**Seeing is Believing: Our Vision 5 x 5**

As you heard earlier, the Community Health Club model was first pioneered in Zimbabwe in the mid-1990s. So what has happened in the twenty years since then? I want to tell you about my recent trip to Rwanda to give you some idea about what I mean by **“Seeing is believing**” the title of this presentation. The other part of the title is “***Our Vision 5x5***” so I had better quickly explain what this is about:

Our **Vision 5x5** is to target the **5 killer diseases** that affect at least **5 million families** in at least **5 new countries** at a cost of less than **US$ 5** per head within the **next 5 years** (2015-2020). **(2) …. (3)**

Also 5 of the most insidious Neglected Tropical Diseases **(4)**

We are also focusing on Infant & Maternal health, especially as it affects the **under 5s** but that would make it **6 x 5s** and spoils the symmetry! The Community Health Club or CHC model of holistic development will of course be our mechanism, **our engine, our locomotive**, as you will soon see, for achieving this **5x5 Vision.** This is because we can now demonstrate after 20 years that: **(5)**

1. CHCs REACH SCALE;
2. CHCs support INTEGRATED Development;
3. CHCs achieve and maintain QUALITY CONTROL.

These three elements: Scale, Integration and Quality Control are crucial for Vision 5x5.

So, on to my recent trip to Rusizi District in Rwanda. **(6)**

This is a district that is one of the poorest in the country with regular outbreaks of cholera and other killer diseases forever waiting to pounce and borders DRC and Burundi.

I went to participate in a five-day workshop that AA was hosting for a delegation from Eastern DRC that included three Provincial Directors of Health. They had come across to Rwanda specifically to see for themselves our CHCs in action. They wanted to go on field trips in order to determine whether our model might enhance their own national Village Health programme or Village Assaini as it is locally called in DRC.

When it comes to Field Trips I resent being ‘led by the nose’! Being taken to villages that have been fore-warned and are thus fully prepared and all geared up for your arrival…. I am sure many of you here will have undertaken Annual Reviews and such tactics will be all too familiar … the usual pre-packaged field trips where the gullible consultants are shown only what is positive to ensure that funds keep flowing? On another recent assignment to another country (not Rwanda!), I was taken to a village where every homestead appeared to have a nice looking latrine with fly cover and neat bowl of ash in place. But I have this bad habit of lifting fly covers and taking a quick photo to see if the latrine has become a fly-breeding site. So to the alarm of my hosts, when I did this and looked inside to establish if they had become ‘fly factories’ I discovered that not one of them had ever actually been used… these were all ***dummy latrines***! Just an arms-length in depth they had all clearly been dug in the few hours before our arrival! And this was officially registered as an Open Defecation Free Village?! Discovering this blatant fraudulence actually stopped the whole national programme … for a while… but that is another story!

Back to Rusizi where we had scheduled two days of field trips for our French-speaking delegation of 18 people from DRC. We gave the organizers a print-out that listed all 50 CHC project villages. This printout included information about village locations; the date each Club had been started; number of members and so on. We suggested that the visitors should randomly select the villages they might like to visit that same day from this list. Clearly this was taking quite a risk and it could have all gone horribly wrong! Anyway, I ended up joining one of the three teams and we drove for over two hours far off into the bush away from the main road and along an almost deserted track until we arrived at ‘our’ village. **(7) ….. (8)**

We stopped the vehicle to find someone who might confirm whether this was the village we were looking for. **(9)**  An old lady peered out from her humble mud hut near the road and, when we asked her, she nodded that this was indeed the village. One of the Provincial Directors of Health from DRC then asked her if she knew anything about a Community Health Club. She once again nodded rather nervously not knowing who we were or why we had stopped outside her house. She was then asked if she was a Club Member and if so did she have a Membership Card. She turned quickly and went back into her dark hut for a moment and returned with her green Membership Card all carefully wrapped in plastic **(10) . (11) (12)**

*She showed us the card and clearly it was being used because about ten of the 24 health topics had already been signed off. So far so good and our visitors were duly impressed. By this time she seemed more relaxed and invited us in to inspect her home. We inspected her hand-washing facility that had water and soap and it was located right next to her latrine.* **(13) (14)** *We were surprised and impressed to see that the squat-hole had been fitted with a ‘hands free’ fly cover and her latrine was clean and few flies in evidence Her yard was beautifully swept, she had a garbage pit and there was a new pot rack, bath shelter and a clothes line. Perhaps most intriguing, she also had a fuel efficient stove made of mud in the hut she used for cooking. We asked her how she had been able to do all this by herself in such a short time and she explained that it wasn’t her but the other members of her club that had been assisting her. Apparently, as we later found out, this idea of the Community assisting the weaker members of the Club to construct hygiene enhancing facilities had become the norm in all the villages that were visited that day by both ourselves as well as the other two DRC teams.* **(15)** *We wandered on through the village inspecting similarly improved homesteads and meeting more enthusiastic CHC members.* **(16) (17) (18)** and **(19)**

