The First Mile: The Potential for Community-Based Health Cooperatives in Developing Countries

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Summary

This post, a slightly revised version of a document written in 2011, presents a model for community-based health cooperatives in Sub-Saharan Africa that is based to a large extent on a

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successful community health mobilization program in Kenya.[2] The paper briefly reviews the persistence of serious health problems on the subcontinent and then presents the cooperative model as an effective means to address health and health-delivery issues in the region. The paper concludes by calling for broader application of the cooperative health model and for rigorous research to document changes in health and mortality indicators in communities served by these cooperatives.

Introduction: The First Mile

By mobilizing community residents to take the lead role in their own health planning and service provision, community-based health cooperatives in Sub-Saharan Africa have the potential to play a critical role in improving health conditions on the subcontinent.

Among international donors and health providers, a widely acknowledged frustration is the difficulty of getting assistance to rural communities that are often the most in need of health services.[3] This gap is sometimes referred to as the "last-mile" problem. From the village perspective, this same mile is the "first mile" toward accessing health services. This paper proposes that community health cooperatives provide a means for villagers themselves to define their priority health needs and to play the lead role in addressing them. These co-ops have the potential to bridge the "last-mile" gap by creating a "first-mile" capability at the village level to take care of basic health problems and to reach out to the health-delivery system when greater assistance is needed.

Dire Health Statistics a Symptom, Not a Cause

The horrendous statistics related to child, maternal, and adult mortality are **symptoms** of Sub-Saharan Africa's health problems**. The underlying problems are health-delivery systems** that don't reach the large majority of the subcontinent's residents. It is important to look at the full context of health-care delivery in the region in order to develop effective strategies for making improvements.

- **Grim health data.** There is no question that, on average, the almost 50 countries of Sub-Saharan Africa, with a combined population of over 800 million people, have the worst

[2] The program was carried out over a 10 period from 2001 to 2012 by CLUSA, a division of the US-based National Cooperative Business Association (NCBA), and funded by the US Agency for International Development. CLUSA stands for Cooperative League of the USA, and is the previous name for NCBA.
[3] For example, International Conference on Global Health, 2008: http://www.globalhealth.org/conference/view_top.php3?id=845;
USAID Deliver Project: http://deliver.jsi.com/dhome/topics/supplychain/lastmile

health problems of all the regions of the world.[4] As an example, over 150 million children in the region under the age of five died between 1970 and 2010.[5] This number is only slightly less than the death toll of all of the wars of the 20th century.[6]

- **Availability of simple, inexpensive interventions.** The large majority of children's deaths and premature adult deaths in Sub-Saharan Africa are preventable by relatively simple and inexpensive interventions.[7] [8] [9]

- **A flawed health-delivery model.** It would be a mistake to attribute the failure to adequately apply these simple and inexpensive interventions in the region to the following factors: poverty; a largely rural population; a shortage of health care providers; unstable, often corrupt governments; and insufficient and, sometimes, ineffectively allocated international health assistance. These factors certainly present obstacles to rapidly improving health conditions on the subcontinent, but they are not the underlying problem, which is **the lack of health-delivery systems that reach down to the local level**.

The Community-Based Health Cooperative Model

How can health services be delivered to villagers dispersed across the countryside?[10]

This is where the community health cooperative model comes into play. The model takes a comprehensive, village-by-village approach to health problems and solutions. It focuses on the part of the population that the current system is least equipped to serve. And it mobilizes community residents to take the lead role in their own health planning and service provision.

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[4] **The Millennium Development Goals Report**, 2010, United Nations, June 15, 2010. http://data.un.org/.

[5] Unpublished infant mortality data sheet, Institute for Health Metrics and Evaluation, University of Washington, email communication, September 2010.

[6] Estimates of war deaths in the 20th century vary. However, many are in the range of 160-200 million. http://www.scaruffi.com/politics/massacre.html; http://users.erols.com/mwhite28/warstat8.htm

[7] Jones, Gareth et al (2005) "How many child deaths can we prevent this year?" **Lancet**.

[8] "Healthy women, better world," UNICEF, June 2010: http://www.unicef.org/maternalhealth/index_554.htm.

[9] Op. cit., **Millennium Development Goals Report 2010.**

[10] The author hypothesizes that the community-based health cooperative model would also be effective in poor urban neighborhoods. However, because the Kenya program on which this model is based is a rural one, the focus of this paper is on the application of the model in rural areas.

