



**Community Health for All**  
Case studies from around  
the world

May 2016

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**Cover photo:** Christine Parakuo (left), her son, and Elizabeth Ntunkosiois live in Sitoka, a remote Maasai village in Narok County, Kenya. Thanks to support from our partner Transmara Rural Development Programme, the villagers now have much better access to healthcare, including visits from a mobile clinic, an all-terrain ambulance and a new dispensary in the village centre.

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In Kenya, our partner Transmara Rural Development Programme is re-training traditional birth attendants (TBAs) to encourage them to take women to hospital to deliver their babies. Although the culture dictates that women give birth at home, too many women are dying unnecessarily due to complications that could easily be dealt with at hospital.

# Introduction

Poor and marginalised people are most vulnerable to the risk of ill health, and least able to face its costs and impacts. Ill health deprives people of their lives and livelihoods and affects the wellbeing of other household members. Good health is vital if individuals and societies are to thrive, because it enables people to participate actively in social, political and economic life.

One of Christian Aid's strategic change objectives is to secure rights to services essential to ensuring healthy lives, coping with emergencies and creating resilient livelihoods.

The Sustainable Development Goals (SDGs) position health as a key feature of human development and recognise that a healthy population makes a key contribution to all three dimensions of sustainable development – economic, social and environmental.

In the past, our health work mainly focused on HIV, supporting partners across Africa and South East Asia to promote safe sexual practices and enable access to critical services for people living with HIV, as well as tackling stigma and discrimination. This included partnering with faith networks to promote a holistic approach to HIV response.

Since 2011, we have built on the successes of our previous HIV work and adopted an integrated community health programme approach (see diagram below), incorporating a wider range of health issues including malaria, maternal and child health, sexual and reproductive health, and other integrated interventions that enable communities not only to be healthy but to thrive and be resilient to the threats and impacts of ill health.



## Our community health work is guided by a Community Health Framework, which sets out three dimensions of change.

- 1. Stronger, integrated community health services:** we ensure our health programmes are technically sound, accord to standards of good practice and meet the expressed needs and priorities of the people they are intended to serve.
- 2. Improved gender attitudes and changed social norms:** our community programmes should expose and address visible and invisible social norms that violate the rights of individuals, reinforce inequalities and exclusion, cause and exacerbate poor health, and prevent certain groups, such as women or minorities, from accessing health services. Examples include tackling HIV-related stigma, gender-based violence and female genital mutilation.
- 3. Accountable, inclusive and responsive health systems:** we ensure that institutions and health systems are accountable and responsive to citizens, that appropriate laws and policies are implemented and that there is an adequate and equitable supply of resources to support appropriate health development approaches.

We support health work that prioritises the right to essential services in Burundi, Ethiopia, Ghana, Kenya, Malawi, Nigeria, Sierra Leone and South Sudan in Africa; and in Myanmar in South East Asia. In Central America, a new Sexual and Reproductive Health and Rights (SRHR) programme has started in El Salvador, Guatemala, Honduras and Nicaragua. There is also a health component in many emergency responses, which also builds on our Community Health Framework and experience.

This collection of case studies seeks to capture our learning and experience working in collaboration with communities, our partners and other actors towards common goals in improving community health. These stories showcase different aspects of our approach, but together they are examples of how we are seeking to secure good health, through the three pillars of our integrated Community Health Framework.

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# Integrating health and resilience

Self-help groups and digital technology build resilience in Ethiopia and Kenya

**Good health is both essential to and an outcome of strengthened resilience as it enables people to participate actively in social, political and economic life.**

Through our programmes, we seek to identify and address factors that affect health, such as income, food security, nutrition and climate change, in order to build resilient and thriving communities.

## **Ethiopia: women's self-help groups**

Two of our partners in Ethiopia, Ethiopian Muslims' Relief and Development Association (EMRDA) and Women Support Association (WSA), are helping vulnerable women of reproductive age, including those living with HIV, to address challenges and risks to their health and livelihoods through self-help groups. These groups bring together women facing common challenges and give them information and skills to help them improve their health and their livelihoods.

EMRDA has supported four self-help groups for women with HIV in Mana and Sekoru districts. WSA is working with 200 groups as part of an European Union-funded sexual and reproductive health project in the southern region.

The groups are trained in self-help approaches, such as group management. They learn about the importance of saving, including maintaining proper records of cash transactions, and are then supported to establish and run a savings scheme that enables them to borrow money and invest in income-generating activities.



A self-help group session supported by WSA in Ethiopia. The women meet weekly and receive advice from a health extension worker who links them with a health facility.

**When Yetnayet Habte's husband died, she took on the responsibility of providing for her family, but didn't have enough money for everything they needed. She joined a self-help group called Bikiltu ('sun') and started saving a little each week. She took out a loan of 300 birr (£9.70), which she used to start selling fruit.**

'There is a ray of change and hope in my family,' Yetnayet says. 'We can now afford two meals per day. Last year, my son dropped out of school due to lack of uniform, books and food. This year I was able to purchase exercise books and pens for him and he returned to school. My daughter also started her education.

'I do not want to be dependent on others now. My self-help group and the EMRDA social worker taught me to be confident too. I was so shy in the past. Now I can speak in public without any fear. I think the future is bright for us.'



