‘I am not Nobody Now: Putting Women at the Centre of Development’
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Our calling as public health practitioners is to make the world a better place for the poorest of the poor. We need to help those who have not had our fortunate start in life. Our job is to help them get their foot on the very first rung of the ladder out of poverty. The first step is surely to ensure the survival of their children, who die needlessly from diseases of the poor. They die because they consume contaminated water, because flies infect their food and rats infect their homes. They die because mothers walk ten kilometers whilst in labour to deliver a baby. Their babies die because their umbilical cord is cut by an auntie with a rusty blade. They die most of all because in the damp mud huts they catch a cold which turns to bronchitis or pneumonia.

This is Segni, a one month old I found dying in a mud hut in the depths of Guinea Bissau, the poorest country in Africa. She had neonatal tetanus which was treated with a jujuj bracelet. Her mother for a child of 15, and the young father has run off. Children die in droves because they catch polio or measles because they were not immunised. In fact 8 million babies die like Segni every year in Africa. There is a horrifying difference between the survival rates of babies born in the industrialized world compared to those who have the misfortune to be conceived in poverty in Africa. For every child born in Europe, there are 16 babies who are born in Africa and will die before their 5th birthday.

For us public health practitioners, the challenge is to prevent the death of 8 million children who die each year in Africa from entirely controllable diseases. ***Huge*** budgets are used to cure the needlessly diseased and health centres are understaffed and lack basic facilities. The 'aid' from developed countries is never enough to tackle the scale of disease in Africa. Therefore, it is of course important to make these limited resources stretch as far as possible. It makes good ***financial*** sense to have more ***holistic*** health promotion programmes which address ***multiple*** diseases rather than ***narrowly*** targeting ***one*** disease. In this way the same overheads are used to address a range of issues. We address, not just diarrhoea, but every disease that can be prevented by good hygiene. Implementers need to get the maximum return on their expenditure and save as many lives as possible. How do we do this?

Let's look at the breakdown of deaths due to various causes. Unicef estimated in 2005 that the number of infant deaths from various causes can be calculated as follows: 17% is due to diarrhoea, 19% to pneumonia, 37% of deaths are from poor birthing, 8% from malaria. However - and here is the important fact - the number of these fatalities would be ***halved*** if the child was properly nourished. Research shows that we can reduce many of these conditions through good hygiene and sanitation, hence the drive in the WASH sector in the past 50 years to increase these facilities. With safe hygiene neo-natal deaths can be reduced by 44% and the number of diarrhoea cases can be reduced by 88%. Handwashing even helps prevent Acute Respiratory Infections (ARI) and some estimate that pneumonia can be reduced by over 30%. We can reduce malaria by 50% by using insecticide treated nets, and immunization can eradicate measles as it has done polio.

It is not rocket science to realise that ***if*** many of these hygiene practices can prevent ***more than one*** disease then we should have programmes that are ***multi-focused***.

Why doesn't this happen?

I believe it is because funding tends to be dished out by donors in silos, along sectors - for HIV, for Diarrhoea or for Malaria. It is these well-meaning but narrow-minded interventions that are driven by donors priorities that cause this screwed development.

Why do funders give money in this way?

Because it is easier to measure a few indicators and target ***one*** disease than have a broad, rather flexible programme than can respond to the needs on the ground. This silo funding is reducing development to the measurement of outputs. Whilst accountability is important. It should not constrain good development. Can you tell me - if you are a mother of a brood of small children - would you walk a kilometre just to be told to wash your hands, over and over again? Mothers tend to want to know everything about all threats to the child's survival. The recipients would argue for an holistic approach.

After the straight jacket of the MDG targets that put people like us in the WASH Sector into a frenzy of latrine counting, we are now seeing a shift which emphasizes ***sustainability*** of change. Instead of quick and dirty projects, practitioners are beginning to call for integrated programmes. However there is a lack of imagination

as to how this can be done. Community Health Clubs are the vehicle for holistic development which can tackle all these diseases.

I imagine you have come to the session because you have heard that our CHC model may provide the design for an integrated programme. You would be right in thinking that we ***do*** have an answer to the dilemma. Sadly, there are so many cynics in the development world, those disillusioned 'old Africa hands' who believe that there are no answers for Africa, there is no magic bullet, there is no such thing as a recipe for change. Rather than listening and comparing our outputs to other similar programmes they are trying to see the flaws in our approach. They doubt our claims because they assume we are punting our ideas for our own profit. For those who cannot believe their ears when I tell them how we have achieved long term sustainable development, I invite you to come and see for yourself. When you see the light in the eyes of rural women, the pride of their kitchen and the robustness of their children you may believe. I am pausing here to show you a short video of what you may see if you came to Zimbabwe***.***

How do we achieve this level of community support?