The model does not assume that village organizations can solve all of their health problems by themselves. Village health co-ops would need to work with public and private health providers. They would need health education as well as services and pharmaceutical supplies from outside the local community. However, the biggest gap in current health-delivery systems – between health providers and residents of rural communities – would be bridged by villagers meeting their own basic health education and service needs and, when appropriate, by seeking health services from outside the community in an organized manner, instead of relying on an understaffed and underfunded health system to reach out to them.

The CLUSA example in Kenya

In 2001, CLUSA, the international program of the National Cooperative Business Association, began providing community health-mobilization services in rural Kenya. Since its first project began in western Kenya, CLUSA has assisted over 2,000 communities to form village, multi-village, women's, and youth-based health associations, and to develop and implement community health plans. CLUSA has also trained over 4,000 village-based community health workers. Altogether, more than one million community residents in Kenya have benefited from this program.[111]

The key features of CLUSA's community health-mobilization model are summarized below.

- **Efficient organizational structure.** There is a small core and intermediate-level staff, and a large number of village-based health workers. For example, in the Western Province project studied by the author, there were three provincial-level staff, six field facilitators, 38 volunteer lead community health workers, and 1,520 volunteer community health workers who provided training and support services to almost 800 village and multi-village organizations.[12]
- **Systematic development process.** The program has a clear step-by-step process for selecting local staff and volunteers, training them, organizing village and multi-village organizations, assisting in the development of village health plans, and supporting their implementation.

[11] At the present time, these associations are not legally structured as cooperatives. However, they generally operate under the same principles as co-ops: voluntary and open membership, democratic member control, member economic participation, autonomy and independence, education and training, cooperation with other health associations, and concern for community.

[12] Nadeau, E.G. (2008) "Synopsis of Community Health Mobilization Research in the Western Province of Kenya," unpublished report prepared for CLUSA

- **Low cost per village.** The cost of the program is very low – well under $100 per village per year in the case of Western Province.[13]
- **Rapid mobilization.** A large number of villages can become active participants in the program in a short period of time.
- **Village-led approach.** The decision of whether or not to participate in the program is made in village-wide meetings.
- **Autonomous and democratically run local organizations.** The village-level health organizations are established and democratically controlled by community residents.
- **Village-based, volunteer, community health workers.** Each village health organization selects two local residents to be trained as community health workers (CHWs).
- **Health plans and priorities determined by villagers.** Village residents are in charge of developing their own health plans with support provided by CLUSA.
- **Implementation of health plans led by villagers.** Local residents play the lead role in implementing their own community health plans.
- **Additional community-based organizations.** Local residents form women's groups, youth groups, HIV-AIDS support groups, and other organizations that carry out their own health education, health services, and economic-development activities.
- **Multi-village coordinating organizations.** These organizations operate like secondary cooperatives, carrying out joint village activities and providing a stronger voice for communicating and negotiating with health clinics, government agencies, and non-governmental organizations than would be possible by individual village associations.
- **Positive health and family-planning outcomes.** Village representatives overwhelmingly report that village health plans are being implemented and that health conditions have improved substantially as a result of better prevention, treatment, and maternal care.[14] [15]

[13] Ibid.

[14] Nadeau (2008) cited above; and "Emerging Community Health Cooperatives in Kenya Save Lives, Improve Village Health," by E.G. Nadeau, in the November/December 2009 issue of the **Cooperative Business Journal.**

[15] Note that these references report on family-planning benefits as well as health benefits identified by community residents. Villagers cite access to family-planning education and contraceptives as important services provided through the village health associations and by the community health workers. Because Sub-Saharan Africa has the highest average fertility rates in the world, these findings suggest a key role that village health co-ops can play in helping rural residents to reduce local birth rates and contribute to a slowing of population growth.

- **Sustainability.** The formation and support of multi-level, cooperatively structured organizations increase the likelihood of sustainable village and multi-village health activities.[16]
- **Adaptability.** The program design in Western Province has been adapted to other Kenyan provinces and can easily be adapted to other developing countries.

