borne diseases.

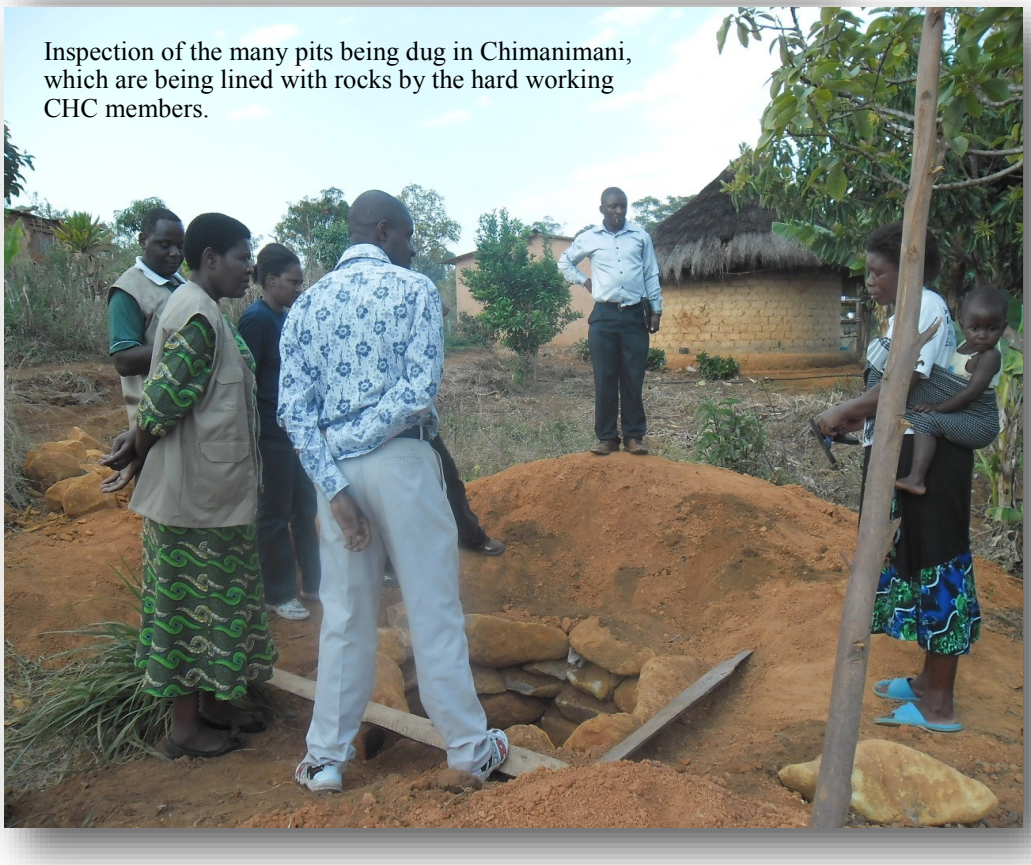
The project in Manicaland covered 23 wards in Chipinge (10), Chimanimani (5) and Mutare Districts (8)in Mutare Urban.
A total of 245 Community Based Facilitators were trained and established 408 Community Health clubs with 23,684 members in 8 months.
63% [15,028] of the CHC membership completed the 20 sessions and graduated at colorful ceremonies held across the project wards.
All 19 nineteen indicators on PHHE syllabus changed across the project with an average improvement of 20%.
Hand washing practices recorded the highest change at 54% increase as the tippy taps were easy to make with readily available materials.
Capacity Building of the Environmental Health department in MOHCC was done through training 60 Environmental Health Technicians
[EHTs in Chipinge[35] and Chimanimani [25] in water quality monitoring and testing leading to the collection and water testing of 95 villages.



Project Officer Canaan Mukusha, really deserves a medal! As it is he is runner up Worker of the Year, having won it once in 2012.

Chimanimani District

Whilst we expect Community Health Club members to respond to the teaching we were amazed by the response in this district, which is on the border with Mozambique and one of the least served areas of Zimbabwe. Zim AHEAD was exceptionally successful at stimulating a high level of self-supply for sanitation. Within 8 months there were 91 households who had build their own VIP latrines without any subsidy. Another 650 pits had been dug and lined by the project end. This is a new bench-mark in community response and we attribute this not only to the desperate need but also to the dedication of our Project Officer, Canaan Mukusha.



