



Annual Report 2013 - 2014



**Africa A.H.E.A.D.
Applied Health Education
and Development**

The 2013 –2014 Annual Report

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Anthony Waterkeyn: Photos & article (**South Africa**)
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Regis Matimati & Andrew Muringaniza Reports (**Zimbabwe**)
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May, 2014

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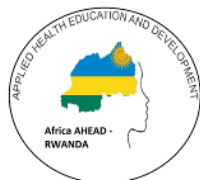
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Front Cover: *Women dance and sing health songs
in Community Health Clubs, Apac District in Uganda, May 2013.*

For more information please visit the website:

www.africaahead.com



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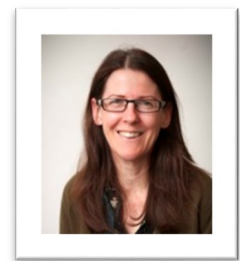
Prof. Sandy Cairncross



Richard Bennison



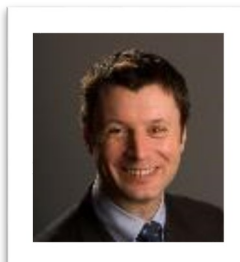
Prof. Richard Carter



Ms. Barbara Evans



Prof. Jamie Bartram



Dr. Darren Saywell

Registration of Africa AHEAD

Since the decision to formally register Africa AHEAD at our Board Meeting in London in April, 2013, we have managed to complete the task in three countries: UK, USA and Rwanda in the past year.

We are now registered as follows:

2001 **Zimbabwe**: Zim AHEAD: Registered Trust: MA1380/200

2005 **South Africa**: Non Profit Company Sect. 21:2005/040379/08

2013 **United Kingdom**: British Charity No: 1151795

2013 **United States of America**: USA-AHEAD:501c(3) 38-3862007

2013 **Rwanda** as Africa AHEAD: INGO registered 177/DGI&E/13

Board of Trustees

UK Board Members:

Chairman: Prof Sandy Cairncross (OBE),
London School of Hygiene & Tropical Medicine

Secretary: Richard Bennison

Prof. Richard Carter: University of Cranfield

Dr. Barbara Evans: University of Leeds / Water Institute

American Board Members

Prof James Bartram: University of North Carolina / Water Institute

Dr. Darren Saywell: Head of WASH, Plan International

African Board Members:

South Africa: Juliet & Anthony Waterkeyn (**Founders**)

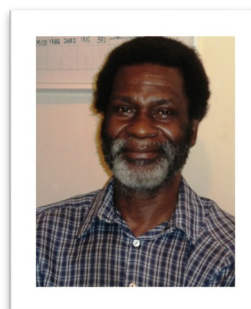
Zimbabwe: Janette Hetherton, George Nhunhama,
Golberg Mangwadu.

Rwanda: Zacchary Bigirimana

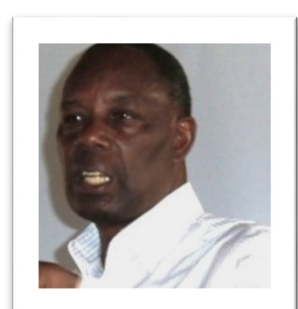
African Board Members:



Janette Hetherton

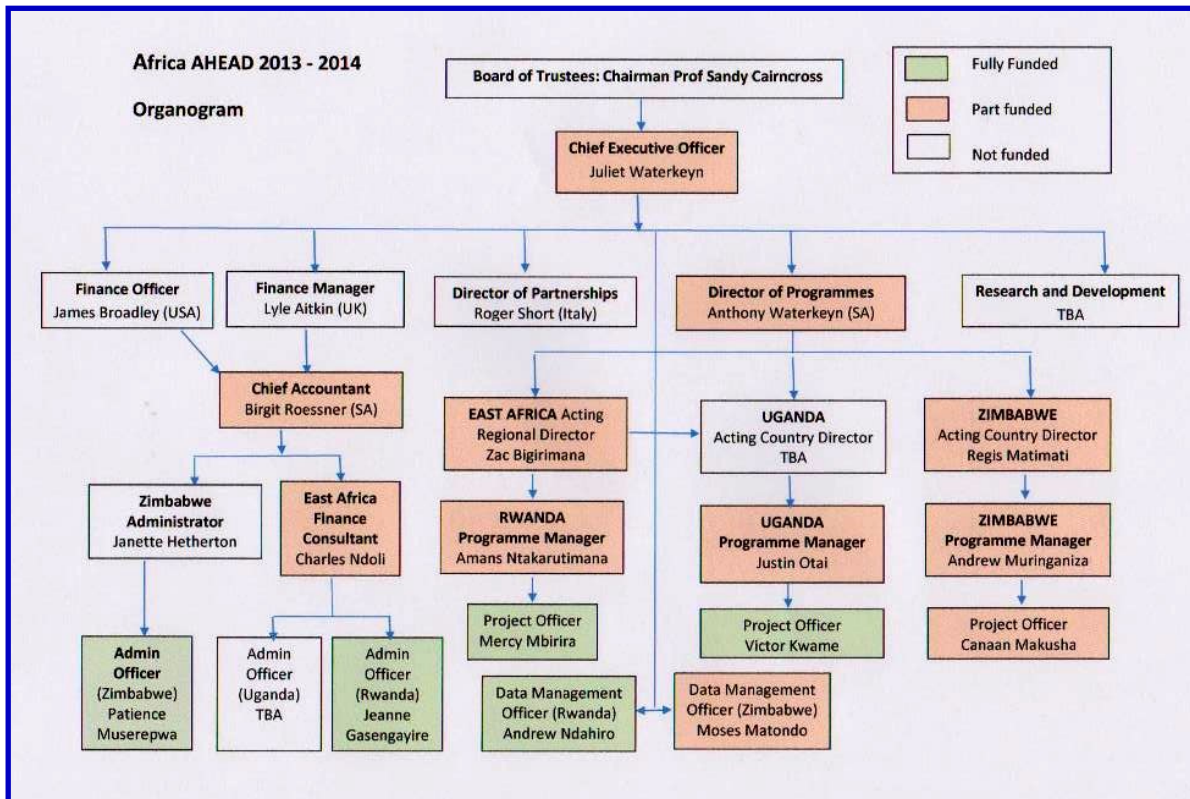


George Nhunhama



Zachary Bigirimana

Africa AHEAD Personnel

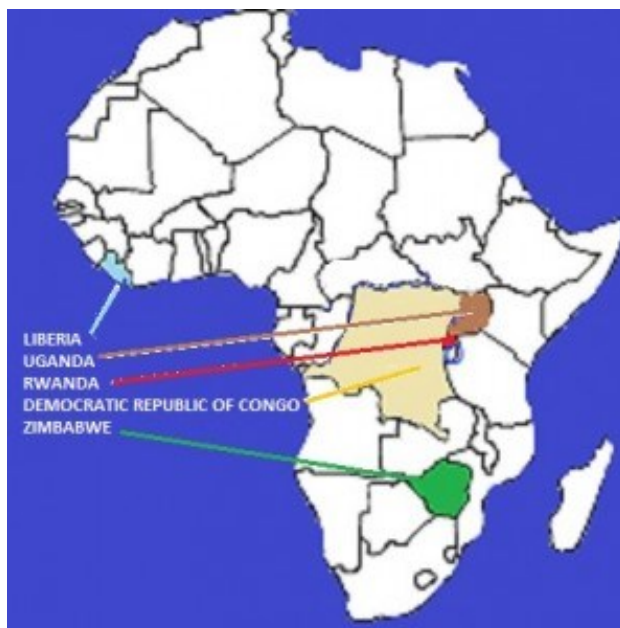


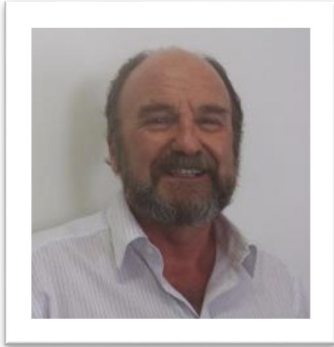
Africa AHEAD blossomed during 2013. In Zimbabwe, in just one year we were working in seven districts across Zimbabwe with a total staff complement of 31 assisting over 172,000 people which is 17% of our 5x5 target to reach 1 million in 5 years.

The programme in **Rwanda**, funded by the Gates, Foundation started in early 2013 and by the end of the year we had 5 new staff .

In **Uganda** we secured funds for a new project start-up and employed two staff, October 2013 in Apac District. Consultancies were undertaken in Sierra Leone, DRC and Nigeria by the Directors.