Later that evening when we all regrouped back at the guest house overlooking Lake Kivu where you can see the lights of Bukavu and DRC in the distance, it was clear that everyone from DRC was pretty convinced and enthusiastic by what they had witnessed that day. This was certainly a really great start for the follow-on three-day workshop where our DRC guests deliberated on how they would now be adopting CHCs into their own national Village Assaini programme from now on. So here is my first example of ***‘seeing is believing’!***

How on earth did we arrive at this point where CHCs are being taken so seriously and beginning to be implemented at scale in national programmes? Back in 2010 when I was first introduced to Dr Richard Ssezibera, Rwanda’s Minister of Health at the time…. actually he is now Secretary General for the whole of the East African Community, he asked me to describe the CHC model to him. I did my best and then rather cautiously proposed that it might be a good idea if he gave his blessing for us to pilot CHCs in a few areas to find out if the model might be appropriate for Rwanda. To my alarm, his response was to suddenly **slam** his hand down hard on his desk! “*Anthony, in Rwanda we do not have time for pilots…. You have been piloting your Health Clubs for years…. go now and prepare a Roadmap for us to roll out these Community Health Clubs across Rwanda*!”

Here’s the so-called Roadmap **(22)** Minister Ssezibera signed off on the Foreword and gave copies to his colleagues in Cabinet. Not long after, President Paul Kagame called all thirty district mayors to a special meeting and handed them all copies of this Roadmap (in Kinyarwanda) entitled ‘*Community-Based Environmental Health Promotion Programme*’. He told his Mayors that he wanted CHCs in all 15,000 villages across Rwanda with immediate effect! What a breakthrough!! Can you imagine, 15,000 villages similar to the ones we have just been looking at in Rusizi with CHCs covering the whole of Rwanda … potentially 9 million CHC beneficiaries!

So this really has been a ***game changer*** for us and demonstrates how CHCs are capable of **REACHING SCALE!** CHCs are no longer just within the domain of NGOs as they have been for much of these past 20 years. The CHC model has been proving itself to such an extent that Ministries of Health and also Local Government have been more willing to adopt this model. CHCs are reaching scale thanks to enlightened Ministers like Dr Richard Ssezibera. And this is not only happening in Rwanda. In Zimbabwe, where CHCs were first pioneered, the Minister of Health, Dr David Pariyenyetwa, recently spent a couple of days with us in the field. He now wants his Ministry to extend CHCs across the whole country and they have recently put National WASH Policies in place to this effect.

Again, another example of ‘***seeing is believing’*** except in the case of Dr Ssezibera, he had the **imagination to see** without having to physically observe the CHCs. He was able to grasp their rationale and full potential. Maybe it is no surprise that he went on to become Secretary General for the whole of the EAC!

So what is it about CHCs that clearly resonates with a Minister like Dr Ssezibera. I would like to believe that firstly, he fully appreciated the CHC approach to be culturally and ethically appropriate for a country like Rwanda that was desperately trying to rebuild a traumatized population after the genocide exactly 20 years ago. He specifically did NOT want a model that used naming and shaming and various top-down bullying tactics for his country. He loved the CHC idea of ‘***Common-Unity’***. In particular he appreciated that CHCs offer a very practical approach that his Ministry could begin implementing right away without depending on Donors. He clearly demanded high impact and of course he wanted a very Big Bang for his Buck!! He was certainly NOT myopically obsessed with ODF and diarrhea! He wanted a hands-on model that was holistic and would address most if not all **preventable diseases** in a fully **integrated** way!

So how are CHCs capable of supporting community-based integrated development? Obviously it is not only hygiene behaviour change (let alone ODF) that is required in order to address a whole raft of preventable diseases; access to safe drinking water, having adequate food and a balanced diet … ultimately income generation are all crucial. After all, it is poverty that is the over-arching cause of poor health…: poor health and poverty being so inter-connected, so inter-linked.

So how do CHCs support ***community-based integrated development***? Let me demonstrate what we mean **(23)** (PIC of Train)

CHCs can also engage village communities in the **‘hardware’** aspects of a programme, like provision of water supply. CHCs have rehabilited old water-points that have fallen into disrepair. CHCs have also been known to ‘morph’ into FAN Clubs: that is Food, Agriculture and Nutrition Clubs. In fact, FAN Clubs have been taken to scale in Zimbabwe and have been clearly shown to lead on to a whole raft of other income generating activities. **(24)** **(25) (26)** . (PIC of Communal gardens)

CHCs are certainly not only about the **‘soft-ware’** aspects of hygiene behaviour change and here is the point: when CHCs are allowed to become the **entry point**, the **engine** pulling the other hardware components of WASH, agriculture, education, livelihoods etc. … in other words when CHCs lead the whole integrated **train** of development then the likelihood of achieving **sustainable community-based integrated development** is significantly enhanced!