We have helped to set up SMS service projects on governance, health, climate and markets information delivery in Kenya. For example, people receive text messages informing them of local weather forecasts or sending them medical appointments.

As a primary objective of the groups is to address health challenges, each one is linked with a health extension worker who educates them on health issues, refers people to health facilities where necessary, and follows up to ensure they get the services they need.

With support from us and our partners, self-help group members engage in various income-generating activities using the loans. At weekly meetings, the groups are given information and take part in facilitated discussions on issues such as reproductive health, family planning, gender-based violence, harmful traditional practices and HIV. This has resulted in increased uptake of family planning services, including long-term contraceptive methods.

The self-help groups have also been platforms for addressing barriers to women's participation in decision making. As a result, one group member has been appointed as head of women's and children's affairs in her district. The groups have also strengthened cohesion among members. For instance, the women now work together to harvest each other's crops, which reduces individuals' workloads and saves them paying for labour.

### Kenya: digital solutions

In Kenya, maternal and child mortality rates are high. Only 58% of women giving birth have the recommended four or more antenatal appointments, and only 62% of births are assisted by a skilled professional, with significant disparities between urban and rural communities.

With technology partner Medic Mobile, we have invested in technology to help health workers and community health volunteers in marginalised areas to manage their caseload and plan for successful births.

Volunteers register pregnant women using text messages. The texts are sent to a web-based platform, which sends automated reminders to schedule antenatal appointments. Health facilities also receive the data and can use it to plan for the appointments. Nurses are able to track women who miss appointments and follow-up on any

issues that may be causing them to fail to seek antenatal support.

The system also shows expected dates of delivery, which helps health facilities to plan. It tracks high-risk pregnancies, enabling the health workers to follow up with the mothers as well as make necessary arrangements for managing the risks, including any emergency obstetric care that may be required.

Analysing data, especially on pregnancy-related emergencies, allows for targeted surveillance based on emerging patterns. With the number of pregnancies expected to increase, the mobile technology is helping to build resilience of the health system by enhancing the capacity to anticipate, plan for and successfully manage pregnancy-related risks. We have developed, tested and refined the system and transferred it to the government.

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Rachel Ivulila is a health facility manager in Machakos County, Kenya. 'Most pregnancy-related deaths, of which there are many, are related to lack of care,' she explains. 'I cannot afford to have a mother or baby die because they missed antenatal appointments. The new system tells me who missed an appointment and my job is to find out why.'

# Strengthening community healthcare

Supporting community health workers in Kenya, Ethiopia and Myanmar



Esther Wasonga gives life-saving health advice to a young woman expecting her first child. Esther was trained by our partner ADS-Nyanza to support people in Siaya country, Nyanza Province, the region with the highest HIV and malaria rates in Kenya.

**We work through our local partners, with communities and health authorities, to strengthen community-level health systems in order to improve the continuum of care and bring about lasting change to the wider health system.**

There is growing recognition that strengthening local health systems and increasing communities' partnerships with the formal health system can help to make access to health services more equitable, increase demand for and use of quality services, and make services more responsive to communities' needs and priorities.

Our approach includes coordinating our work with existing health systems rather than creating parallel

structures; building the capacity of communities to contribute to improved governance and accountability; strengthening referral systems and tapping into the structures already in place in the community, such as women's groups, faith leaders, traditional birth attendants and community development committees, to strengthen their engagement and capacity to collaborate with the formal health system.

## **Kenya: training community health actors**

In Kenya, our partners are working with communities, the Ministry of Health and other actors at county level to strengthen community-level health systems.

Across the regions where we support health programmes, we have:

- strengthened more than 120 primary healthcare units, centred around a local health facility
- trained more than 3,000 community health workers
- set up community health committees
- formed support groups for mothers
- helped 500 traditional birth attendants to change their roles to educating pregnant women and referring and accompanying them to deliver at health facilities.



**Annah Cheruyot is a former traditional birth attendant who has been trained to accompany mothers to the health facility and support them during labour and birth.**

'I have delivered many babies, I do not know how many, but we have equally lost many of them, which has been devastating for the families,' she says. 'I have learned that we can avoid many of the difficult experiences by delivering babies at the hospital. It is also absolutely right for husbands to allow their wives to regain their strength before they get pregnant again so that they are stronger at delivery. I am happy that, through God's grace, I have done my part to help save families at the hardest of times.'

This has improved demand and coverage of health services at community level – including malaria, HIV, and mother and child services, and preventative, promotional and curative health services.

In one of the projects, funded by the European Union, our work to reorient traditional birth attendants has more than tripled the number of births at health facilities over a period of 33 months.

### **Ethiopia: supporting health extension workers**

Under the UK aid-funded Programme Partnership Agreement programme, our partners Ethiopian Muslims' Relief and Development Association (EMRDA) and Amref Health Africa have worked with the Ministry of Health to strengthen the capacity of health office personnel and health extension workers to provide quality HIV, tuberculosis and malaria services in two districts in Oromia region. This has also enhanced their capacity in effective referral systems.