Africa AHEAD Countries of operation in 2013 / 2014





*Anthony Waterkeyn,
Director of Programmes*

2013 - 2014

Africa AHEAD

Overview of Programmes

The past year has been a momentous year for our organisation as we celebrate 20 years since the very first Community Health Club was established in Makoni District in Zimbabwe. 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 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 nearly 1,000 new CHCs were established with direct funding from USAID and ACF. We had a total compliment of 30 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)**

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 external Evaluation of CHCs is extremely exciting for us as an organisation. We expect a positive finding from the Randomised Control Trial of the CHC model in Rwanda when preliminary results come out in 2015! The WASH Sector is looking for an alternative methodology to achieve behavior change and it is expected that interest will increase in the CHC model.

As **Africa AHEAD** in Rwanda we have now signed a joint MoU with the Permanent Secretary of MoH who have requested our support with the implementation of their national Community-Based Environmental Health Promotion Programme (CBEHPP). This combination of Africa AHEAD (international with HQ in UK) and Zim AHEAD as 'local partner' will significantly enhance the potential for our growth within the WASH sector in the SADC region and beyond.



*Regis Matimati, Acting
Country Director, Zimbabwe*

Zimbabwe AHEAD Overview

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. Although USAID / OFDA was emergency funding we are looking for ways to scale up 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.

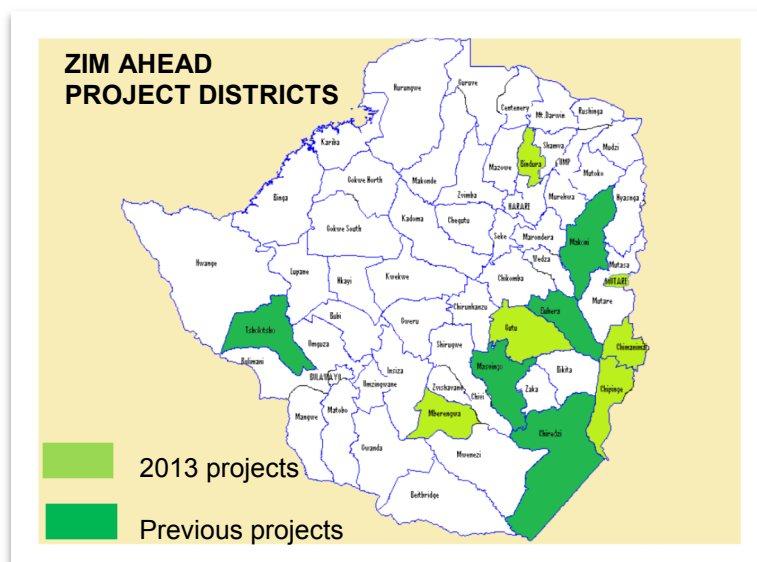
2013 saw an all time high for the number of beneficiaries we reached this past year thanks to proper funding at scale. With a staff of only 12 field officers we started up a total of 883 Community Health Clubs and 73 School Health Clubs in 12 months. This amounts to 44,444 CHC members which equates to 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 were conducted as planned to receive updates and reports as well as to issue out project and program logistics and I was able to visit the project sites to keep a hands on feel of the programme as well as network with the stakeholders.



ZIMBABWE Project Summary

44,444 CHC Members
171,445 direct beneficiaries
in one year



Zimbabwe

Number of Districts	7
Community Based Facilitators	430
School Based Facilitators	73
Number of Rural wards	54
Number of Villages	429
Number of Households	89,797
CHC Households	40,496
Community Health Clubs	883
School Health Clubs	73
CHC Membership	44,444
Total Direct Beneficiaries	171,445

Project	Partner	Value US\$
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

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	69,556	35,843	68%	803	53	39,560	166,151

URBAN	CBF	SBF	Ward	n/a	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	4,650	7.50%	80	20	4,884	5294

Blanket Coverage of CHCs in Gutu and Mberengwa Districts (ACF/EU)



Andrew Muringaniza,
Programme Manager

The project was in two stages:

Y.1: Community Health Clubs

Y.2: School Health Clubs



CHC members at their club venue, showing ground map of sanitation

457 Community Health Clubs were started in partnership with ACF, in 429 villages, within 11 wards of Gutu and Mberengwa, Masvingo Province, in 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.

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.

Exceeding targets: Within six months, this project had exceeded its target of 450 CHCs with a total of 457 Community Health Clubs. At the end of the six month training, there were 17,578 members. 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. Average attendance for 20 sessions were 89%. That's discipline!