Inspection of the many pits being dug in Chimanimani, which are being lined with rocks by the hard working CHC members.

Small Towns Hygiene Promotion and Capacity Building: Chipinge

Date to start and finish: November 2012 - October2013
Funding: UNICEF /ACF
Donor: UNICEF WASH Fund
Partner: ACF
Project Manager: Randandu Chipise

District: Chipinge, Manicaland
Number of Wards: 8
Number of CHCs: 29 CHCs; 12 Market place clubs; 10 school health clubs
Number of members: 2,144 (Males 220, Females 1924)
Number of beneficiaries: 25,676
Cost of Project: US$134,000
Cost per beneficiary: US$5.2

Children, like their parents, enjoy the participatory activities in the health sessions.

Objective: To reduce morbidity and mortally through provision of Hygiene Promotion to people affected by diarrhoeal diseases.

In partnership with ACF in the Chipinge town, 31 CHCs were established in 8 wards of Chipinge town [10 at market places] with a total membership of 2,144 men and women and 25,676 people as indirect beneficiaries.

10 School health Clubs were established in all the schools within Chipinge Town. Colorful graduation and prize giving ceremonies for School Health Clubs saw the project ending in October 2013, which left the town transformed into a cleaner environment with organized residents.

Urban Clean ups: Above the registration of members in a community Health club, is followed by 6 months of weekly sessions which enables the CHC to be come united in its appreciation for cleaner environment. Below: Before the Zim AHEAD Project, clean up days organised by the CHC and finally the council helps to remove the mounds of refuse. This transformation took place in Chipinge and Bindura Towns in 2013, thanks to the Urban Wash Fund that supported our partners ACF and GAA (WHH).

CHIPINGE RURAL DISTRICT COUNCIL wrote to us:
'May we also take this opportunity to thank you for the wonderful work you did in the last project and for the cordial working relationship which both enjoy.

Project Title: Hygiene Promotion and Capacity Development Programme for Bindura Town

Donor: UNICEF Wash Fund
Partner: GAA (known as WHH)
Project Manager: Morgan Haiza

Date to start and finish: October 2012 -Sept 2013.
Number of Wards: 12
Number of Community Health Clubs: 17
Number of CHC members: 1,038

Number of SHCs: 10
Number of School Health Club Members: 733
Number of Direct Beneficiaries: 5,294
Number of Indirect Beneficiaries: 44,033

Cost of Project: US$117,000
Cost per beneficiary: US$2.65

Objectives:

1. To increase equitable access to WASH services for vulnerable people with a special focus on gender.
2. To improve hygiene practices among the residents of Bindura with special focus on gender and vulnerability.
3. To improve the operational performance of Bindura Town Council as well as enhance the sustainability of services, and measure the impacts of implemented interventions.

Hygiene Promotion and Capacity Development Program for Bindura Town.

In partnership with WHH supported by UNICEF the Bindura Town public health promotion project which started in October 2012 ran successfully and ended in September 2013. In spite of delayed permission from Government, once started the project built trust between the residents and local authority through Customer Care training for council staff, gender and vulnerability mainstreaming for staff and the disable community members as well as CHCs, SHCs and market place Health Clubs. One massive cleanup campaign was organized which brought together club members and the local authority resulted in huge amounts of informally dumped solid waste being moved to the designated dumpsite. One officer, Morgan Hayiza, was deployed to run it.

This successful project covered the 12 wards of Bindura Urban and saw the establishment of 17 CHCs with a membership of 1,038. A total of 10 School Health Clubs were also established with a membership of 733 school children benefitting from knowledge and good hygiene practices. The Bindura Municipality is now proud of improved service delivery in water provision, waste management, a clean town and good relations with the residents as the CHCs are now recognized as the link between the Bindura Town Council and residents.

Urban Community Health Clubs clean up their suburbs in Bindura Town

Monitoring Community Health Clubs

Above: Programme Managers, Andrew Muringaniza (Left) and Cecilia Chinhengo project Manager (Right) and M&E Officer, Patricia Determan (Middle)

Right: Gutu Project Officers: Collecting data in the field: Tendai Ndachengedzwa (Left), Fanuel Chihota (Back), Moses Matondo (right) who is now full time Monitoring Officer, and Project Officer, Canaaan Makusha (Front)

Knowledge Management

Zimbabwe AHEAD is particularly interested in understanding the processes which are happening in the projects and to accurately measure the impact in terms of outcomes of hygiene behavior changes. Over the years we have developed a practical tool to track proxy indicators of improved hygiene and we do this through a base line and an end line in all our projects.

