



Global
Health
Ministries

CBPHC KEY LEARNINGS

Community-Based Primary Healthcare (CBPHC) Key Learnings from the Field: Experience from Consultants Serving Faith-based Partners

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Global Health Administration Partners (GHAP)
CBPHC Task Force

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Executive Summary: GHM-GHAP Key Learnings about CBPHC

Global Health Ministries (GHM)¹ has engaged with key country partners in Community-Based Primary Health Care (CBPHC) projects for nearly 15 years. From those projects and partnerships, we have learned much about CBPHC. Those lessons can inform continuing work in CBPHC in countries where we currently have projects and in countries that may be interested in developing CBPHC projects with GHM's collaboration. Below are the "Key Learnings" from CBPHC projects in El Salvador, Nicaragua, Nigeria, Madagascar, and Tanzania. These have been prepared by Global Health Administration Partners (GHAP)² consultants who have been involved over the years that the respective 'Community Health Worker (CHW)³ projects have existed.

From the Key Learnings in each partnership, note that there are some important overarching themes across many, if not all, of these projects. Through experience with our partners we have identified these elements as important for successful outcomes. These themes include:

- **Gain Leadership Support:** get agreement from local leaders such as bishop, pastors, church medical staff, and elected leaders as well as national leaders.
- **Use an Evidence-Informed Approach:** use models such as Jamkhed Comprehensive Rural Project (CRHP) and/or SEED-SCALE to develop a locally owned approach.
- **Build Broad Community Ownership:** empower local communities to assess, decide, and prioritize what health problems they want to address and to develop strategies to address them.
- **Strengthen CHW Program Fundamentals:** establish CHW selection criteria, appropriate curriculum, and supervisory mechanisms to enhance performance and accountability.
- **Build Sustainability:** consider evolving funding in stages, such as a) Start-up, b) Expansion/scaling, and c) Integration with the broader community's and/or country's health system.
- **Develop Monitoring and Evaluation Tools:** use methods to measure progress that create opportunities to learn and make regular adjustments to program activities.

¹ GHM, Minneapolis, MN, is a faith-based NGO that partners to improve health in 14 low-resource countries in Africa, Central America and Southeast Asia.

² GHAP, the consulting arm of GHM, works by invitation to help strengthen leadership, governance and financing of a country partner, with special focus on community-based primary healthcare (CBPHC).

³ Community Health Workers (CHW): this somewhat generic term is commonly used in the field but we note that depending on the country, language and program scope, a different but similar if not equivalent term may be used, such as *promotoria* (in Spanish) or *agente communautaire* (in French).

KEY LEARNINGS from EL SALVADOR

Prepared by Tim Iverson, MSW, MDiv and Sandy Iverson, MS, RN, CPNP

Program Design: The Church's community health program was built from the bottom up with locally elected leadership and priority health needs and training topics selected through community meetings. The program is structured to be practically useful in providing first aid/ first responder service. As a community-based initiative, it is responsive with preventive education and campaigns around locally identified health issues, knowledgeable through on-going training. It focuses service in small villages with three representatives from each who are trained as health promoters and organized around a lead pastor and congregation.

Community Engagement and Empowerment: CBPHC needs to be built from the ground up in communities, and so there is a need to conduct surveys of the community members' health needs and resources in order to begin building the program on their wisdom, passion and real needs. The survey then sets the agenda for on-going training in health topics and skills geared to community needs. The Salvadoran Lutheran Church is composed of communities it organized and supported to survive during the country's years of civil war, and its people are accustomed and dedicated to taking responsibility for advancing their own community's health and well-being. These communities are practiced in innovating ways to survive in times of violence and insecurity, and are guided by the church's "Theology of Life" which holds that God's reign on earth includes the right of all people to justice, security, health, and abundant life.

Use of CHWs—Selecting and Training, Managing and Supervising, Integrating into Health System and Community Support: Health promoters are ideally people already respected and selected by their neighbors, and are committed to the health and well-being of their community. A pastor/nurse on the national staff provides supervisory management both spiritually and technically over a network of regional health promoter teams associated with 50+ congregations whose pastors facilitate local activity. A training curriculum has been developed and refined over ten years with new topics added by the promoters themselves based on local needs. Promoters are continually taught to know their limits, and especially not to concern themselves with how to treat and cure disease, but rather how to share knowledge and practice in how to prevent disease. Promoters are motivated by faith to serve their communities, and not paid for their service, but receive benefits of being equipped with first aid kits and provided with on-going education and meals and reimbursement for transportation expenses on training days. As they have grown in knowledge and practice, they have attracted the collaboration of government health facilities, municipalities and school systems to provide preventive education. Such collaboration should be a key goal of a mature CBPHC program that establishes a seamless and comprehensive community-based health system, but also the foundation for advocacy and spin-offs of CBPHC initiatives, such as in-school health education, that should be appropriately assumed by the government.