District	Wards	Villages	H/holds	CHCs	M/ship	Pot racks	Refuse pits	Unsubsidized 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%

Summary of achievements in hygiene behavior change in two Districts

School Health Clubs: An empowering & sustainable approach

Partner: Action Contre la Faim
Funder: EC
Period: Feb. 2012 – January 2014
Ref No: EuropeAid/129509/C/ACT
Number of Wards: (11)
 Gutu: 5, 6, 7, 19, 23
 Mberengwa: 24: 23, 25, 26, 27, 36
Number of School Health Clubs: 53
Number of SHC members: 3,101
 Gutu: 1,712,
 Mberengwa: 1,488
Number of beneficiaries: 15,825
Total Project cost: US\$ 500,172
Cost of SHC Project: US\$246,000
Cost per beneficiary: US\$ 4.42
Cost per SCH Member: US\$79



Wash Hand facilities outside all the classrooms

School Health Clubs were 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. Upon completion of their session each member was awarded a certificate and the schools were presented with a wheel barrow and two hard brooms for participating in the program. 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 SHCs was 98% due to the compulsory attendance at schools. In Gutu 1,633 out of 1712, and in Mberengwa 1,389 out of 1,488 members of SHCs completed sessions. Members were predominantly female: 62% were girls in Gutu (1,024); whilst in Mberengwa it was 60% (899) of registered members.

Cholera Mitigation through Community Health Clubs

Chipinge Rural District

Period: October 2012 - September 2013

Donor: USAID (direct funding)

Partner: Local Authority

Project Manager: Rangandu Chipise

Wards: 16, 20, 21, 22, 23, 24, 26,27,
29 & 30

Number of EHTs: 5

Number of Facilitators: 146

Number of CHCs: 235

Number of CHC members: 14,795

Number of beneficiaries: 60,139

Cost per beneficiary: US\$ 2.77



A Model Kitchen: One of 5,986 such works of art that are the hall-mark of a Community Health Club Member

Decorated Kitchens:

Kitchen hygiene improved significantly with over 86% practicing safe food hygiene with 3 different indicators: 87% members had refuse pits (43% improvement), 86% were using individual family utensils for eating (33% improvement), and 92% had pot racks (21% improvement). In addition 5,986 households (58%) had decorated kitchens indicating a high level of effort being made in this project to upgrade kitchens (*see photo above*)

Saving Clubs

Social capital that was generated by the training resulted in CHCs evolving into Community Based Organizations (CBOs) participating in Income Savings and Lending at their own initiative. These were started within the 86 CHCs (23%) in the 3 districts as the club members realized the need for self financing of activities to compliment health and hygiene education. The wanted to be able to buy such items as soap, kitchen utensils, cement for latrine construction, borehole spares etc. Each club member contribute US\$1 weekly at the club venue each time the club met. The contributions were then directed to a specific activity with the Club Executive Committee monitoring the progress.



Savings groups distribute goods that they have brought to improve their homes with their own money.

Chimanimani District

Period: October 2012 - September 2013

Donor: USAID (direct funding)

Partner: Local Authority

Project Manager: Canaan Mukusha

Wards : 13,16,21,22 and 23

Number of EHTs: 4

Number of CHCs : 111

Number of Facilitators 76 (58 f.)

Number of CHC Members: 7187

Number of CHC graduates : 4,765 (66%)

Number of beneficiaries: 30,185

Cost of project: US\$ 166,666

Cost per beneficiary: US\$ 5,52



One of the 91 unsubsidized VIP latrines built

Massive sanitation response

Whilst we expect Community Health Club members to respond to the teaching we were amazed by the response in this district, which is one of the least served areas of Zimbabwe. As Chimanimani is on the border with Mozambique, many of the CHC members were coming across the border to join. The project officer is very experienced and was exceptionally successful at stimulating a high level of self-supply for sanitation. Within 8 months there were 91 households in this district who had built their own VIP latrines without any subsidy. Another 647 pits had been dug and lined by the project end, which is a new level of community response.

Outstanding Handwashing uptake

Hand washing practices recorded the highest change at 54% increase as the tippy taps were easy to make with readily available materials. Not only did every house have at least one hand washing facility, 28% had more than one, indicating a complete conversion to the importance of washing hands after using the toilet and keeping hands clean generally.