However we have found the need for dedicated assistants to keep this data properly and to analyse the results of our field officers, who seldom have the time to collate and make sense of these measurements. We have therefore each year tried to attract an intern from an international university, who being newly qualified with a Masters Degree, are looking for field experience. In 2013, Patricia Determan was with us for 5 months, and helped us review our M&E strategy. She collated data from the field in both the USAID and the ACF programme that showed interesting results as it highlighted the outcomes of the CHCs.

New Africa AHEAD Website: Online Portal for Community Health Clubs

Dr. Juliet Waterkeyn has developed the CHC monitoring booklet which was tried in three districts. We are still working on refining this tool. She has also created a website to capture data on all CHCs in real-time such that by the click of a button all CHC information is available on the website.

This website **www.chcahead.org** is due to come on-stream in the next few months and most of the CHCs from the past year have already been registered on this online portal. This is intended to become the international portal for all CHCs in different countries and to-date already includes the Africa AHEAD projects in Rwanda and Uganda. Eventually this will enable field staff to upload the household inventories that they collect as well as provide a link to the Mobenzi Website where base line surveys collected by cell phones by field workers, can be immediately collated.

Each CHC will have its position and vital statistics recorded, so that all future projects can be channeled to existing CHCs, so building on development projects rather than constantly starting again with new structures. It is hoped that the Ministry of Health in each country will use this information for coordination of public health initiatives as well as providing mitigation against epidemics such as cholera.

The portal will also provide visibility for the CHCs and encourage them to monitor and manage their own health status. They will be able to upload photos as well as project reports on a monthly basis. This is the way of the future for our CHC initiatives.

A Model Kitchen: One of thousands that are the hall-mark of a Community Health Club Member

Zimbabwe AHEAD is part of the AFRICA AHEAD '5x 5 Challenge'

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.

Targets are 'SMART'

Specific: The five diseases are: Diarrhoea (cholera), Tropical Enteropathy (stunting), Malaria, Intestinal worms and Eye & 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.

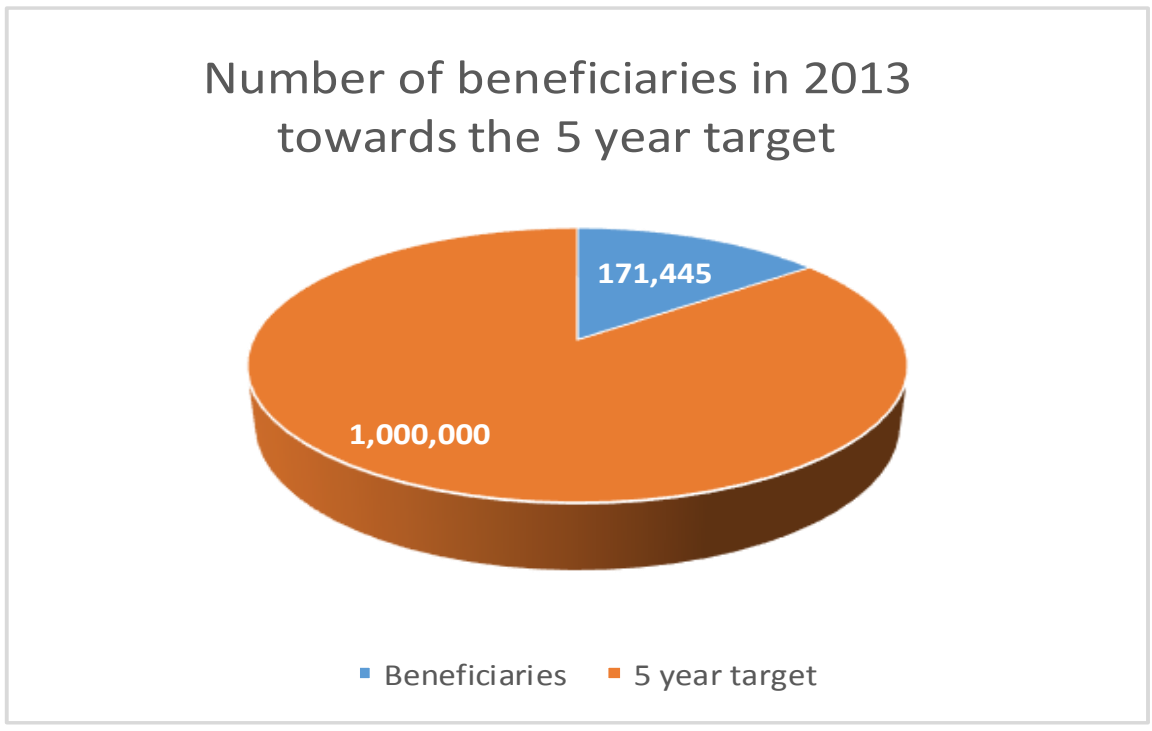
Measurable: With a fixed target group within a defined number of CHCs, communities themselves actively monitor observable proxy indicators of non-risk hygiene behaviours that are proven to reduce the above targeted diseases using our standard monitoring tool, the CHC Household Inventory, collected using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