The programme has developed what it calls 'health development armies' – organised groups of women volunteers who complement the work of the health extension workers and help to strengthen

the engagement and leadership of community members in their own health. Each volunteer identifies five 'model' families who receive training, health education and mentoring from the volunteer until they are following good health practices and health-seeking behaviours. The women in the model households then identify and mentor five other households, creating a network of model families and mentoring networks. Throughout the process, the health extension workers provide monitoring, supervision, technical support and information materials to the volunteers.

Thanks to the volunteers, more people are seeking health advice and adopting new ways of living that are healthier.

**Amarech Shimelis has changed her attitudes to where she gives birth and how she raises her children as a result of the programme.**

'I used to give birth at home but now, due to the [advice of the] health extension worker, I give birth at the hospital,' she says. 'I breastfed my daughter up to six months and then I started on solid food. I want to have one more baby. Then it will be enough, because I don't have the capacity to raise more than three children.'

Health Extension Worker Zelalem Kitaw says: 'Due to the training provided, our services have become more effective. There were too many cases of maternal and child death but now they have been reduced.'

### **Myanmar: reaching remote communities**

In eastern and southeastern Myanmar, remote communities have historically been neglected by formal health services. A UK aid-funded emergency healthcare initiative supported community-level healthcare provision through its three implementation partners: Backpack Health Worker Team, Karen Baptist Convention (KBC) and Knowledge and Development for Nation-Building (KDN). By training, equipping and mentoring thousands of people to provide frontline health services, including mobile health workers, village health workers and traditional birth attendants, the project made basic primary healthcare services available at the community level.

Within three years, more than half of women in areas covered by KBC and two-thirds of women in KDN areas had attended at least four antenatal visits. Skilled birth attendance had doubled in KBC areas, and increased by more than half in KDN areas, while more than 40,000 children had accessed health services including vitamin A supplements and deworming tablets.



**Amarech Shimelis has been supported by our network of health extension workers and volunteers. Her children have been vaccinated and she gave birth in hospital.**

# Integrated community health programming

Addressing communities' overlapping needs in Kenya, Nigeria, Malawi, Ethiopia and Burundi

**Integrating services tackling various aspects of health, including different illnesses and conditions, and preventative and curative services, is at the centre of our community health work.**

Communities have multiple and often overlapping needs and health programmes should seek to address these needs through integrated approaches. We aim to see community health issues tackled holistically and from the communities' perspective.

## Building on HIV successes

Over the past four years, we have built on the successes of our HIV work to incorporate a wider range of health issues including malaria, tuberculosis, maternal and child health, sexual and reproductive health. We also support other interventions that enable communities not only to be healthy but to thrive and be resilient to the threats and impacts of ill health.

The UK aid Programme Partnership Agreement (PPA), funded by the British Government, runs from 2011-2016 and has played a key role in fostering integration of health issues across five countries (Kenya, Nigeria, Malawi, Ethiopia and Burundi), and has enabled more than 5 million people to access information and essential services related to a wide range of health issues.

In all the country programmes, we support primary care approaches to deliver a holistic package of preventative care, health education and referral for higher-level curative care.

## Challenges to greater integration

While we have increasingly adopted integrated programming, some major funding streams still focus on single health issues. Examples include the Global Fund Malaria Programme in Nigeria and maternal and child health

programmes in Kenya and Malawi, funded by the European Union, the UK Government and the Scottish Government.

Where this is the case, programming approaches are designed to support delivery of services in a way that is integrated as this will not only increase access to multiple related services, but will also support the strengthening of the wider health system. In Kenya for instance, the maternal and child health project has partnered with international NGO FHI 360 to integrate interventions



**A meeting of a support group for women living with HIV in Homa Bay, Kenya, which has the country's highest rates of HIV and malaria rates. The group is supported by our partner ADS-Nyanza and helps women to challenge stigma, encourage each other to 'live positively' with HIV, and seek treatment.**

for the prevention of mother-to-child transmission of HIV.

## Nigeria's 'fruit bowl' approach

In Nigeria, we use a 'fruit bowl' approach, with a menu of interventions that respond to a wide range of health priorities including malaria, HIV, maternal and child health, nutrition, family planning, and sanitation and hygiene.

We work with other organisations including the Marie Stopes International Organisation of Nigeria (on family planning services), Water Aid Nigeria (on improved sanitation and hygiene) and Vitamin Angels (on Vitamin A supplements and deworming for children under five). The programme is implemented through five local partners, in conjunction with the Ministry of Health.

We have reached more than 1.7 million people in three states (Benue, Edo and Plateau) and the Federal Capital Territory. There has been a marked improvement in communities' knowledge about preventative health practices, and health facilities have recorded a rise in the uptake of services.

Mary was one of the people to benefit. She explains: 'Since I've had a net I rarely get malaria, but before it was a regular problem. The community agents have helped teach me how to use the net: you must fold the mosquito net under the mat and sleep inside so the mosquitos cannot enter the net. They also taught me that if you have any sickness or a headache or fever to go to the clinic [for treatment].'