	Wards	Start up meetings	CHCs	Community Health Club Members Trained		Community Based Facilitators Trained		EHTs Trained
				Total	Female	Total	Female	
District	CHC areas	Attendees	Total	Total	Female	Total	Female	Total
Mutare	8	1024	22	1,702	(90%)	12	12	0
Chimanimani	5	1083	111	7,187	(85%)	76	58	4
Chipinge	10	2281	235	14,795	(92%)	146	118	5
Totals	23	4,388	368	23,684	(90%)	234	188	9

Summary of Beneficiaries in USAID/OFDA Programme in 3 districts

Urban WASH funded by Unicef in Chipinge and Bindura

Chipinge Town

Project period: 1/2012 -10/2013

Funding: UNICEF /ACF

Partner: ACF

Project Manager: R. Chipise

Province: Manicaland

Number of Wards: 8

Community Health Clubs: 31

Market Place Clubs: 12

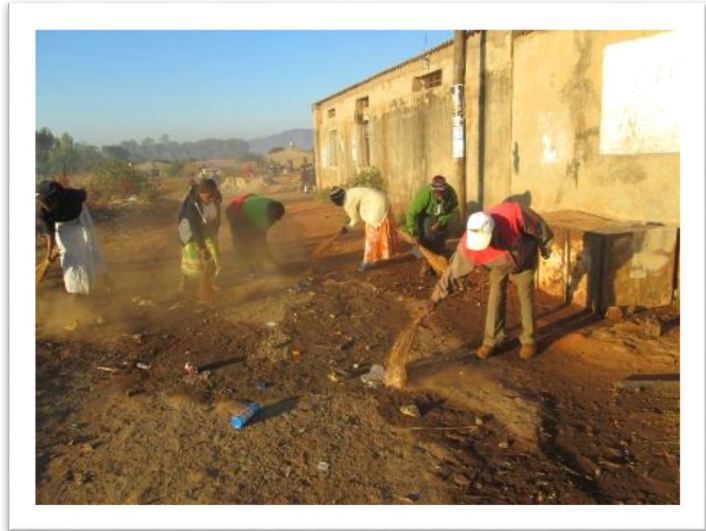
CHC members: 2,144 (89% f)

School Health Clubs: 10

Indirect beneficiaries: 25,676

Cost of Project: US\$134,000

Cost per beneficiary: US\$5.2



Clean ups , removing tons of garbage regularly done by CHC members

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

Community and School Health Clubs

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:

We have found that people in town join a Community Health Club just as readily as they do in the rural areas as they enjoy socialising and working together on community projects. The training is the usual 6 months of weekly sessions which enables the CHC to become united in its appreciation for a cleaner environment. Before the Zim AHEAD Project the town was filthy with large piles of rubbish everywhere (see above). Clean up days were organised by the CHC and finally the council helped to remove the mounds of refuse.

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.'

Small Towns Hygiene Promotion and Capacity Building

Bindura Town

Project period: 10/2012– 8/2013
Funding: UNICEF Wash Fund
Partner: GAA (known as WHH)
Project Manager: Morgan Haiza
Province: Mashonaland Central
Number of Wards: 12
Community Health Clubs: 17
CHC members: 1,038
School Health Clubs: 10
School Members: 733
Direct Beneficiaries: 5,294
Indirect Beneficiaries: 44,033
Cost of Project: US\$117,000
Cost per beneficiary: US\$2.65



School children show membership cards of the health club

Objectives:

1. To increase equitable access to WASH services for vulnerable people with a 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, sustainability of services, and measure the impacts

Government Capacity Development

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 disabled community members as well as CHCs, SHCs and Market Place Health Clubs.

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. 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. 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.

Community Based Environmental Health Promotion Programme (CBEHPP)



Why we chose the CHC Model for a National Programme

Joseph Katarwa, Head of Environmental Health Department,
Ministry of Health, Rwanda

Extract from an interview by Lisa Nash, Blue Planet

*Wherever we have introduced CBEHPP, the community is doing well.
Wherever we have not, they are demanding CBEHPP.*

Our program started in 2009. In the beginning we wanted to harmonize all the hygiene education efforts used by the different NGOs and agencies to give them guidance and put in place a full policy that had not existed up until then. We found out, however, that the education programs given at that time were 'half cooked'. It would not work to try to use them to teach the community.... We did not want to introduce CLTS because it depends on shaming and it is very coercive. It was very important for us in Rwanda to build a program that depended on building local relationships and trust. It was up to the community to decide what they wanted to do and to do it together. Once you use coercive methods like CLTS, you destroy the trust and community friendship. There can be no strong foundation to build on, and no future between you and the community. We wanted the program to last a long time and to continue to be used by the community to speak of the importance of sanitation and hygiene, as well as help them create new income-generating ideas. This would not have been possible with CLTS.