Education of Community/Volunteers/Staff: Every 1-2 months promoters are trained on health topics identified by them as relevant to their communities, and they in turn, provide individual and group education or local campaigns in their communities. Over ten years they have grown to become advocates for health services and continuous improvement of health conditions before government authorities.

Evaluation and Monitoring: Intentional, formal evaluation of outcomes of health interventions has not yet been established. Anecdotal reports and observation confirm that the program continues to be appreciated and impactful. Lack of evaluation of outcomes can handicap community health initiatives with information needed to improve their work and demonstrate to participants and community members as well as government and external funders and donors that such initiatives are an effective and sustainable approach to improving community health.

Leadership and Governance: The church is ideally suited to engage in a community-based health program because the local congregations and leadership make it possible to reach every corner of each community with this concrete expression of the love of Jesus. It is essential, however, that the larger church leadership first believe in and be committed to health as integral to their ministry, and in building the capacity of community members to be agents equipped to enhance community health. In El Salvador we were blessed, first, with the leadership of the bishop in this regard, and then with managing leadership at the national level of a pastor/nurse who led with this commitment, was knowledgeable of public health needs and practices and effective in training and motivating community volunteers, and who genuinely loved and cared for her people. They are led by a national staff pastor/nurse and locally facilitated by congregational pastors of the church, and have formed a national council of leaders elected from the micro-regional teams to share learning and challenges from their communities, exercise quality control, and bring knowledge and experience from throughout the country to influence government policy and practice in public health.

Financing and Sustainability: The program is designed to be sustainable in that health promoters are not paid but rather serve their communities as empowered and enthusiastic volunteers, and expenses are primarily for training, event food and transportation costs. Financing relies on the continuing support of donors who believe in CBPHC and are associated with El Salvador, and costs will likely increase if formal evaluation practices are established.

What Could Have Been Done Differently? I believe that evaluation is a discipline that a program grows into over time, but I would like to be more intentional about introducing the practice as early as possible.

KEY LEARNINGS from NICARAGUA

Prepared by Tim Iverson, MSW, MDiv and Sandy Iverson, MS, RN, CPNP

Program Design: The program is modeled after the CBPHC initiative in El Salvador and aided in its planning and initial trainings by Pastor Conchi Vanegas, Coordinator of the health program in El Salvador. Health needs and resource assessments were completed in eleven communities where Lutheran congregations served as the meeting site, with each electing three people to be trained as their health promoters, and a training curriculum was developed and executed to address identified community health issues.

Community Engagement and Empowerment: Going to and meeting in the communities and asking residents about their health needs and resources and basing subsequent training on their responses engaged and empowered the community. The leadership of Pastor Conchi as a Salvadoran/pastor/nurse with 10 years of experience with CBPHC in assessment and training, and the participation of the national and local pastoral leaders facilitated the community's "buy-in."

Use of CHWs—Selecting and Training, Managing and Supervising, Integrating into Health System and Community Support: Over-all management is done by national health coordinator, Rev. Dr. Soliette Lopez, and local supervision is done by local pastors. Health system integration was invited by the government's ministry of health from the outset (as opposed to the slow and organic integration in El Salvador).

Education of Community/Volunteers/Staff: The national coordinator is a physician pastor with a passion for public health (we could not have been more fortunate). Education of promoters proceeds according to topics and issues identified by the communities.

Evaluation and Monitoring: Emphasis in early stages has been on identifying the needs and topics, completing training, and "doing" the program of preventive education and first aid. Based on experience in El Salvador, introducing the intentional practice of evaluation will occur earlier.

Leadership and Governance: As in El Salvador, we have been blessed with committed leadership. The national health program coordinator, a physician currently seeking a master's in Public Health, is an excellent health educator and a believer in health as a human right of all people. The bishop of the church is supportive of the program as is her daughter, the national coordinator of pastoral ministry, who was "converted" to health as integral to church ministry during our community assessment stage of development. At present there is no governing body, other than the informal guidance that occurs during periodic training and planning meetings of the promoters.

Financing and Sustainability: The Nicaraguan Church and country is even more poor than in El Salvador, and financing relies entirely on donor support. Sustainability at some level is “baked in” to the program, since trained volunteer health promoters can continue preventive education and health campaigns in collaboration with the government ministry of health, but the program will not mature in knowledge and practice without the on-going training that modest grant funds make possible. The South Dakota Synod of the Evangelical Lutheran Church in America (ELCA) has a sister relationship with the Nicaraguan Church and has provided half the needed funds together with GHM since the program’s inception.

