Global Health Ministries

Helping the hands that heal

NIGERIA

2016

COMMUNITY BASED HEALTH - BUILDING LEADERSHIP & CONSENSUS

In 2016 we will complete the CBPHC Pilot Phase and begin a transition to the Expansion Phase I. Measurable results in health are visible, yet the largest success is the development of this model in spite of the viciousness of Boko Haram and an environment where CBPHC was not taken seriously. Expansion will mean applying this model in areas with an LCCN clinic.

Nigeria

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OVERVIEW OF THE CBPHC PILOT PROJECT

The story of the Lutheran Church of Christ in Nigeria (LCCN) is an amazing one. It grew over a century to a membership of over 1.7 million in a state with a population of about 4 million. At one time the church had a very effective and admired health care system. However, it was a passive system, meaning that it served primarily patients that were fortunate enough to make it to one of the clinics or their general hospital. The Danish mission founded and heavily subsidized the system. During the 1980's and 90's the subsidies decreased, and the health care system went into a state of advanced disrepair. By 2010 this once powerful system was barely surviving in the form of isolated clinics run by ill equipped and unsupervised staff.

In 2010 GHM signed a memorandum of understanding with the LCCN. The goal was to help rebuild the church's primary health care system. The clear objective was to improve ***population*** health in the areas served while continuing to improve ***patient care*** in LCCN health institutions. The integrated model of "Jamkhed Comprehensive Rural Health Program," (www.jamkhed.org) in India was chosen to guide these efforts.

A Pilot Project was launched in two underserved and remote areas (Wakka and Dingai). Two teams of two persons each focused on CBPHC were sent into these pilot areas. A Coordinator of CBPHC oversaw their efforts. The two teams, known as the Mobile Leadership Teams (MLTs), mobilized the communities. Health and Development Committees were established in each village. Villages were encouraged and helped to identify their own needs and to select a development project. Coordinators of four (4) other programs of the LCCN Health Services (Water, Malaria, Health Education and Institutions) aided the MLTs.

This was an opportunity to develop a model of community-based primary health care (CBPHC) that is appropriate and effective, not only for the LCCN in Adamawa, but eventually for other churches and countries in Africa.

A Coordinating Committee was established for each of the two areas. Communitywide discussions were held to define and prioritize the problems and develop plans. Each village selected a female Village Health Worker (VHW). The VHWs conduct regular home visits where the focus is on malaria prevention, sanitation and clean water, use of oral rehydration for diarrhea, infant and child feeding, promoting mother and child immunizations, promoting prenatal care at the government (LGA) clinics, providing clean home deliveries and exclusive breast feeding until age 6 months.

Leader of Village Health Workers, Waka

IMPACT GOALS OF THE CBPHC PILOT PROJECT

1. A viable CBPHC model created with potential for sustainability that can be transplanted to other areas, states and neighboring countries
2. State Ministry of Health makes long-term and effective commitment to integrated CBPHC and to the role of faith based and initiated programs.
3. Near and distant communities petition LCCN Health Board to create CBPHC programs in their areas.
4. State Ministry of Health and Local Governments develop well financed structures that encourage and enable community-based programs.
    - Increase food and economic output by 30%.
    - Decrease specific mortality/morbidity.
    - Decrease mortality of children under age 5 yrs by 50%.
    - Reduce the incidence of childhood malaria by 50%.
    - Reduce the prevalence of child malnutrition (under age 5) to less than 5%
    - Reduce the incidence of dehydrating diarrhea by 50%
    - Reduce infant mortality rate by 20%
    - Decrease maternal mortality by 20%
    - No cases of cholera, neonatal tetanus, polio, pertussis or measles
    - HIV prevalence decreased and Women empowered to protect themselves from HIV infection

ACCOMPLISHMENTS

CBPHC

- Participating number of villages: 17 (13 in Wakka and 4 in Dingai area)
- Total population covered: 13,550
- VHWs trained and active: 71
- Sanitation committee in all villages
- 935 children under age 5 years screened for malnutrition in 2013 in both pilot areas and treatment program begun for 45 mildly malnourished and 8 severely malnourished children. No severe malnutrition reported since.
- Education classes held: food security, poultry raising, and traditional cosmetics
- Development projects completed: renovation of a classroom block, purchase 15 benches and 20 mats for a primary school, roofing a primary health clinic, installed a rock bed for

a deep gully crossing, 2 hand pump boreholes, 5 hand dug wells, 4 geophysical surveys for wells yet to be dug

- Development projects begun but not completed: 14 hand dug wells in various stages of completion, primary health clinic.

Malaria

- Malaria prevention / use of Long Lasting Insecticide Treated Bed Nets (LLINs):

Pregnant Women

Year	2012	2015				2016
Quarter	2*	1	2	3	4	1
# Pregnant women		96	46	69	66	97
% sleeping under net	27%	63	60	73	91	92

Children under age 5 years

Year	2012	2015				2016
Quarter	2*	1	2	3	4	1
# children < 5 yrs		916	388	745	977	1078
% sleeping under net	30%	73	67	91	92	93

*May 2012 Evaluation

Institutions/Clinics

Renovation of the Demsa Health Center is almost complete. Dr. Joseph has been there now for over a year and is providing very good leadership. While Demsa provides **medical care** for the area, including **emergency surgery,** its larger function will be to provide **training for clinic staff and VHWs** as we launch the Expansion Phase of the Community-based Health Program.