That's why we started our version of the CHC model, the Community Based Environmental Hygiene Promotion Programme (CBEHPP). The many different hygiene education approaches were not reaching the community. There was no sense of sustainability. The CBEHPP brought a sense of sustainability to the efforts. It gave people the feeling that they themselves needed to solve their problems, not someone from the outside. It also gave them the confidence that they could solve their own problems, because they solved problems together when they were part of CBEHPP. They saw with their own eyes that it worked.



Seeing is Believing
Delegation from the DRC visit the CBEHPP Programme in Rusizi and are converted by the community achievements seen in the CHCs

Support for Ministry of Health in Monitoring of Community Health Clubs

Juliet Waterkeyn, CEO Africa AHEAD

In 2010 the Ministry of Health requested Africa AHEAD to assist , and we in turn asked the Gates Foundation to support research in Rwanda to ascertain the cost effectiveness of Community Health Clubs when taken to scale. The Gates Foundation engaged IPA (Innovation for Poverty Action) as the evaluation team to conduct a Randomised Control Trial while Africa AHEAD supported the Ministry of Health to monitor the programme properly.



It was decided that MoH, with assistance from AA ,should provide the 'classic' demonstration of the CHC Model in 50 villages in Rusizi District as well as 50 CHCs in the Lite arm, and 50 Control villages. The household inventory developed in conjunction with AA, was adopted by the Ministry of Health in Rwanda and 60,000 booklets were printed and distributed for all NGOs and districts to conduct the survey. Whilst the base line which was collected manually in September 2013 it was a heavy job to computerise it and the results were questionable. By contrast the mid term 'mobenzi' survey, done in May generated results the same week of collection.

Online International Registry of Community Health Clubs

The Mobenzi data can be instantly accessed by relevant users at national level, through a new website set up by Africa AHEAD in the past year which will provide a monitoring system for community health clubs internationally. This is an online registry for all implementing organisations and government which will allow each CHC to have its own page with all information updated by project officers in the field. There are three monitoring tools at present:

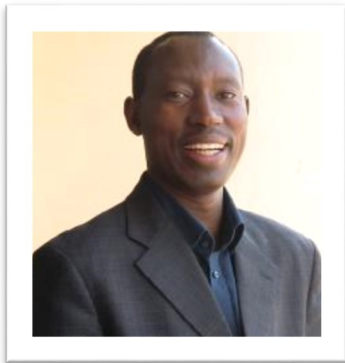
1. Registration of CHC, detailing number of members, GPS location, facilitator contacts, latest news and photos
2. A monthly CHC report detailing diseases reported by members, as well as latest training sessions done each CHC.
3. The household inventory with 30 observations of hygiene which will enable assessment and comparison between CHCs

A monitoring Officer, has been seconded to the Ministry of Health to assist in the start up of the CBEHPP website and train in the use of the survey.



*Andrew Ndahiro
Monitoring Officer MoH*

Monitoring Behaviour Change and Improved Health Outcomes through the Community Health Club Methodology in Rwanda



*Amans Ntakarutima
Programme Manager*

Period: June 2012 - June 2015

Donor: Bill & Melinda Gates Foundation

Partner: Ministry of Health EHD

Project Manager: Amans Ntakarutima

District : Rusizi District

Number of CHC Members: 2,700

Number of CHC graduates : n/a

Number of beneficiaries: 13,500



Workshop participants for CHC Trainers, November, 2013 .

Training of Trainers

After the training of 50 CHC Facilitators in February 2014, weekly health promotion sessions started in the 50 selected villages of the implementation arm of the trial. This began with the registration of CHC member's, election of CHC committees, village mapping, agreement on meeting days, venue and time in partnership with local leaders before health sessions began.

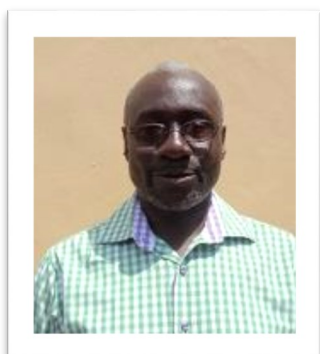
CHC progress in hygiene and sanitation behavior and practice

After 3 months of CHC activities, most CHCs have covered at least 10 topics. When you visit villages, you are likely to be welcomed by joyful men and women, who are empowered and self confident from the achievements of their homes: clean homes, hygienic drinking water storage, pot racks, step and wash facilities, clean bedding, kitchen garden, bath shelter in construction with good progress in getting and use of hygienic latrines. We have found that it is easy to start off CHCs but the CHC evolves beyond the planned activities and has a life of its own. When CHC members are together they inspire each other, which pushes all the CHC members to plan and decide on other beneficial activities and projects.

