I am always filled with joy when I am at a gathering focusing on the community level in Africa. This is because after years of observation I have come to the conclusion that in Africa, if development doesn’t happen at the community level, it doesn’t happen; however loudly we may shout from our capital cities. And when it happens in the community, it then happens in the nation. I have reason to believe that if the last 50 years of post-independent Africa had focused on development with a community focus we would be far ahead of where we are. But better late than never! So thank you, USAID-funded Health Care Improvement project, for making this Regional Meeting happen!

Surprisingly, we still have skeptics regarding the community approach to health and development in Africa. Those who discourage the community-approach make a simplistic choice of either health care in facilities or in the communities! Yet specialists on the community-approach are not advocating for abandonment of health facilities but rather insisting that formal national health systems need to begin with the community level as the foundation of national health systems in order to provide a strong base on which to build the other levels of the health system. Taking the community as the foundation for the health system is particularly important for sub-Saharan Africa.

Why is the community particularly important in Africa: to promote universal access to health care. The large proportion of people living far away from health facilities can only get to health care through health services at the community level. For those close to facilities but kept away by socio-cultural barriers, the community approach becomes a bridge between the traditional and the modern and facilitates progress towards universal access. Through the community-approach, positive cultural practices can be identified and reinforced (e.g. breastfeeding) and thus build the self-confidence of the people in a continent that has suffered oppression and racial discrimination that undermines confidence. It also facilitates group adoption of new norms (e.g., small family size) that are hard to adopt as individuals as well as health-promotive practices through incorporation into life-styles at the individual, family and community levels.

In the 1970s, the Kenyan public health professionals recognized that the observer status of people in their communities perpetuated the continuation of community helplessness and continuing high burden of disease. This resulted in projects to explore Community-Based Health Care (CBHC) in Kibwezi (African Medical & Research Foundation - AMREF) and in Kakamega (M.K. Were) prior to and as a contribution to the Alma Ata Conference of 1978.

According to the experience in Ghana, the following is stated. “Despite a decade of trials of various strategies for achieving ‘Health for All’ in the 1980s, research demonstrated that in 1990
more than 70% of all Ghanaians still lived over 8 km from the nearest health care provider (Ministry of Health 1998) and rural infant mortality rates were double the corresponding urban rates. Improving access to health care delivery therefore remained a central goal of health sector reform.” This is what led Ghana to the establishment of the Community- Based Health Planning and Services (CHPS) in the late 1990s which is giving more impressive health outcomes than was the case before. A key factor in the success of involvement of people in their communities in sub-Saharan Africa is the fact that leading causes of illness and death in sub-Saharan Africa are preventable as shown in the following table.

**Leading causes of disease and death in the sub-Saharan Africa region are preventable.**

<table>
<thead>
<tr>
<th>Rank</th>
<th>0-4 years</th>
<th>5-14 years</th>
<th>15-29 years</th>
<th>All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Malaria</td>
<td>Lower respiratory infections</td>
<td>HIV/AIDS</td>
<td>HIV/AIDS</td>
</tr>
<tr>
<td>2</td>
<td>Lower respiratory infections</td>
<td>HIV/AIDS</td>
<td>Tuberculosis</td>
<td>Malaria</td>
</tr>
<tr>
<td>3</td>
<td>Diarrhoeal diseases</td>
<td>Road traffic crashes</td>
<td>Violence</td>
<td>Lower respiratory infections</td>
</tr>
<tr>
<td>4</td>
<td>Perinatal conditions</td>
<td>Measles</td>
<td>Lower respiratory infections</td>
<td>Dianrohal diseases</td>
</tr>
<tr>
<td>5</td>
<td>HIV/AIDS</td>
<td>Trypanosomiasis</td>
<td>Road traffic crashes</td>
<td>Perinatal conditions</td>
</tr>
</tbody>
</table>

The role of the Community Health Worker (CHW) is critical to this process. The trained CHW who is known to the community and accepted by them became the rallying point to provide health services that contribute to:

- Primary prevention of conditions so that the disease/condition doesn’t occur at all;
- Secondary prevention through prompt treatment/management best carried out close to where people live and to the level CHWs are trained;
- Prompt referral to health facility when the CHW cannot manage.

Thus community level health services can transform communities into centers of vibrant health with dramatically reduced disease burdens. The drastically reduced disease burden results in reduced load on health facilities and contributes to making them more effective in their roles. CHWs work best when communities support the CHWs in their roles.

**Support structures for the community health worker.** The following has been noted with respect to appropriate support to health services at the community level in Africa. Ghana notes that, “sustained community health committees for governing the community health service system”
has been essential for success. In DRC, “Communities participate through community management committees.” “Peer-based and community-based support of CHWs is also recommended. More senior CHWs can provide direct supervision or oversight at the community level, and community-based organizations or health committees can be engaged to provide oversight and review of CHW performance.” With reference to the ground-breaking Kakamega Project, carried out in the 1970s, it has been reported. “Community health committees (CHCs) were crucial for maintaining the momentum of community engagement.”

Referring to Kenya’s National Health System where community health services constitute the Level 1 in the health system, AMREF’s ongoing work notes, “The key drivers of health care services at Level 1 are the Community Health Workers (CHWs), Community Health Extension Workers (CHEWs) and Community Health Committees (CHCs).”