# Challenging HIV stigma

Changing attitudes in Myanmar, Nigeria and Ethiopia

**HIV-related stigma is one of the main barriers to HIV prevention, treatment, care and support. Concerns about facing discrimination or violence from families, communities and workplaces can prevent people from seeking information, getting tested, or adopting safer behaviours for fear of raising suspicions.**

Stigma also acts as a barrier stopping people disclosing positive status. If people are afraid to say they are HIV positive, they are less likely to seek psychosocial support and treatment and keep to treatment regimens.

Misconception and unaddressed public fears about HIV may lead to those who have disclosed their status facing prejudice, rejection, abuse and exclusion, impacting negatively on their social and economic lives. They may also experience poor treatment when trying to access basic services, such as health and education. Overall, stigma undermines the ability of individuals and communities to protect themselves from infection, or to remain healthy if they are already living with HIV.

We have been working with our partners to challenge discrimination and promote care and support across communities, through a variety of approaches.

## **Myanmar: Positive Living Centres**

In Myanmar, in collaboration with our local partner Metta Development Foundation, we have established two Positive Living Centres. These drop-in centres aim to create a safe space for people living with HIV (PLH), and support them to live healthy and positive lives to both protect themselves and help to protect the wider community from HIV.



**Galaw Bawn Hkaw receives support from the Positive Living Centre where he now volunteers, educating people about HIV. 'I'd like to be a role model for others,' he says.**

The centres are run by HIV-positive staff who have received training and act as role models to other HIV-positive people, encouraging them to adhere to treatment routines and to reach out to others in the community.

The centres strengthen PLH networks and groups of PLH, supply resources to support information, education and communication to increase awareness around HIV, provide social and peer support services to build strong links within communities, and work with local authorities and healthcare providers to advocate for healthcare budget and support. They also provide counselling, health education training, nutritional and livelihood support, and children's summer camps.

A review of the project carried out in 2015 found that the centres had increased the involvement of PLH in community activities and in decisions that affect them, and had raised their confidence and reduced the stigma and discrimination they faced. Events run by the centres in partnership with communities for people both with and without HIV had helped strengthen relationships and contributed to the breaking down of stereotypes. PLH are now more likely to be included in social events, such as weddings and birthday celebrations. There was also significantly improved access to treatment and care services for PLH.

**Ah-Yaw, a young man living with HIV in Myanmar, has received support through a Positive Living Centre.**

'I started getting ill and lost a lot of weight. A friend took me to the Positive Living Centre. That's when I found out about HIV and decided to get a blood test for HIV. That was six years ago.

'When they found out about my status, most of my friends started discriminating against me and stigmatising me. I became so depressed. Then I made new friends from the centre. They give me counselling, health education and encouragement that made me stronger. I have learned many things by attending trainings.

'I now participate regularly in peer group meetings and enjoy the activities we do together. I am also serving as a peer volunteer.

'I feel like I live in a very caring environment. My friends from before have also come to understand me and treat me very well like before, because they also receive support from the centre.'



**In Nigeria, Bridget Anyagaligbo bought 10 chickens with a loan from a local savings group. She is now able to earn extra money selling eggs.**

**Nigeria: People Living Positively**

In Nigeria, we have supported the People Living Positively – South to South Learning project to increase access to quality care and support services for PLH and their families in collaboration with healthcare providers. The project has also sought to improve HIV-affected households' economic security through establishing savings and loans associations (SLAs); reduce HIV-related stigma, discrimination and denial through a rights-based approach; and strengthen organisations led by or representing people living with HIV.

At first, communities were suspicious of the SLAs, seeing them as a group for PLH only, which seemed to reinforce stigma and discrimination. Following sustained awareness-raising activities, and seeing the successful enterprises being implemented by members, increasing numbers of people without HIV have sought to become part of the groups, breaking down some of the barriers and reducing stigma. The associations have both economically empowered PLH, enabling them to buy the food and medications they need, and strengthened relationships between people with and without HIV in the community, supporting PLH to be treated equally.



**In Ethiopia, mothers living with HIV and HIV-positive mentors meet regularly to support each other to live a full life and help tackle stigma.**

**Ethiopia: tackling stigma and discrimination**

In Ethiopia, we are working with the government and national partner NGOs to tackle issues of HIV stigma, discrimination and denial. Through awareness raising and the use of trained advocates, we are helping to create spaces for discussions and HIV education, and support PLH to live a normal life by linking them to support groups and counselling. The project also links with local police forces, using volunteer advocates to deliver testimonies at community policing forums to build understanding of HIV, and supports police to take active roles in addressing cases of violence against PLH.

Across these programmes, our efforts and those of our partners have helped to reduce significantly HIV stigma, denial, discrimination and inaction. Over the years, our work has evolved to tackle other types of stigma and discrimination that affect people's ability to enjoy good health, for example around family planning issues. Learning around tackling HIV stigma has informed our approach, which seeks to identify, understand and respond to social norms that act as barriers to accessing health services.

# Tackling gender-based violence

Changing the rules of behaviour in Kenya



Community Health Worker Mary (far right) shares stories with traditional birth attendants (TBAs) in a Maasai community in Narok South, Kenya. TBAs assist women to give birth at home, often with dire health consequences, including performing FGM. With support from our programme, the Maasai Council of Elders now opposes harmful traditional practices, such as FGM.

