DATA BRIEF

CHAMC
CHRISTIAN HEALTH ASSET MAPPING CONSORTIUM

REVIEW AND ANALYSIS OF FAITH-BASED COMMUNITY HEALTH PROGRAMS

ASSEMBLED BY THE CHRISTIAN HEALTH ASSET MAPPING CONSORTIUM (CHAMC).

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EXECUTIVE SUMMARY

Faith-based organizations (FBOs) provide a substantial portion of healthcare services through community health programs (CHPs). Still, the scope and breadth of CHPs are not well understood and are difficult to quantify. The Christian Health Asset Mapping Consortium (CHAMC) completed a review and analysis of faith-based CHPs in February 2024 to highlight their critical role in delivering healthcare to underserved communities and the importance of community health workers (CHWs) who support them.

This brief examines a representative sample of FBOs that conduct CHPs, describing what they do and how they do it. Of the 168 FBOs researched and contacted, 30 were found to operate 208 CHPs. CHPs were classified using two frameworks, dividing them into eleven focus areas and five intervention methods. The brief calls attention to the lack of information available about where and how faith-based CHPs work and their impact on the health system.

We recommend local and international FBOs register summary data on their CHPs through CHAMC's dataset registry: **https://faithhealthassets.org/dataset-registry/**. CHPs should be promoted alongside health systems as part of whole-of-society health system planning. The data presented in this brief are just a snapshot of faith-based CHPs; further research is needed to quantify CHPs and ensure community health programs are recognized as essential health assets.

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INTRODUCTION

Faith-based organizations (FBOs) provide healthcare services via faith institution-owned health facilities, congregations, and community-based organizations that are local, national, or international.[1–2] One area where many FBOs impact is improving community health through operating community health programs (CHPs) and supporting community health workers (CHWs). CHPs run by FBOs in low- and middle-income countries (LMICs) provide important health services often missing from national and global datasets that focus on health facilities.

CHPs can take many forms; they may provide:

- Health education
- Case management
- Basic preventive health care
- Home visits
- Support to individuals navigating the healthcare system

CHPs can be staffed by CHWs, lay workers, clergy, and other healthcare professionals. They can be run by churches, hospitals, local clinics, or other entities.

CHWs are recognized as vitally important in providing community health services in the drive toward achieving universal health coverage.[3] According to a December 2017 WHO report, at least half the world's population lacks access to essential health services.[4] While it is accepted that CHWs can help fill the gap in formal healthcare services in underserved areas and populations, the CHW definition is not clear. The International Labor Organization defines CHWs as individuals who "provide health education, referral and follow-up, case management, basic preventive health care, and home visiting services to specific communities."[5]

The WHO has a more encompassing definition, defining CHWs as members of the health system who reside in the community, provide community-based health services, are either paid or volunteer workers, are not professionals, and have between a few hours and two years of training.[3,6,7]

The WHO also highlights six key functions of CHWs:

- Delivering clinical care
- Encouraging the use of healthcare services
- Providing health counseling and education
- Data collection and record-keeping
- Creating relationships between community members and the health system
- Providing psycho-social support

CHWs are also referred to as lay health workers, front-line health workers, close-to-community providers, and lady health workers.[6] For this analysis, the term community health worker will be used but can be applied in any scenario that uses the above terms. The brief also uses the WHO definition for CHWs as it encompasses more situations in which CHWs work and allows a greater breadth of organizations to be included.

INTRODUCTION (CONT.)

CHWs are effective change agents in their communities for many reasons:

- Most CHW programs place trained CHWs in their home communities, allowing them to gain the community's trust, nurture a close relationship with their communities, understand the cultural norms, and have cultural sensitivity, and speak the language.[8] Language barriers and cultural differences are particularly important in countries with many ethnic groups.
- CHWs know their communities well, can provide surveillance for danger signs, and help mobilize a community.[9–11] In Pakistan, CHWs provide needs assessments and monitoring, primary healthcare services, disease surveillance, and help to integrate prevention and preparedness after emergencies.[12]
- Due to the trust their community places in them, the CHWs are able to facilitate the community's engagement with the healthcare system.[13–15] In Afghanistan, some villagers call the CHWs "village doctors" as a sign of respect.[16]
- CHWs create positive relationships with communities when the CHWs have supportive supervision, continuing education, adequate supplies, and are respected as members of the health workforce.[3,7] CHWs can be supported by FBOs (such as the ones listed below in Table 2), governments (such as in Afghanistan), non-governmental organizations, or a combination of these.