In 2016 the Medical Director for Demsa attended the Jamkhed CRHP Diploma course and will be well poised to transform Demsa into a training center. Construction will begin in 2017 on a new building to provide lodging for students and a training area. The original funding (25 – 40 Foundation) for the training center was to provide well and pump maintenance training for LCCN's Water Program. Rather than build two training centers in two different locations, it was decided to create one training center at Demsa for both the Community Based Health Program and the Water Program.

Water

In Nigeria almost 68,000 children under the age of five will die this year from diseases caused by poor access to water (WaterAid Report, 2016). Globally, 650 million people have no access to clean water. The health impact of dirty water is staggering. Half of the world's malnutrition cases are linked to chronic diarrhea caused by lack of clean water, good sanitation and good hygiene including hand washing with soap.

In 2016 in Adamawa, Nigeria 11 communities are raising 30% of the cost of a well with the promise that GHM will pay the other 70%. Since 2009 there have been 46 communities that received new or improved wells thanks to partnership with Global Health Ministries. The community takes the first step by paying for a geological survey to determine the best location for a well. At that point a realistic estimate for the cost of a well can be made. Local investment in the geological survey counts toward their 30%. While GHM raises funds and reviews the requests, the community identifies a "well maintenance team." To date 46 teams function in Nigeria. Thanks to this project, over 22,000 people in Nigeria have access to clean water today.

Health Education

Health education has been integrated into church life at many levels. One measuable example is the 2,331 women Bible Study leaders who teach about malaris (awareness, prevention, and risks) at least once a month.

Health Board

During this period (2010 – 2016) the Health Board assumed a more independent status within the church in terms of managing its finances and developing relationships with outside agencies. Management and oversight has been improved. The Board is also better informed about how to build a healthier and more sustainable primary health care system that balances patient needs with population needs and realities. It is learning the value of harnessing the energy of communities to improve health and to make health care both more effective and efficient. We have been particularly encouraged by the leadership provided by Mr. Emmanuel Sabiya who assumed the role of CEO in 2015 and by the effect the Jamkhed Diploma Course had on him.

CHALLENGES

Boko Haram in Dingai area:

- The Dingai area was particularly targeted by the extremist movement Boko Haram during 2014 and 2015. Eighty LCCN members were killed during this time and seventeen churches burned. The Mobile Leadership Team was evacuated from there in November 2014 and was assigned to help the team in Wakka until they slowly restarted the Dingai work in August 2015.

Baseline and end evaluation:

- A professional Minneapolis-based program evaluator assisted in reviewing a broad baseline survey done in 2012 and designing a 2016 re-evaluation. After careful review, his conclusion was that the data collected in 2012 was problematic and did not create a reliable baseline. He suggested that we conduct the 2016 evaluation by means of Focus Group Discussions (FGD) and assisted in the preparation of these. A separate set of questions was prepared for six groups (Area Health and Development Committees, Village Health Workers, Local Government Clinic staff, Mobile Leadership Team, LCCN Women's Fellowship Malaria program and the LCCN Health Board). Independent staff with experience were hired to lead the discussions and to report back to the CBPHC Program. The FGD attempted to measure the degree to which empowering methods were used and ownership of program goals was achieved. (*See Report of 2016 Evaluation*). Impact Goals 1 and 3 were reached and there is a good deal of indirect evidence that the program has made a significant impact on the participating communities.

Bottom-up methodology:

- The key to CBPHC is empowering local communities to become partners with health care systems in solving problems and owning health outcomes. This requires a bottom-up approach and patience. Learning these bottom-up and empowering approaches has been our biggest challenge. The program staff grew up in top-down systems.
- Several training courses at the Jamkhed CRHP helped immensely.
- A senior Jamkhed staff member carried out an on site evaluation/training exercise with the team in 2015 (*see attached Report by Nuwayina Briska*).
- The two month Diploma Course attended by the CEO Mr. Sabiya (2015) has been transformative in preparing leadership for the future. In 2016 by Dr. Joseph (Medical Director of Demsa Health Center) and Mr. Joseph Antibas (Coordinator of Malaria Program) have completed this course.

Increasing local funding:

- We have built support for the program among key leaders in the LCCN. The LCCN is committed to progressively increasing its financial support of the program. This will be, nonetheless, a continuing challenge.

THE FUTURE: 2017-2019

Integration:

- LCCN Health Services has five separate programs; Institutions/Clinics, Water, CBPHC, Health Education and Malaria (the latter run by the LCCN Women's Fellowship). In 2017 there will be a focus on integrating these into one program with common vision, mission, methods and resources. GHM will provide direct consultation services to the CEO of LCCN Health Services for integrating and unifying these separate programs.

Leadership:

- The program now has six staff members who understand and are deeply committed to the empowering bottom-up methodology. The next phase will be built around these people.

Institutions/Clinics

- In 2017 GHM will suppy equipment for the operating room at the renovated Demsa Hospital. The resulting surgeries will provide needed assistance to a wide variety of patients as well as an increased revenue source for LCCN Health Servces.
- Construction will begin in 2017 on a new building to host interdisciplinary training at Demsa. The new building will provide lodging for students as well as a training area.
- A Prosthetic Limb Workshop will be founded in Demsa as another vital service to the community.

Expansion Phase I:

- We have over the past five years developed a working model in two remote communities. Now the task will be to reorganize our staff and find ways of integrating our new model and methods into one or two existing (struggling) LCCN clinics and their surrounding communities. In 2017 we will define roles for Community Health Workers (MLT staff) in integrating our model in 1 or 2 dispensaries and utilize Demsa in training dispensary and VHW personnel.