**Gender-based violence is a pervasive global issue, taking many forms, and associated with entrenched social norms and attitudes that value men and boys over women and girls.**

Violence can have multiple and long-lasting negative effects, not just from initial physical injuries, but also reproductive and other long-term health issues, increased vulnerability to HIV and other sexually transmitted infections, psychological trauma, and subsequent behavioural problems.

Women are at increased risk of experiencing violence if they live in communities where violence and discrimination against women are considered socially acceptable. Our approach is to tackle one of the root causes of gender-based violence – the imbalance of power between men and women.

In Kenya, we and our local partners Coalition on Violence Against Women (COVAW) and Centre for Rights Education and Awareness for Women (CREAW) are using SASA! – an innovative internationally recognised model of community mobilisation

developed by activists in Uganda – to tackle violence against women and its associated health impacts.

SASA! (Start, Awareness, Support, Action) creates understanding of the connections between a lack of power and the rules of behaviour that are considered acceptable in a society. The approach avoids focusing on blame and instead encourages community members to think about the positive effects of balancing power relationships between men and women. ‘Sasa’ is Swahili for ‘now’ and SASA! aims to generate discussion that leads to immediate local-level action.

Our programme has held a series of community dialogue meetings where... men and women are supported to recognise their own powers and their ability to use that power to tackle violence and discrimination.

Using the SASA! model, our programme has held a series of community dialogue meetings where, through guided discussions, men and women are supported to recognise their own powers and their ability to use that power to tackle violence and discrimination.

While the programme originally intended to focus on female community activists, findings from the baseline gender and power analysis led the programme to be adapted to include men as gender advocates and activists. A number of men have been trained in the SASA! approach alongside female advocates and are now themselves facilitating the community dialogues.

The programme has engaged with a wide range of community stakeholders, including women, men, religious and traditional leaders, the media, the police and healthcare providers,

helping them to use their influence to tackle acceptability of violence and to advocate for the implementation of policies that protect women's rights. The programme also works with local health facilities and paralegals to establish systems for appropriately identifying, documenting, treating and referring victims of sexual violence.

Initially, the programme faced challenges, including resistance to changing deeply rooted cultural traditions, such as female genital mutilation (FGM) and forced marriage; sexual and reproductive health issues being seen as 'only a women's issue'; and taboos against women participating in formal decision-making spaces.

Now the SASA! model is proving to be effective in helping to change attitudes and negative social norms, and the programme is having a positive effect on women's health and wellbeing. Key successes to date have included:

- the Maasai Council of Elders openly committing to oppose harmful traditional practices including early and forced marriages, FGM and wife battering
- establishment of a gender-based sexual violence technical working group at county and sub-county levels to improve coordination between stakeholders in health, psychosocial (practical, emotional and social) support, the police and the judiciary
- a 50% rise in cases of gender-based violence being reported by communities increasingly aware of their rights and the harmful effects of violence
- increased capacity of medical and legal workers to manage cases with sensitivity.

**As the only female chief in her area in Narok County, Kenya, Silvia Naisuako has faced many challenges, including resistance from both men and women.**

She received training on the SASA! model and learned how change in the community could be brought about by creating awareness and supporting behaviour change. She has become known for championing matters using the SASA! approach on issues such as domestic violence, involvement of women in decision making and the eradication of FGM.

'People could not accept a woman leader. At first I had to use force and arrests to affirm my authority. Participating in the SASA! training equipped me with skills and empowered me to empower other women. The training helped me realise the importance of using participatory approaches to preventing violence against women and to challenge norms that justify violence and men's power over women.'

Our programme is continuing to mobilise communities to identify their own responses to gender-based violence and to work with the technical working groups and other actors to establish a survivor protection plan for victims of violence. Learning from this programme has led to the SASA! model being replicated in other areas of Kenya and in Malawi.



**Lucy Sekento went through FGM as a girl. Now a teacher in a Maasai village in Narok County, Kenya, she has talked openly about her experience and the traditional Maasai attitudes towards the practice.**

# Working with faith leaders

Promoting behaviour change through faith leaders in Burundi and Sierra Leone



Pastor Tharcisse Harerimana is a member of BUNERELA+ . Supported by Christian Aid, this network of HIV-positive religious leaders challenges ignorance and stigma about the virus.

**Faith leaders are uniquely positioned to contribute towards efforts to tackle damaging social attitudes and behaviours, particularly in communities where the majority of people are believers.**

Faith leaders are often highly respected, trusted and well-known members of their communities, able to rally people to work for a common goal. Not only are they influential in guiding the direction of thought on cultural and social norms and practices, religious institutions often play a role in delivery of health services to underserved populations.

We recognise the role of faith leaders in influencing decision making around social norms, and in particular in challenging harmful cultural norms and supporting men and women to make healthier choices for themselves and their families and communities.

## **Burundi: engaging religious leaders**

In Burundi we have been working with faith leaders to implement innovative faith approaches, such as SAVE (Safer practices, Access to treatment, Voluntary counselling and testing, Empowerment) and Tamar, to challenge social norms that negatively impact on health.