Much of the appeal lies in the love of knowledge that is a feature of the rural areas of Africa. Every member is give a membership card, and they can see immediately what they will learn. We have 20 sessions which include ***all*** the disease that can be prevented and a whole raft of changes that are expected from the CHC member. Some may argue that the 'community' cant be burdened with so many practices, or that they are incapable of learning so much. We have found the contrary to be true. The capacity of rural women to learn is incredible, they are like sponges soaking up information. This is because there is an intellectual starvation amongst the poor. They crave knowledge as much as they need food.

The membership card provides encouragement to complete every one of the 20 sessions in the 6 month training. Every time a member attends a session the facilitator signs their membership card. When they complete the card they receive a certificate. The graduation ceremony is a big event and women relish the glory of being seen receiving a certificate. Our trick to get high attendance levels is as simple as that. The only reward for full attendance of the 20 sessions is a simple certificate. People in Africa really value certificates highly. We give no other inputs, no cement, no drinks at the venue – nothing. People supply their own needs, they build their own

latrines and sort out their own homes. This gives them pride and a sense of achievement. It does not make them into dependent beggars, waiting for handouts.

We achieve high levels of hygiene behaviour change as is shown in this chart - one of many similar programmes with the same high levels of achievement. The household inventory is a standard tool which we use in Africa AHEAD, it is a spot observation of indicators at each home taken by the chairperson of the CHC. They are things which can be easily observed, and which indicate a change in hygiene behaviour. You can see from the change, before and after the training the difference in the hygiene practice. Taking 16 key indicators we see there was on average 80% buy-in. This is high by any standards. We find members building latrines and cleaning up their water sources and this 'practical' homework is the second stage of the process, moving from 'knowing' to 'doing' or praxis, practising what you know.

We also know that if people are adhering to these non-risk practices, disease will be more or less prevented. So, have we seen reduction of disease on the ground? One programme in Makoni District in Zimbabwe between 1995 and 2001 where 88% of the households were in a CHC showed a dramatic reduction in five most prevalent diseases: diarrhoea, bilharzia, skin disease, ARI, eye disease and malaria. Your research shows that to be able to achieve this type of reduction you need a high density of CHC households in the health centre catchment. In areas where CHCs had been going for five years the impact of the reduction of the CHC activity can be sustained. There was a reduction in diarrhoea cases from 2,200 per year to 32 in the fifth year. All of the five diseases were maintained at less than one hundred cases per year, and this low level persisted. By contrast, in areas where the CHC was stopped after two years, the number of cases began to rise again and continued to rise. What do we learn? We realise that to maintain good health in the area, the CHC needs to be sustained over time.

How do we keep a health club alive? By going to Stage 3: the Food Agriculture Nutrition (FAN stage). For the members who have achieved a certificate the reward is to be given a share in the communal nutrition garden which is get up often at the local school. Each member is given five beds to grow a variety of vegetables and they are taught how to increase yields with fertility trenching and organic methods of mulching and crop rotation. With more variety of home grown vegetables children eat a balanced diet and develop better immunity systems. This enables them to survive illnesses, better than malnourished children with miasmas or kwashiorkor. In addition women can sell their produce and raise their standard of living, and we have seen

how members use this additional income to build latrines and ensure they have all recommended hygiene enabling facilities. The FAN achievement is another story, and space does not permit me to elaborate on it now. This is Stage 3 in the integrated and holistic vision we have of best practice in development. Stage 4 is when the villages has become fully functional and begins to address more sensitive issues such as basic rights, literacy and gender issues. The whole Model of AHEAD, 'Applied Health Education and Development' is a 4 year process which ensures sustainable livelihoods.

For those who need to be convinced by numbers, we can make a rough calculation of the number of reported cases that we can save through good hygiene. Let us take 100 cases - we can reduce number of reported diarrhoea cases from 37 to 21, and this can be can be halved again to 14 if the child is well nourished. Pneumonia can be reduced from 19 cases to 9 . The grand total would be to save 62 out of 88 deaths for every 100 cases. Scaling this up to the 8,000.000 child deaths reported per year in Africa, we could theoretically save nearly 5 million cases, if we used the Community Health Club throughout the continent.