New water-points are far more likely to be managed and maintained properly if the whole Village Community has gained clear and well-articulated Public Health awareness. Why?? Well I think it may be because the whole community by now deeply understands and appreciates the importance of their new water supply or communal nutrition garden or whatever. They fully appreciate that their health and livelihoods utterly depends on it! But most important, they have learned how to cooperate and trust each other; they now possess Common Unity of purpose. Their social capital and in particular the confidence and influence of women within their community will have grown substantially.

I hope that by now you are beginning to see how CHCs have potential of ***Reaching Scale*** (as in Rwanda) and supporting ***Integration*** (e.g. Zimbabwe). Now we need to investigate how CHCs can also achieve the third and final element: ***Quality Control***. Another example from Rwanda: Gates Foundation agreed to fund AA to ensure that our ***classic recipe*** for CHCs was properly adhered to in Rusizi district that we spoke about earlier. By being assisted to ensure **Quality Control** for the CHC recipe or model, we have enabled the MoH in Rwanda to really get to grips with and appreciate the **full potential** of the CHC model. In other words we have **‘raised the bar’** for their entire national programme. It has ‘**set a new yardstick’** for the whole country! MoH and LG are now able to call all districts to account and to measure up. They can put policies and guidelines and ‘Roadmaps’ in place to ensure that standards are maintained and sustained. This is what I mean by CHCs achieving ***Quality Control***. **(27) (28) (29)**

Incidentally, Gates Foundation is also funding a Randomised Control Trial in Rusizi to evaluate the health and socio-economic impact of CHCs. They are also looking into aspects around women’s empowerment and social capital. And here we have yet another fine example of ***‘seeing is believing’***. After a short conversation with Gates’ Head of Global Health at a conference just like this one (at the University of North Carolina’s ‘Water & Health’ Conference); He immediately got it in one! Early results of this RCT are expected a year from now and we await them with bated breath! But in the meantime, MoH and LG in Rusizi are ‘over the moon’ with the way their communities are responding and changing for the good.

The question that has baffled us for some years now is: Why, if CHCs are so great and tick all the boxes, has it taken two decades for the idea to be taken up? I would love to hear your views on this? For my part I think there are three possible reasons:

1. Lack of imagination… an inability to ***‘see’*** a solution even when it is there
2. Cynicism & apathy that leads to inertia
3. Deliberate denial

***‘Lack of imagination’*** That CHCs are only suited to a small NGO like AA and not to government-led programmes that Reach Scale. Such types are more likely to benefit from ‘**Seeing is believing’** tours like the one we arranged in Rusizi for DRC.

***‘Cynicism, apathy & disbelief’*** I remember a PS of the Ugandan MoH who said that hygiene behaviour change was simply not possible in the short-term and it was only going to be through educating the girl-child and thus the future mothers of the nation that things would ever be likely to improve. I go the distinct feeling he was passing the buck onto the Ministry of Education!

Then there is the more sinister ***‘Deliberate denial’***. What is this all about? Why is it such an effort to change the attitudes of seemingly intelligent people who are in charge of development agencies and government ministries? Why is this such a challenge?

It seems to me that it is much easier to achieve behaviour change ‘***downwards***’ in a rural village than to try to effect change in an ‘***upwards’*** direction***.*** In other words it seems near impossible to change the attitude of so-called ‘wise and intelligent’ people in leadership positions despite providing them with evidence! Sadly those in Deliberate Denial appear to be far more concerned with protecting their personal interests and funding flows … as we discovered when we literally unearthed those ***dummy latrines*** I told you about!

So, can we take on **Vision 5x5**? ‘Yes we Can’ (as Obama used to say)! Both of our AA hubs in Zimbabwe and Rwanda are very well positioned to invite MoH officials from neighboring countries to come for **‘seeing is believing’** tours after which we can readily support their CHC training and mentoring needs.

This is not all just about a couple of old farts like us hanging on to life by our finger nails! These two hubs in Rwanda and Zimbabwe are staffed by exceptionally talented and mostly young trainers. Some have been in leading positions within the WASH and EH sectors. They are such seasoned and passionate CHC trainers who absolutely ***believe what they have been seeing*** for years. They are more than ready to help disseminate CHCs to their respective neighboring countries in SADC and EAC.

Already we are partners (with Oxfam, ODI & Tearfund) in the winning Consortium we established for our bid for ***DFID’s WASH Results Challenge Fund***. DFID seems keen that CHCs are piloted in both Liberia and DRC. As with our French-speaking Rwandan team who are already engaged in support of DRC, our English-speaking Zim team was poised to initiate CHCs in Liberia this past month. However ebola has complicated things? We are also in discussion right now to get CHCs going in Tanzania and to greatly expand CHC coverage in Uganda… So already that is four new countries we are talking about… only one to go to meet our 5x5 …and hopefully there will be many more? **(2,998 words)**