'Tamar' is an approach developed in South Africa that uses biblical references as a starting point to address gender-based violence, particularly sexual violence against women and girls. Working with BUNERELA+ (Burundi Network of Religious Leaders living with or personally affected by AIDS), we also support the SAVE approach, in which HIV-positive religious leaders, from various faiths, challenge ignorance around the virus and use their influence to encourage greater openness and understanding, while also promoting good practices, such as HIV testing. In both approaches, faith leaders are trained and supported to develop and

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‘Because people trust them, when they started participating in the revised burial practices, people knew they could trust it and resistance ended. The participation of religious leaders was a game changer.’

**UN staff member, Sierra Leone**

implement action plans, integrating key themes into their daily work to tackle stigma, discrimination and violence.

The success of partnering with faith leaders on these approaches, and the strength of relationships built with interfaith networks, have enabled us to build on this approach and broaden the focus to include other health issues where cultural beliefs and values create barriers to the use of health services, such as family planning.

In Burundi, there is a very high maternal and child mortality rate. One of the key factors is a high fertility rate, prompted by low use of contraceptives. Research carried out in 2015 found that religious factors were significantly influencing people’s decisions not to use contraceptives because they were concerned over perceived potential condemnation or social exclusion from faith groups if they used family planning services.

In January 2016, we launched a new programme in Burundi that aims to engage religious leaders in promoting family planning. The programme is partnering with a network of Anglican, Catholic, Pentecostal and Muslim leaders to harmonise messages on family planning. The programme works with faith leaders to build their understanding and develop effective messaging that allows them to use their position to educate and support their congregations to exercise choice in this area.

### **Sierra Leone: key role of faith leaders in the Ebola response**

In Sierra Leone, faith leaders played a key role in the response to the outbreak of Ebola in 2014. Before the epidemic, we were already working with faith leaders to champion women’s empowerment and had established a network of leaders shortly before the Ebola outbreak was confirmed. This proved to be invaluable in contributing to the Ebola response.

Faith leaders undertook critical roles, including:

- conducting modified religious practices and promoting safe burial and good hygiene
- addressing widespread stigma that arose against Ebola survivors by communicating culturally relevant and accurate messages about the disease, together with religious messages about compassion and acceptance, particularly targeting communities who had received Ebola survivors
- participating in community-based teams who publically ‘welcomed’ Ebola survivors back into their villages
- engaging in anti-stigma activities, such as monitoring and reporting cases of stigmatisation, engaging local authorities and community stakeholders on issues of stigma, and participating in radio debates and discussions around stigma



**In Sierra Leone, faith leader Sheikh Kamara educated his community about the Ebola epidemic and explained how they could help stem the spread of the disease.**

- providing ongoing psychosocial (practical, emotional and social) support during and after the outbreak to individuals and families affected by Ebola.

The role they played in the Ebola response in Sierra Leone is not just evidence of the influence faith leaders can have as behaviour change agents; it also highlights the role they can play in wider resilience work and in strengthening the health and wellbeing of their communities. Along with our partners, we are continuing to build on this with ongoing dialogue and coordination of wider health, gender and social norms work.

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‘Who is better placed than the church to take on this work? We are trusted by the population and we are scattered everywhere; especially in the villages. If we use the network of churches, the message passes very quickly.’

**Bishop Martin Blaise Nyaboho, Diocese of Makamba, Burundi**

Quotes on this page taken from *Keeping the Faith: the role of faith leaders in Ebola response*, Cafod, Christian Aid, Islamic Relief and Tearfund, July 2015, christianaid.org.uk/Images/keeping-the-faith-july-2015.pdf



# Community health governance

Empowering communities to have a voice in Nigeria, Malawi and Kenya



Women in a remote Maasai village in Narok County, Kenya, celebrate the opening of a dispensary in their village.

**In Nigeria, Malawi and Kenya, our health programme has offered people practical ways to challenge systems that perpetuate inequalities.**

We develop ways for community members to participate in decisions over budget allocations. We support community health units and encourage people to use the services they offer. We test new approaches to healthcare, then influence the local government to invest in what works. We also bring government officials, community representatives and religious leaders together to plan healthcare.

We have introduced social accountability mechanisms to make sure that communities can play a part in audits of health projects and resource allocation. Communities are now able to monitor resource use and use their findings to lobby for improved services.

## **Nigeria: communities set their own agenda**

In Nigeria, we've supported Community Development Committees to teach people about their rights and empower them to engage with local authorities to demand quality health services.

The committees were trained and supported to develop a Community Health Agenda, a list of priorities identified by all stakeholder groups. Our partners also seek to influence state and local government bodies on the planning and resourcing of primary healthcare services.

## **Malawi: scoring local services**

In Malawi, our 'community scorecard' approach enables communities to assess health service providers, rating their services and performance using a grading system. Issues that communities identified as needing improvement using the scorecard approach include poor sanitation and hygiene in health facilities. Area Development Committees responded by providing temporary sanitary facilities: for example, bathrooms were provided at Nyungwe Health Centre, while community members were encouraged to contribute bricks, sand and labour towards the construction of permanent bathrooms and toilets.

## **Kenya: community members track resource use**

In Kenya, our partner the National Council of Churches of Kenya has supported communities to engage their leaders and local government. Community members use simplified tools to track resource use and gather evidence to influence prioritisation of health service allocations from government funds designed to support local-level development and Ministry of Health projects.