Early indications of behavior change

Already, private behaviour is becoming a public concern, with the general consensus from the critical mass ensuring that all individuals are discouraged from poor hygiene behaviour in favour of agreed and accepted standards and norms.

H²O Health Plus: Apac Pilot Project of Community Health Clubs in Uganda



*Justin Otai,
Programme Manager*



One of the 35 villages visited to mobilise for the start up Community Health Clubs

Project period: 10/2013– 9/2014
Funding: Blue Planet / ILF
Partner: International Lifeline Fund
Project Manager: Justin Otai
District : Apac District, Uganda
Number of Sub Counties: 6
Community Health Clubs: 35 / 75
CHC members: 2,100 approx.
Direct Beneficiaries: 12,600 approx.
Cost of Project: US\$66,000
Cost per beneficiary: US\$5.20

International Lifeline Fund (ILF) are providing boreholes in Apac district, Uganda and needed to health promotion to enhance the impact of Sanitation and Hygiene promotion within the communities. Africa AHEAD was asked to start 75 Community Health Clubs.

Community Mobilization was done at all levels before implementation, resulted in a good working relationship within the project scope. 35 Community Based Facilitators were selected through community participation from 35 Villages in Apac in 6 Sub counties. Procurement of training materials, T/shirts, Inventory books, Motorbike, phone, and tools for latrine construction is complete. A 5 day CHC training workshop was conducted by Justin Otai in Apac, which involved 35 CBFs, 6 H/As, 6 ILF staff and key district officials presided over the opening and closure. Certificates were given to the participants with CHC training manuals. 35 CHCs have been formed, membership varies from 50-100, averaged at 60. All committees are in place. Memberships cards have been distributed. Members are meeting every week to continue with other club activities such as songs, drama as they await to start full sessions. A one day orientation training on the inventory has been conducted for the enumerators who are the CBFs, in all the Sub counties. The Survey was done 5th-15th May. 2014. AA has had 4 coordination meetings with ILF and the district to streamline activities and 3 visits have been conducted to the field by ILF and the Consultant to measure progress. Being a new partnership operating in a new project area, progress sometimes is slow. **From** December March the community was heavily engaged in farming but despite this by April 2014, after only three months, the project is up and running and it is likely that all targets will be met.

Prospects for 2014 - 2015

ZIMBABWE

- USAID WASH project with DAPP has been approved for Goromonzi and Chipinge starting in June. It is a two year project for slightly more than half a million dollars.
- We have been awarded 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.
- We have submitted an Expression of Interest to UNICEF for 14 towns WASH public health promotion penciled to start in June 2014.
- 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.
- We are in the process of submitting a proposal to USAID OFDA to scale up the programme in Chimanimani, Chipinge, Mutare and Chiredzi as well as spread over the border to Mozambique in an effort to mitigate against Cholera.

EAST AFRICA HUB: RWANDA, KENYA & TANZANIA

- We are submitting a Proposal through the Blue Planet Group to start School Health Clubs
- We submitted a proposal to World Bank, Global Partnership for Social Accountability to set up Umbrella committees in six districts in Rwanda for Community Based Environmental Health Promotion Programme.
- An ambitious proposal to scale up CHCs in 5 Districts has been submitted to the Rwandan Development Board.
- We have submitted a proposal to USAID Development Initiative Venture to start up CHCs in two Counties in Kenya with a view to scaling up in Kenya and regionally
- Partnering with SEI , we have submitted a Concept Note to the Human Development Innovation Fund, (Dfid) to introduce the CHC Model over three years in order to scale up a national programme in Tanzania like CBEHPP.

DFID SUCCESS — DRC & LIBERIA

Through the DFID's WASH Challenge Fund we have been successful in obtaining funding with the OXFAM Consortium to implement 150 pilot CHCs in eastern DRC in three provinces: North Kivu, South Kivu and Maniema; in partnership with Tear Fund In Liberia we will be training Concern and the Liberia WASH Consortium, to pilot at least 20 CHCs.