KEY LEARNINGS from MADAGASCAR

Prepared by Carol Berg, MPH, PHN, BSN, RN and Karen Plager, PhD, FNP-BC

Key Background: Various iterations of the CBPHC approach have been implemented in Madagascar since the 1970s.⁴ Since some of these programs were not sustained, SALFA, the Malagasy Lutheran Health System, is committed to adapting its CBPHC design and implementation, scaling strategy, and local ownership. SOFIHI is a new CBPHC initiative begun in 2018. The aim is to incorporate the training of community health nurses (CHNs) through a post-diploma certificate program developed at the Malagasy Lutheran School of Nursing (SEFAM) into SALFA's rural health centers' (RHCs) outreach to surrounding local communities (three pilot sites in initial stage). SOFIHI is still in its initial stages of development (the first class of CHNs graduated April 2020) and CBPHC implementation through RHCs/communities is progressing slowly because of COVID-19 restrictions in the country.

Program Design: The CHN students learn SEED-SCALE principles during their certificate program to use as a model to work with communities surrounding the RHCs where they are assigned. The Jamkhed Model is also taught in the CHN curriculum and applied with supervision during the CHN practicum. GHM sponsored the training at the Jamkhed CRHP in India for previous AVIA staff and most recently for the SOFIHI Coordinator and selected CHN program teachers and students of the first CHN cohort.

Community Engagement and Empowerment: Communities are most likely to be engaged and empowered when they initiate the desire for CBPHC in their communities. It is essential to learn the context of each community and assess existing assets and strengths that can be drawn upon from the outset (leadership, resources, etc.). Experience has shown that key to engagement and sustainability is working directly with existing community committees and/or developing these local committees in collaboration with community leaders and members (e.g. development,

⁴ Footnote on background of CBPHC programs in Madagascar: A version of the Community-Based Primary Health Care (CBPHC) approach was first initiated in the 1970s in Madagascar to mobilize communities (at the fokontany or village level) to improve health in several remote areas served by Lutheran hospitals (referred to as "well baby mobile clinics"). Subsequently, community health outreach was implemented under leadership of the Malagasy Lutheran Church (MLC) in collaboration with the American Lutheran Church (followed by the ELCA and GHM) through these programs:

- FFT (Primary Health Care program operated in five major regions with a nurse-led team who supported CHWs in villages throughout their regional service area in the 1980s): Lutheran World Federation ended funding due to inadequate accountability of program leadership.
- FAV (Fahasalamana Aty Avaratra) in northeast region of Madagascar: Lon and Mynna Kightlinger worked with this program in the 1990s and some of the work continues currently.
- AVIA (Anosy Villages Integrated Actions) in southeast region of Madagascar: This partnership with SALFA (funded through GHM) addressed priority health needs of this poorest region of the island as well as integrated development initiatives (water projects, schools, nutrition, evangelists, and economic development). GHM ended collaboration with this program in 2017 due to inadequate financial accounting practices (despite provision of extensive technical assistance) and uncorrected human resource concerns.

health, women's, men's, youth, etc.). Community members are the experts and should lead decision-making.

Use of CHWs—Selecting and Training, Managing and Supervising, Integrating into Health System and Community Support: Madagascar has a government system (sometimes in cooperation with large international organizations like John Snow, Inc. and USAID) to recruit and train CHWs (known as *agents communautaires*). There is a wide variation in how well the CHWs are locally supported by the government's Primary Care Clinics. The AVIA team worked directly with CHWs in communities to support them in their role and provide some basic continuing education in cooperation with the governmental health district/public health office. The SOFIHI CHNs will work with CHWs in the communities surrounding their assigned RHCs to assist them in carrying out their role and provide continuing education consistent with government guidelines and local health priorities.

Education of Community/Volunteers/Staff: Specially trained CHNs, as previously noted, are key staff in RHCs for outreach to surrounding communities for CBPHC development, implementation and evaluation. In cooperation and collaboration with CHWs and local and district government bodies, they will provide education to communities, staff, and volunteers.

Evaluation and Monitoring: Baseline community health assessment that directly engages and empowers community members is key to ongoing evaluation and monitoring to measure impact of CBPHC activities. In the case of SOFIHI, the evaluation plan is in the process of being developed as part of the RHC-CBPHC implementation phase which is just beginning (June 2020). Key measurement indicators will be chosen in collaboration with community input. It has been helpful to hold periodic Zoom meetings of the SOFIHI team (Malagasy colleagues and GHM staff/ GHAP consultants) to discuss progress of program implementation.