**In Sitoka, a Maasai village in Narok County, Kenya, they are celebrating the opening of a new dispensary.** The roads are nearly non-existent so having a dispensary in the village will transform their lives. To access even basic healthcare before, villagers needed to hire vehicles to travel to either Loggarian or Kilgoris hospitals, which was costly and took a long time.

Chief Kaka and some of the village elders, with support from our partner Transmara Rural Development Programme (TRDP), visited the governor to put pressure on him to get a nurse for the clinic and to get better health service for the community. After years of work, the dispensary is now open.

Tom Opee is field worker for TRDP and has worked with the community in Sitoka for 11 years. During that time he has seen a big shift in the community: rather than waiting to be given something they are now empowered to demand their rights.

'When we first came, people were tied to their culture and very resistant [to change]. We worked with local pastors and community leaders to get health messages across. We would visit people's homes and talk to them. We would keep going back until we got the message across.

'The change in this time has been tremendous. There is now demand from the communities for health care. [They] mobilise their own resources to come up with the structures, such as the dispensary at Sitoka.'

# Improving maternal health service delivery

Encouraging people to hold leaders to account in Ghana



Mothers from Savelugu community, a small farming community in northern Ghana, the poorest part of the country with the worst maternal health care. The community is one of many being supported by our outreach work, including informing mothers about the importance of giving birth in a health facility rather than at home. Successful community-led advocacy efforts have also led to the government increasing the number of midwives posted to rural communities, and new resources for maternity wards.

**We believe that every mother should be able to give birth safely with the medical care she needs.**

## Improving accountability

With our partner SEND Ghana, we are implementing a three-year initiative called IMPROVE: Improving maternal health service delivery through participatory governance. The project is running in 30 districts across the three northern regions of Ghana (Upper

East, Upper West and Northern), with funding support from the European Union. IMPROVE aims to contribute to reducing maternal mortality and morbidity by supporting citizens to monitor government financial allocations and spending on maternal health, to observe the quality and effectiveness of service delivery, and to demand transparency and accountability. The main goal is that citizens in the districts are effectively holding the government

to account, leading to improved accountability, responsiveness and service delivery in the area of maternal health by the end of 2016.

The project also aims to support citizens to engage in regular and successful interactions with Metropolitan, Municipal and District Assemblies (MMDAs), and uses the media to get people's voices heard effectively and to share lessons learned.

## Focus on taxation

One of the key project activities is sensitising selected District Citizens' Monitoring Committees (DCMCs) across the three regions on taxation and how tax revenue can support the provision or improvement of quality maternal health care.

Through training sessions, the participants become more aware about maternal health issues, people's rights to free healthcare, the National Health Insurance Scheme, and available services.

The sessions encourage citizens to demand more transparency and accountability from public duty bearers. And, at the same time, they remind participants of their responsibilities to pay taxes in order to play their part in mobilising revenue so that local government bodies can continue to improve health services.

## Communities empowered

Since the project started and as a result of the training sessions, community members are now empowered and agreed to form a Community Health Committee in each area to monitor and demand accountability from the district assembly with regard to how revenues are spent.

For example, as a result of these activities, one district assembly asked Christian Aid and SEND Ghana to support them to design a database to help them to identify and track the number of taxpayers and their professions in the district, which would in turn enable them to better forecast how much revenue could be generated.

Following the training events, DCMCs carried out a budget-tracking project looking into investment in and spending by the health system. The final report, *Making Safe Motherhood a Reality: the issue of financing*, revealed that:

- though there was marginal growth in the health budget from 2011 to 2013, the total allocations fell below the Abuja Declaration target of at least 15% of the country's annual budget and were largely spent on salaries
- financial flows to the District Health Management Teams (DHMTs) and health facilities were observed to be erratic. Many DHMTs hardly received their quarterly allocations and did not know when the funds would be disbursed
- doctor-to-population ratios in the three regions ranged from 1:22,894 to 1:53,064 – well below the WHO recommended standards of 1:600.

The report recommended that the government systematically increase budget allocations to the health sector, in line with the Abuja Declaration, and train more doctors and midwives for posting to deprived areas.

There is growing evidence that some MMDAs are using data from project community durbars (meetings) and the budget-tracking survey to make decisions. The Tolon and West Gonja DHMTs and Savelugu Nanton municipal assembly have carried out community durbars on maternal health and have invested in facilities including a maternity ward at Savelugu hospital, community-based health compounds and motorbikes for the Municipal Health Management Team, for example.

With SEND Ghana we are now training 30 DCMCs in the use of budget-tracking tools to enable them to collect and analyse revenue and expenditure data for sharing with citizens.

**Michael Awaana is the coordinator for his DCMC, working with local NGO Sustainable Integrated Development Services Centre (SIDSEC).** He has taken part in one of the tax training sessions and is now sharing his new knowledge with other DCMC members so they can give accurate information to the wider community.

'This training has enhanced my knowledge,' Michael explains. 'It was very practical and I learned how to relate the importance of tax revenue to development, in this case to maternal health.'