Converting Cooperative-like Organizations to Cooperatives

The community-based health associations organized by CLUSA in Kenya are usually informal entities. However, it would be a small step to develop the village and multi-village health organizations, and some of the women's, youth, and other groups into formally organized cooperatives.[17]

There are several advantages to adjusting the CLUSA approach so that the focus is on the formation of registered cooperatives rather than informal organizations:

- **Transition to Self-Support.** Many cooperatives in both developed and developing countries receive outside financial and technical assistance in starting up.[18] The keys to a co-op's successful transition to self-support is that the members develop a strong sense of ownership and commitment to the survival of the organization; that its operation is based on a sound business plan; and that the co-op adapts that plan as the organization and its environment change over time.
- **Formal Legal Status.** Even though the large majority of informal village health organizations developed by CLUSA in Kenya have proven to be sustainable thus far, the fact that most are not registered legal entities could limit their long-term survival.[19]

[16] As of March 2008, when the author conducted field research in Western Province, virtually all of the village health organizations formed in 2001 and 2002 were still in operation and the large majority of community health workers trained at that time continued to provide services to their villages.

[17] These informal associations generally operate under the same principles as co-ops: voluntary and open membership, democratic member control, member economic participation, autonomy and independence, education and training, cooperation with other health associations, and concern for community.

[18] Even in the United States, the large majority of agricultural cooperatives, rural electric cooperatives, and credit unions would not have gotten off the ground without outside assistance such as agricultural extension agents, federal and state legislative and financial support, and, in the case of credit unions, private philanthropy.

[19] For example, Papa Sene, Djingri Ouoba, and the author conducted research on a community health project that CLUSA had carried out in Burkina Faso in the mid-1990s. ("Living Up to the Bamako Initiative: Strengthening Community Participation in Burkina Faso's Health Care System," unpublished paper for CLUSA, 2007.) Largely because of the short duration of the CLUSA project, the village-based organizations did not have adequate time to develop their own long-term base of support. After CLUSA's departure, the government did not provide adequate follow-up support. As a result, nearly all of the informal village health organizations established during the project had ceased operation by 2006.

- **Business Orientation.** People own a co-op and therefore generally have a greater commitment to it than to a non-profit or informal organization. As a business, a co-op is focused on having a positive bottom line and on generating a financial return to its members in order to stay in operation. Non-profits often have an external orientation and are dependent on others for their survival. Because of its business orientation, a co-op is more likely to continue operating after the external funders and organizers are gone.

Next Steps

There are three key next steps for further development of the community-based health cooperative model in Sub-Saharan Africa:

1. **Reinstate CLUSA's health mobilization work in Kenya with an explicit emphasis on organizing community-based health cooperatives.** The program ended in 2012 because its 5-year contract with USAID was completed. However, given its effectiveness, it deserves additional funding.
2. **Implement the model in other Sub-Saharan African countries.** Expansion of the model to several countries in addition to Kenya would be an excellent means to more broadly determine its effectiveness and to test its adaptability in different political, economic, and social contexts. A major constraint to the expansion of the model is the need to secure grant support from USAID and/or other development donors.
3. **Rigorously evaluate the effectiveness of the model.** Although CLUSA carries out monitoring and evaluation of its health-mobilization work in Kenya, and the author of this paper has conducted case study and focus group research on the program in the Western and Coast provinces of Kenya, a detailed, longitudinal evaluation of the program should be conducted by an independent, third-party entity in order to measure the cooperative health model's effectiveness and to identify ways to refine the model. For example, a university-based research team could collect baseline data on a range of health measures in new Kenyan communities to be served by CLUSA and in a control group of communities not receiving CLUSA assistance. The research team would then carry out annual updates to determine what, if any, changes have occurred as a result of the program. The same kind of independent research approach could be carried out on the adaptation of the model to other countries.

Conclusion

This paper has made a case for the application of a community-based health cooperative model in Sub-Saharan Africa. Key potential benefits of the broad application of such a model on the subcontinent are:

- Addressing the “last-mile” problem – the persistent inability of current health-care delivery systems to effectively reach village residents.
- The potential of village-based cooperatives to be first responders to, and “first-mile” providers of, health education and health care.
- The experience of CLUSA’s community health programs in Kenya during the past decade.
- The ability to modify the CLUSA approach into the development of community-based health-care cooperatives.
- The low cost and the potential for rapid expansion and sustainability of the model.

The article presents three next steps to expand and test the model: CLUSA applying an explicit co-op approach to its work in Kenya, expanding the model into other countries of Sub-Saharan Africa, and rigorously and independently evaluating the effectiveness of the model.

Tens of millions of lives are at stake in rapidly identifying and implementing effective ways to improve health conditions in rural communities of the region. Village-based co-ops have the potential to be a key part of a health-delivery strategy that could be put in place quickly and on a broad scale.