Leadership and Governance: Engagement and empowerment of communities for leadership and governance of CBPHC programs is essential to sustainability. An ongoing mobile health or supervisory team is vital to the success of local leadership and governance. CBPHC is envisioned to be integral to SALFA RHCs (through CHN leadership) so that collaboration and cooperation between the communities and the health care system will be a core commitment of SALFA.

Financing and Sustainability: GHM was funder for AVIA and for the SOFIHI-CHN program (which is funded by GHM for 5 years until 2024) with a decreasing amount of funding from GHM and increased responsibility for funding of SALFA-CHN program and SOFIHI by SALFA and SEFAM. Funding and sustainability are probably two of the most difficult aspects of CBPHC. SOFIHI is exploring different streams of revenue to become more financially independent from GHM (e.g., funding from other NGO partners, lab services fees, etc.).

What Could Have Been Done Differently? Not have a pandemic occur in the middle of a new start-up program! As SOFIHI is still in its infancy, this question will be answered after the program is able to fully implement the CBPHC approach in the three pilot RHC sites.

KEY LEARNINGS from NIGERIA

Prepared by David Thompson, MD, MPH

Key Background: The Lutheran Church of Christ in Nigeria (LCCN) has a membership of over 1.5 million, most of whom are in Adamawa State. The Danish Sudan Mission invested heavily in health care and the result was a highly respected health care system. However, as the missionary staff and their subsidies departed in the 80's and 90's, the system began to deteriorate. During this period the government also took over the main mission hospital. For the rest of the health facilities, there was a poorly carried out transition from mission to church ownership. The church's desire at the beginning of its relationship with GHM was to "bring back the glory of the past." LCCN accepted GHM's commitment to help rebuild its health care system on a CBPHC foundation. We started with a *pilot project* in two remote and underserved areas of the State. The program then expanded out of the pilot areas and now that experience will be used to begin rebuilding the clinics as part of a renewed LCCN Health Care System.

Program Design: Community Engagement and Empowerment:

- Starting with a pilot project provided time to:
 - Find a model that was appropriate to this specific setting.
 - Build energy and local investment in the two areas.
 - Allow church leadership, particularly the Archbishop and the Diocese leaders, time to see the logic and benefit of CBPHC and how that could provide a strong foundation for the rebuilding of their health care system.

Use of CHWs—Selecting and Training, Managing and Supervising, Integrating into Health System and Community Support:

- Community initiative and support increased more rapidly in the expansion communities i.e. those communities who had observed the activities of neighboring Pilot Project villages.
- Training at the Jamkhed CRHP⁵ was particularly effective for program leaders and selected Bishops.
- Getting the support of the Muslim part of the community took patience and perseverance. Muslim young people in particular were drawn into the program. They ultimately participated at all levels (CHWs, Village Health & Development Committees)

Education of Community/Volunteers/Staff:

- Single young women with basic community nurse training⁶ were *key* to helping organize, lead and supervise work at the community level. The question now is how marriage will affect

⁵ Comprehensive Rural Health Project located in Maharashtra State, India (Christian)

⁶ Community Health Extension Worker (CHEW – an entry level of nurse trained for community work)

Evaluation and Monitoring:

- Decide early in the life of a CBPHC program how important monitoring and evaluation are to the long-term success of the program and find the human resources needed to lead this successfully.
- Provide training and resources early on to assure the level of confidence that has been predetermined.
- Find people to gather community data for regular reports who have the necessary skills to do so. Many of our CHWs lacked the skills needed to do this consistently.
- For baseline and final program evaluations:
 - o Use accepted survey tools.
 - o Commit to a budget that will lead to a successful completion of the survey.
 - o Make sure that the person who designs and oversees the evaluation:
 - + Has the experience and computer programming skills to oversee the effort and provide the necessary training.
 - + Can be in the field full-time with the evaluation team to solve problems that come up and to monitor their work.

Leadership and Governance:

- The church and program leadership were able to build the program with only episodic visits by the GHM consultant. This ultimately resulted in a higher degree of ownership⁷.
- Medical doctors have a good deal of “unlearning” to do before they can become effective leaders in a system which is seeking to introduce community-based programming.
- The members of the church’s Health Board need mentoring/guidance to become *representatives* of their Dioceses & its clinics rather than isolated/top-down advisors.

Financing and Sustainability:

- Community-based health programming does not generate enough income to cover training and supervisory costs. Capacity building is needed for this partner to discover innovative ways of raising funds to support this.