Michael led a training exercise in Naro community in the Upper West region, with the assembly member and other key leaders taking part. Men and women both contributed and shared their views and experiences. The discussions led people to start to ask questions about how their collected taxes were being used. Even though the assembly member gave some information, it became obvious that there is a need for more interaction between community members and the district assembly.

# Empowering communities

## How a community-monitoring project adapted to the Ebola crisis in Sierra Leone

**When the deadly Ebola outbreak spread through West Africa in 2014, it had a devastating impact on people's lives and livelihoods.**

Ebola disrupted many development projects, including the accountable health service delivery project that our partner Network Movement for Justice and Development (NMJD) was running in Kono District in Sierra Leone's Eastern Province.

### **Community health-monitoring volunteer groups**

Before the outbreak, NMJD had set up 10 community health monitoring volunteer groups, each composed of

five women and four men, across five chiefdoms, to demand better health services and support the operation of existing health facilities.

NMJD organised several training and mentoring sessions, and clear strategies and action points were set for each group. Several sessions were required before the groups fully understood the issues surrounding poor health service delivery and the strategies they could employ to drive change.

The volunteers collected data on daily attendance, immunisations, births and deaths at public health units (PHUs)

and specifically whether women and children were attending the women and children's clinics. They told communities about their rights and entitlement to free health care, and they worked on community development projects.

### **Responding to a changing context**

As the Ebola epidemic escalated, the groups were already working in their communities and so were well positioned to contribute to the Ebola response. NMJD therefore revised the project to focus on breaking the chain of transmission of the disease.



Women wash their hands at a mobile health clinic in Freetown, Sierra Leone. Since the Ebola epidemic in 2014, hand washing is a vital part of daily life now, to prevent transmission of disease.



**Members of NMJD's Youth Against AIDS club were trained to raise awareness about HIV, and answer questions in their communities. During the Ebola outbreak, many of them used their training to disseminate messages to prevent Ebola transmission.**

The groups were trained in Ebola prevention, control and risks to ensure that volunteers gave out the correct information and stayed safe themselves. They were also given crash courses in how to raise awareness about the disease.

Volunteers began going door to door and taking part in radio discussion programmes, talking about how to prevent transmission of Ebola. They carried out advocacy for more treatment, holding centres and logistics, and promoted the accountable use of resources mobilised for responding to Ebola. They encouraged the media to engage duty bearers and to provide information to the public; and they monitored the entire Ebola response programme in Kono District.

As the epidemic worsened, three additional community health monitoring volunteer groups were formed in two new chiefdoms. Some group members were placed directly in structures set up at the local level to combat the spread of the epidemic.

### Winning acceptance

Some health officials working in the district were initially reluctant to accept the community health monitoring groups, which they saw as an extra layer of bureaucracy. With NMJD, we worked to win the acceptance of the District Health Management Team (DHMT) and other officials for the

groups. Initially, it took six months to establish the groups, but the DHMT soon embraced them and it only took a few weeks to establish the additional three groups during the Ebola crisis.

### Major success

Residents in the targeted chiefdoms are now fully aware of the risks, prevention and control of Ebola and apply the preventative methods – a major success for the volunteer groups.

By March 2015, there were 8,383 confirmed cases of Ebola in Sierra Leone, including 253 cases in Kono District. But only one out of the 13 targeted communities was reported to have had a confirmed case.

### Lessons learned

In dealing with large-scale epidemics such as Ebola, public health advocacy is essential in ensuring public support for and adherence to by-laws and health advice. The role of local communities is particularly critical in monitoring change in both practice and behaviours.

In governance programmes, it is very useful to ensure that local communities are part of the change process and their capacity is built, especially for sustainability. Building local people's capacity not only allows them to play a useful role in the project for which they are trained, it will also enable them to deal with unforeseen issues that

**Esther Ellie, Chair of the community health monitoring volunteer group for Bayama PHU, and her team brought about real improvements in the lives of poor and marginalised people in Tankoro Chiefdom.**

'Before the project, we in this community did not think that we had a role to play in the health services delivered to us by the PHU,' Esther explains. 'The project has taught us to understand that we do not have to wait for the central government all the time. We need to do something on our own.'

The group succeeded in rehabilitating their PHU and getting 24-hour electricity, a nurse, a dispenser and vaccinator. 'I have learned that people can do things for themselves,' Esther says. 'We now support our nurse, and we have been able to furnish our PHU with electricity, new beds, new doors and additional staff.'

Esther's achievement is all the more significant as she emerged as a leader in a traditionally patriarchal environment.

may emerge. The community health monitoring volunteer groups were able to engage successfully on Ebola issues because of their prior involvement in monitoring health service delivery.<sup>1</sup>

Initially, misconceptions on Ebola held by various communities affected awareness-raising efforts. The use of local volunteers to spearhead community awareness campaigns and address knowledge gaps was crucial in the fight against the epidemic. The involvement of community volunteers, particularly women, in health governance in their district allowed them to understand their role in the development process and served as an impetus for them to accept ownership of and responsibility for health service delivery.



An HIV- positive mother and her HIV- free child in Ethiopia. Thanks to support groups and mentors, HIV-positive women learn how to prevent HIV transmission to their babies.



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