Achievable: We are aiming for 5 million households. Assuming a conservative 75 members in each CHC this implies a target of 66,666 CHCs, which in five years is 13,333 per year. This would be 1,333 per country in 10 countries per year.

Relevant: This objective is clearly in line with the MDG and post-MDG objectives 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

ZIMBABWE AHEAD IS AIMING TO PROVIDE 1 MILLION BENEFICAIRIES IN FIVE YEARS : IN 2013 WE HAVE ACHIEVED 17% OF THIS TARGET



Prospects for 2014

USAID WASH project with DAPP has been approved for Goromonzi and Chipinge starting in May. It is a two year project for slightly more than half a million dollars.

We have landed a Service Provider consultancy to do CHC ToTs and backstopping support to CNFA - IMC project in Gwanda, Tsholotsho, Bulilima and Mangwe Districts for 2014 for about $100,000.00.

We have submitted an Expression of Interest to UNICEF for 14 towns WASH public health promotion penciled to start in June 2014. We are hopeful our bid will win.

We are also developing a radical new programme through Public Private Partnership with corporate funding from south Africa which will enable a social enterprise to sustain Zim AHEAD core costs through mobilizing CHCs as a market for hygiene enabling facilities.

Zimbabwe A.H.E.AD

INCOME AND EXPENSES FOR THE YEAR ENDED 31 DECEMBER 2013

		To 31 Dec 2013
REVENUE		
	Grants Income	664,680.07
	Training Material Sales	104,623.37
	Other Income	18,839.89
	Total Income	**788,143.33**
PROGRAM EXPENSES		
	M&E Baseline/Monitoring	2,862.00
	Personnel	226,610.73
	Fuel Expenses	34,765.53
	Other Program Activities	103,688.73
	Promotional Expenses	37,087.75
	TOT Workshops	32,644.54
	Graduations	9,931.60
	Facilitators Allowances	35,685.91
	Accommodation & Travel	8,925.00
	Vehicle Insurance & License	5,846.04
	Training Material Printing	81,313.72
	Communication Expenses	10,465.00
	Per diems & Transport	19,663.00
	Motor Vehicle repairs & Maintenance	28,301.30
	Field Office Rentals	10,413.22
	Consulting & Professional Fees/Audit Fees	4,888.55
	Total Grant Expenses	**653,092.62**
ADMINISTRATION EXPENSES		
	Audit Fees	2,680.66
	Personnel	75,536.91
	Bank Charges	7,198.65
	Board Expenses	231.39
	Computer Repairs & Software Expenses	1,676.46
	Courier & Postage	31.00
	Staff Medical and Bereavement Expenses	1,820.00
	Office Moving Expenses	1,901.59
	Vehicle Insurance & License	1,948.68
	Depreciation, Amortisation and Impairments	23,513.32
	Office Lease Rentals	13,400.00
	Motor Vehicle repairs & Maintenance	9,433.77
	Office teas and Cleaning Materials	3,585.03
	Parking & Toll Fees	897.00
	Photocopying & Stationery	6,926.33
	Office Repairs & Maintenance	447.00
	Office Security [dog]	210.00
	Utilities	5,220.19
	Total Administration Expenses	**156,657.98**
SURPLUS/ LOSS FOR THE YEAR		**(21,607.27)**