We need to save 8 million children's lives in Africa every year.... can the CHC model be scaled up to achieve this huge challenge. Well, it will take time but as Mother Theresa once said, to a skeptical government official when he asked her how she expected to make any impact on the millions of dying paupers every day. *'How do you get to the millions... you start with one, and you keep counting til you reach a million.'*

We started the CHCs in 1995 and have been slowly notching up little successes throughout the continent, wherever we have worked. After 20 years we calculate that our direct impact, just my husband and myself, working as consultants, and training teams who have started CHC programmes in 11 countries, we have been able to reach 1.5 million people. This 1.5 million does not factor in the indirect beneficiaries from the many CHCs that have been started by other NGOs whose staff we have trained and who have used our training material. That 1.5 million beneficiaries is nothing compared to the impact Africa AHEAD has had by the introduction of the CHC model into Rwanda, where it has been taken on by the Ministry of Health as a national programme. The Community Based Environmental Health Promotion Programme has now reached every one of the 14,860 villages in the country with an estimated 6 million beneficiaries. Rwanda is one of only five countries in Africa which were able to reach the MDG target. But that is another story.

How do CHCs work in emergencies?

Zimbabwe suffered one of the most extreme cholera epidemics ever seen in Africa in 2008/9. There were over 100, 000 cases recorded of which 4,500 people died. In Mutare we have a case study of a high density suburbs where we started 50 CHCs and had a high density of members. They cleaned up the solid waste and improved their sanitation and hygiene and the Council took heart and started to improve the sewerage system. The people work with local government and make government more effective. Not one person died of cholera in Sakubva.

How do CHCs work? How do we get this buy-in?

There is a bit of social science behind the design of this model. We believe public health is a group concern. Unlike most development that focuses on the ***individual***, we target people as individuals within a functional ***group***. We format this group and we ensure it is functional. This process of achieving a functional group (a community health club) takes 6 months to a year, and within that time we can predict a high level of behaviour change. Why? - because people are social beings. Humans are predictable, we are herd animals. Our CHC model is a *recipe* which works if the right ingredients are used. And like every good model it can predict the outcomes, if the recipe is properly followed.

Let's go back to the ***concept*** of 'community'. Many development organisations take it for granted that the 'community' is functional. Sometimes we have a romantic image of rural living as being interdependent and communal, extended families all helping each other and looking after their old people - unlike our industrialized nuclear families in the West. In fact, there is seldom 'common unity' in a rural community and life is far from coordinated. When the community do get together, it tends to be for funerals or emergency handouts. Do men and women have a common vision? Do the young share the dreams of the older generation? Not at all. Think of Thomas Hardy's time in England a century ago and you understand what is happening in Africa now. Farmers coming to town to escape the poverty, the drudgery and the tedium of the rural areas. The old and disabled are left behind, and the wives. We should not take it for granted that communities are functional.

If we want our projects to work, we have to build up a functional community before we even start with our contributions. We have to build social capital, the invisible glue of trust and reciprocity that makes neighbours in a community thrive. We know

what makes most people, particularly women, happy. Singing, dancing, dressing up, and being together. Women love working together, doing projects together.

We asked the CHC members what is the difference between themselves and non members. They answered and I quote,

'There is a lot of quarrelling between non-members but CHC members are always busy, we are always doing something productive, improving our homes and our hygiene.'

Where did the idea of the CHC come from?

The inspiration is the Boy Scout movement. I saw how children enjoyed achieving the small challenges in the scout training and getting rewarded by a badge or a card ticked. I thought that we all like to tick the boxes, adults as well as children. It is a sense of achievement. The membership card provides the boxes to be ticked.

The membership card is the difference between our health promotion technique and others. We use it to give people have a sense of identity and belonging. They sign as CHC members not just to receive something material, but they accept a new way of life, a new set of *values* which they consider to be progressive. A CHC gathering is not so different from a Church group. We want to get people to appreciate the ***value*** of health and hygiene. All we offer is information and a chance to get together to discuss, no more. The trainers are from the village and all we do is empower them with the skills to facilitate a dialogue session, to enable the fellow villagers through participatory activities to debate health issues. They learn through their own experience and their peers. They take action together because together they decided what needed to be done. This is real community development, it comes from within, because values have been changed. It is a type of conversion, like a religious conversion. We all know the saying *'Cleanliness is next to Godliness'*. Well, a culture of clean living, and the expectation of good health is one which can be developed.

Remember: We offer no material incentives at all, no cement, no hand-outs, nor refreshments but only give a certificate for full attendance. Is this enough to get the crowds? Apparently it is. Of the 2000 or more CHCs we have started in the past 20 years, most CHCs have between 70 and 150 members. Our completion rate for the 20 sessions, which involves one meeting every week for six months varies from 60% to 99%.