What Could Have Been Done Differently?

- Spend much more time and effort at the beginning to build ownership at the level of the church leadership and Dioceses. Ultimately it was the success of the pilot projects and the demand that created in adjacent communities that convinced the church leadership.
- Setting training curriculums and standards for the CHWs should have received more attention at the beginning.

⁷ There was a debate at the beginning about whether a full-time program director with real CBPHC experience should be hired to help start the program. The decision was to not hire such a leader from the outside.

KEY LEARNINGS from TANZANIA

Prepared by Magdeline Aagard, EdD, MBA, RN

Key Background: GHM has been engaged in projects in Tanzania for many, many years. GHAP's first consultation was with Ilula Hospital in 2008. Though this did not involve CBPHC, it serves as part of the foundation for GHAP's work in Tanzania. Though there have been several projects in Tanzania that have had components of CBPHC, this report is focused on the Community Hospital Alliance Program (CHAP). CHAP was a joint project between GHAP and Empower Tanzania, Inc. (ETI), a 501c (3) which has been operating in the Same District of TZ for several years. ETI started a community health educator (CHE) program with one CHE in each ward of Same District. It was through this program that ETI realized that the Maasai in Same were not provided the same health education because of their remote location. ETI asked GHAP to collaborate in CHAP.

Program Design: Community Engagement and Empowerment: CHAP was designed to provide health education and promotion, simple illness and injury care, through community health workers (CHWs) and connect the Maasai with the health system.

Use of CHWs—Selecting and Training, Managing and Supervising, Integrating into Health System and Community Support: ETI and GHAP consultants brought the idea of CHAP to the leaders of the 21 villages. Many of the village leaders wanted a physical medical facility rather than CHWs; however, when they realized that building medical facilities was not going to happen, they were excited about the idea of a CHW program.

Given the criteria that the CHW needed to be a married woman who was fluent in Swahili, the village members chose their CHW(s). The ETI and GHAP consultants interviewed each of the chosen CHWs to understand their level of interest in healthcare, their level of education, fluency in Swahili, and to get to know them better.

Working with the Same District Medical Officer, an Assistant Medical Officer (AMO) and a Clinical Officer (CO) were appointed to supervise the CHWs. The AMO was responsible for the CHWs on the East side of Same and the CO for those on the West side. They were given a stipend for gas for their motorbike and time supervising. They were to meet with the CHWs monthly in one of the villages and collect the monthly data reports.

The CHWs contacted the supervisor when they had questions, or to refer someone to the local health facility. The CHW could also call the local health facility directly to refer someone. The CHW was responsible for meeting everyone in the local health facility, communicating with them at least monthly, and assuring they were integrated with them.

The communities were very supportive of the CHWs.

Education of Community/Volunteers/Staff: The CHWs were provided 15 days of initial training. The curriculum was designed by 2 TZ nurses, an MD and nurse from the U.S. The curriculum was based on the TZ traditional birth attendant training and the home-based care curricula, as well as information we felt was important that the CHWs be taught. We also taught them how to gather data using the tool that the ETI and GHAP consultants developed. Three days of refresher training was provided annually. Every year a new skill was added.

Evaluation and Monitoring: Basic data was collected monthly. This was used by the supervisors to plan monthly education and to follow up on referrals to the health facilities. Annual data collection was conducted to collect demographic data and key measurements.

Leadership and Governance: Supervision as noted above. ETI provided the in-country oversight of the program.

Financing and Sustainability: Financing was obtained through grant funding. Sustainability was an issue because the CHWs and supervisors received stipends, the motorbikes for the supervisors needed gas and maintenance, and the supervisors received stipends. GHAP completed their participation after five years. ETI had a bit of funding remaining but it is unclear what the plan was after the grant funding ran out. The Same District government had initially agreed to pick up the program at the end of five years and pay for it, but when GHAP left, the government did not have the funds to run the program.

What Could Have Been Done Differently? Overall, the program implementation went extremely well. The two issues that were a significant problem were: data collection and sustainability. The issues with data collection and what could have been done differently are too numerous to go into here, but it is essential to collect data, it just needs to be done better/differently. Sustainability is always an issue when you have grant funded programs. We talked about it constantly over the five years of GHAP's involvement. We had many wonderful ideas about sustainability; however, they were ideas that we would need expertise to implement, expertise that we did not have.

What we learned from CHAP is that it needs to be clear from the outset whether GHM/GHAP or its partners are willing to make the long-term commitment to funding the program. If not, then the question should be asked whether GHM/GHAP should be involved in the program.