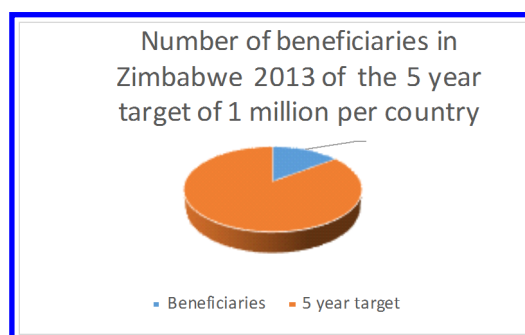
AFRICA AHEAD

5 x 5 Challenge

<p>In the next 5 years the reduction of 5 top killer diseases with 5 million people benefitting in at least 5 countries at less than 5 US\$ per person</p>	<p>2015 - 2020</p> <p>Pneumonia, Diarrhoea, Malaria, measles, malnutrition</p> <p>one million in each country</p> <p>Rwanda, Zimbabwe, Uganda, Liberia & DRC</p> <p>families of a community health club member</p>
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‘SMART’

- Specific:** Controlling the critical diseases listed above we will contribute substantially to improving child survival and minimize early deaths and morbidity of under 5's.
- Measurable:** With a fixed target group within a defined number of CHCs, communities themselves actively monitor observable proxy indicators of non-risk hygiene behaviours that are proven to reduce the above targeted diseases using our standard monitoring tool, the CHC Household Inventory, collected using cell phone technology for data collation.
- Achievable:** We are aiming for 5 million beneficiaries. Assuming a conservative 75 members in each CHC this implies a target of 66,666 CHCs, with each member having an average of 5 family members. This makes a target of 13,333 CHCs in total for the five years. Between five countries this would be 2,666 CHCs per country in total or 533 CHCs per year. With proper funding this is achievable as In Zimbabwe we trained 833 CHCs in 2013.
- 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:** In partnership with other NGOs and government we expect to achieve this target within 5 years in each country



INCOME STATEMENT - 12 Months Ended December 31,2013

	South Africa US \$	Rwanda US \$	Zimbabwe US \$	USA US \$	Consolidated 2013 US \$	Consolidated 2012 US \$
REVENUE						
Income	\$143,392.36	\$327,297.00	\$767,565.65	\$0.00	\$1,238,255.01	\$947,548.36
GRANT EXPENSES						
Grant Expenses	\$126,266.55	\$79,624.40	\$689,904.52	\$950.00	\$896,745.47	\$506,318.35
GENERAL EXPENSES						
General Expenses	\$11,840.36	\$5,437.83	\$30,029.22	\$90.00	\$47,397.42	\$89,529.10
NET INCOME	\$5,285.44	\$242,234.77	\$47,631.91	(\$1,040.00)	\$294,112.12	\$351,700.91

BALANCE SHEET December 31, 2013

	South Africa	Rwanda	Zimbabwe	USA	Consolidated 2013	Consolidated 2012
ASSETS						
Cash at Bank	\$2,663.51	\$242,259.72	\$62,643.23	\$155.58	\$307,722.04	\$414,025.52
Supplier Control Account	\$1,455.76	\$0.00	\$0.00	\$0.00	\$1,455.76	\$0.00
Trade & Other Receivables	\$31.72	\$0.00	\$0.00	\$0.00	\$31.72	\$2,912.00
Inventories	\$0.00	\$0.00	\$6,775.00	\$0.00	\$6,775.00	\$21,258.00
Total Current Assets	\$4,150.98	\$242,259.72	\$69,418.23	\$155.58	\$315,984.51	\$438,195.52
Fixed Assets	\$1,282.93	\$0.00	\$55,350.00	\$0.00	\$56,632.93	\$30,138.25
Total Assets	\$5,433.91	\$242,259.72	\$124,768.23	\$155.58	\$372,617.44	\$468,333.77
LIABILITIES						
Accounts Payable - Grant Money	\$0.00	\$0.00	\$5,686.00	\$908.15	\$6,594.15	\$57,760.28
Accounts Payable - Other	\$0.00	\$0.00	\$0.00	\$3,856.76	\$3,856.76	\$0.00
Shareholders/ Directors Loans	\$3,610.06	\$24.95	\$0.00	\$0.00	\$3,635.01	\$8,663.93
Reserves	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$3,686.00
Retained Income/ Loss b/fd	(\$3,461.59)	\$0.00	\$71,450.32	(\$3,569.33)	\$64,419.40	\$46,522.64
Retained Income/ Profit current	\$5,285.44	\$242,234.77	\$47,631.91	(\$1,040.00)	\$294,112.12	\$351,700.92
Total Liabilities	\$5,433.91	\$242,259.72	\$124,768.23	\$155.58	\$372,617.44	\$468,333.77