As one women remarked, *'When I was born, I got a birth certificate. The next one I knew I would get was a death certificate. I expected nothing in between. However now I have another certificate. My husband and my children respect me for my knowledge. My in laws also see I am a good wife and a knowledgeable mother. I am not Nobody now!'* In Africa it means a lot to be acknowledged by the community.

I hear people muttering under their breath, *'Ah! but people don't change just because they have* ***knowledge****.'* This opinion is the influence of the recent counter-intuitive ideas of Social Marketing, which hold that people don't wash hands because they want to be healthy, but because they want to be smart. This may be true for the man in the street, and I emphasise 'man' because I think men are more concerned with prestige and status than women. Women learn for the right reasons, they are interested in knowledge because they want their children to thrive.

When women were asked; *'What do you like best about a community Health Club'* the most common reason the gave was, *'We need the knowledge!'* Once people have gone through a CHC training I can assure you they change for the right reasons. They want to be healthy.

True, 'Knowledge' is not enough to make everyone change, it is ***necessary*** but not ***sufficient***. Some more rationale people may change just if they know the facts, particularly if it affects the survival of their children. Others less pro-active, need to ***experience*** pain before they are convinced. You get HIV, you see a child die, you start to believe that what you have heard may be true. Seeing is believing. However you may still not have the *will power* or energy to take action. Perhaps you are lazy, or tired , or you don' t have the money or you have different priorities. All these things stop people adopting a new behaviour. Then there is the ***self-doubt***. A lot of women are used to deferring to their husband and can't make their own decisions. If they do, they get into trouble, so they wait until their husband is sober enough and even then he may not make an informed decision. These are the reasons that behaviour change does not always follow information. Uneducated people (and some very educated people) are wary of doing something new, they don't have the confidence to make an individual decision. They are risk adverse. The poorer the person, the less they can afford to take a risk - they wait and see. They hedge their bets in case the new technology doesn't work.

Our theory is that individuals need to ***know***, they need to experience to ***believe***, but this ***individual*** response particularly in Africa, needs to be reinforced by the ***group***. If there is group consensus on the values of the group then there will be change.

As Nyerere once said, *'In Africa we sit under a tree until we agree!'* The CHC provides that group peer pressure, but it is positive and helpful, never does it name and shame.

Behaviour change professionals are social engineers. If we want to change a community we should be more ***scientific*** in our efforts. We should not address the ***end*** of the process, and put a ***sticking plaster*** on the wound, we need to start at the beginning where the ***trigger*** for change lies. We need to change the core ***values***, then the ***norms*** (habits) will change automatically. The support from the peer group is what shifts people into action, particularly if it is the critical mass. People don't like to be difference. The term for this is 'fashion'. Everyone changes for difference reasons, some because they understand and some because they want to be the same as everyone else.

Community hea;lth clubs put women at the centre of development. Here is the story of one person: Mrs Toriro, who joined a health club, from a rural village in Zimbabwe. She listened and learnt and got her certificate. When it came to the next stage she volunteered to teach other women how to make clay pots for bee hives. She went up the ranks and became a district trainer. She build rooms onto her house and got all her childten educated through the sale of her produce. How many women like Mrs Toriro have been empowered by the values that the CHC had given, emboldened to take action, enabled to control their own health. CHCs can help the disabled and the infirm.

Nyasha had been crippled from birth and lived alone with his mother in abject poverty. However he is a tin smith. When our bee keeping project got going he was asked to make smokers. He made so many that he could build his mother a new house. This is the power of CHCs to help the disabled become empowered and respected. This is the power of CHCs to save children's lives, to prevent disease and make the rural areas as comfortable as urban homes. These are the kitchens of CHC members, they are works of art. A community Health club is a vehicle for change. Just like a steam train, once the CHC is functional it can drag any type of programme along. This is sustainable and integrated development.

Archbishop Desmond Tutu could have been describing the effect of a Community health Club when he explained the concept of Ubundu:

‘A person with Ubuntu is open and available to others, affirming of others, does not feel threatened that others are able and good, for he or she has a proper self-assurance that comes from knowing that he or she belongs in a greater whole and is diminished when others are humiliated or diminished, when others are tortured or oppressed.’

The conscience of the nation Nelson Mandela championed equal rights for women worldwide, saying, “As long as women are bound by poverty and as long as they are looked down upon, human rights will lack substance.” The CHC helps women work together and provides a means of organisation and empowerment so they are masters of their own health.

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