Kenya’s experience without and with community health committees (CHCs). Experiences without CHCs- From an evaluation in 2004 it was noted that the updated and refined policy framework (1994 – 2004) had not resulted in improvement of health indices. In fact, practically all the indices had deteriorated. Infant mortality rates, child mortality rates & maternal mortality rates had all increased. Therefore, the focus of the 2006 – 2010 Health Sector Strategic Plan was on REVERSING THE TRENDS. A new key feature of this plan was the introduction of the Community Health Strategy (CHS), with guidance from Kenya’s past experiences as well as experiences from elsewhere. The focus of the implementation from 2006 - 2010 was on CHWs and CHW supervisors, known as CHEWs, i.e. Community Health Extension Workers. Some community units had established CHCs on an ad hoc basis. There were no standardization criteria as a benchmark to monitor selection, training and performance.

An evaluation in 2010 supported by UNICEF pointed to significant improvement in community units where CHS was under implementation in comparison to those where it wasn’t. Analysis of these results brought out the observation that had CHWs worked in an environment with clear support, implementation of the community health strategy would have resulted in far greater positive changes e.g., in environmental sanitation. With support from MSH /USAID & under the leadership of Kenya’s Ministry of Public Health and Sanitation, a meeting for stakeholder analysis of the implementation of the community health strategy took place in early 2011. That meeting came to the conclusion that there was need to have a systematic approach to the establishment of community health committees.

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1 Health Policy and Planning 20(1): 25-34 The Ghana Community-based Health Planning and Services Initiative for scaling up service-delivery innovation: Frank K. Nyonator et al. pg. 26
2 Public Health Training in the Democratic Republic of Congo: A Case Study of the Kinshasa School of Public Health, Nancy Mock, Ph.D. et al. pg. 33
3 One Million Community Health Workers: Technical Task Force Report 2011 pg. 35
4 Ibid., pg. 35
5 African Medical and Research Foundation, Final Evaluation Report -Busia Child Survival Project (BCSP), Busia and Samia Districts, Kenya October 2005 – September 2010 supported by USAID/HIDN/CSHGP
Experiences with community health committees. The stakeholders meeting came to the following decisions: Overall responsibility of CHCs should be in the community unit. Leadership and governance oversight of community health services in each community unit was to be the responsibility of the community health committee. The roles and responsibilities of the CHCs were to:

- Provide leadership and governance oversight in the implementation of health activities and related matters in community health services at level 1;
- Prepare and present to the link Health Facility Committee (and to others as needed) the community Annual Operational Plan (AOP) on health related issues at level 1;
- Network with other sectors and developmental stakeholders to improve the access of the Community Unit (C.U.) to health services;
- Facilitate resource mobilization for implementing the community work plan and ensure accountability and transparency in the use of resources mobilized;
- Carry out basic human resources and financial management in the community;
- Plan, coordinate and mobilize the community to participate, along with themselves, in Community Dialogue Days and Community Health Action Days through social mobilization skills;
- Work closely with the link Facility Health Committee to improve the access of the CU to health services;
- Facilitate negotiations and conflict resolution among stakeholders at level one;
- Lead in advocacy, communication and social mobilization;
- Monitoring and evaluation of the community work plan including the work of the CHWs through established regular review meetings;
- Prepare quarterly reports on events in the CU;
- Hold quarterly consultative meetings with link Facility Health Committee (HFC).

The Competencies required of the CHC in order to fulfill the roles and responsibilities were:

- Effective leadership and management skills
- Communication skills
- Mobilization and management of resources
- Networking
- Report writing
- Record/book keeping
- Basic analysis and utilization of data
- Basic, planning, monitoring and evaluation skills.
- Performance Appraisal skills
- Conflict resolution Skills.
Curriculum for Community Health Committees (CHCs) and training manuals were to be developed to ensure that CHCs has these competencies.

Criteria /Eligibility for Membership in CHC. There should be 9-11 members in the community health committee selected on the following basis, ensuring an odd number of members in each CH committee:

1) Adult of sound mind and good standing in the community;
2) He/she should be a resident in the area;
3) Ability to read and write at least in one language: local or national;
4) Elected/selected from the sub location;
5) Demonstrated role model in positive health practices;
6) Demonstrated leadership qualities;
7) Representative of an interest group in the community e.g. village, women who should be at least 1/3 of the CHC, faith communities, youth, disabled. The CHC shall ensure equality of representatives among the villages without going beyond 11 members.
8) Demonstrated commitment to community service.

The supervisor of the CHEWs (Community Health Extension Worker) was to be secretary to the CHC and also have responsibility as technical adviser to the CHC. CHWs are to select from among themselves 2 CHWs to be on the CHCs.

Preparation for training CHCs. Taking into account the roles and responsibilities of CHCs, required competencies and the criteria for membership in the CHC as well as the agreed upon composition of CHCs, the planning process moved on to the preparation of the training documents. With continued technical and financial support from MSH /USAID and the involvement of partners involved in the implementation of the community health strategy in Kenya, a process was set in motion for the development of training materials as well as processes for preparing for the training events themselves. These processes went through a number of steps resulting in the production of the curriculum & draft trainers’ manual. These went through pilot testing and adjustment prior to the release of the trainers manual. These manuals are now in use.

In conclusion, abandoning the responsibility of improving the health of communities to CHWs is most likely to compromise the potential of the contribution of CHWs in transforming communities through health development. From the experiences of a number of countries in Africa, the presence of carefully established community health committees with overall responsibility for leadership and governance in community health services provides the enabling environment for the work of the CHWs.

Specifically, when the CHC takes on the responsibilities of looking after the relationships with the Link Health facility and the overall mobilization and engagement of the entire community, the energies of the CHW are targeted to home visiting, community case management activities
and using community forums provided by the CHC to advocate for improved health status. The CHW is then in a position to urge the community to forge ahead on specific issues. It is therefore crucial for the community to be clear on its roles in community health services and in supporting the work of the CHW.

Thank you for your kind attention.