The number of CHWs at any given time is very fluid and, therefore, is very difficult to quantify. CHWs stop working or volunteering for many reasons, including but not limited to lack of reimbursement, family pressure, family moving out of the area, a new job, or a lack of supervision, trust, or respect.

Because of this fluidity, rather than attempting to track the number of CHWs themselves, we are quantifying the number of faith-based community health programs (CHPs) under which CHWs work. The Community Health Impact Coalition (CHIC) has a **live database** of countries with accredited and salaried CHW groups, providing a helpful reference point.

In an effort to understand the number of faith-based CHPs, the **Christian Health Asset Mapping Consortium** collected, analyzed, and summarized data from FBOs in LMICs to quantify the number of faith-based CHPs in each country and describe their focus areas and methods of intervention. Ultimately, this brief aims to help the global health community better understand the breadth and scope of CHPs operated by FBOs and help quantify the impact FBOs have in their communities.

METHODS

An initial list of Christian FBOs operating in LMICs was obtained from **Christian Connections for International Health (CCIH)**, a network of Christian health-related organizations and individuals around the world, and the **Accord Network**, a community of Christian relief and development organizations. All FBOs were contacted via email or their "Contact Us" page. Websites were also reviewed for information on CHPs. If other organizations were found in this review, they were also added to the list. All FBOs were contacted at least twice. FBOs that had no connection to health were removed from the list.

Identified CHPs were then classified based on two frameworks describing "what" they do and "how" they do it (Table 1).

The first framework divides CHP focus areas into 11 categories:

1. Health education (faith-based leader health education on gender-based violence (GBV), HIV, poverty, substance use, hospital chaplain training, and healthcare worker training)
2. Infectious diseases (HIV, TB, malaria, leprosy, etc.)
3. Nutrition (provide nutritious meals, teach gardening, CHWs trained in nutrition, and other nutrition programs)
4. Noncommunicable disease services (cardiovascular disease screening and prevention, cervical cancer screening, hypertension, diabetes, cancer, palliative care, and other chronic diseases)
5. Community services (community nurse programs help individuals navigate the healthcare system, community health promotion, community clinics, distribution of winterization materials, human trafficking and child abuse prevention, mobile clinics to remote villages, disaster preparedness, and child marriage education)
6. Disability services (provide health care to disabled individuals and education of parents of disabled children)
7. Mental health (suicide, domestic violence, and substance abuse education)
8. Family planning services (sexual and reproductive health programs and teenage pregnancy prevention)
9. Maternal and child health (preventing mother-to-child HIV transmission, maternal and newborn health, and child immunization programs)
10. COVID-19 (COVID-19 vaccination education and administration education)
11. WASH (provide toilets, menstrual hygiene education, recycling education, and solid waste management)

The second framework describes the approach or method of intervention FBOs used to implement their CHP. These five categories include:

1. Education (community health education, awareness, and sensitization)
2. Health worker visits (mobile units and house visits)
3. Campaigns (immunization days and family planning days or other)
4. Outreach (helping people navigate the healthcare system)
5. Outreach (assisting people who need ongoing or continuous care)

See **Table 1** on the following page.

Table 1
Frameworks for Understanding "What" Faith-Based CHPs Do and "How" They Do It

CHP Focus Areas	Method of Intervention
Health education Infectious disease Nutrition Noncommunicable disease services Community services Disability services Mental health services Family planning services Maternal and child health COVID-19 WASH	Education Health worker visits Campaigns Outreach - system navigation Outreach - continuous care

RESULTS

One hundred sixty-eight FBOs were researched online and contacted, of which 11 FBOs directly responded (two FBOs had CHPs that were also found online, and nine FBOs did not have CHPs), and 30 FBOs were found to have CHPs based on information on their websites.

Table 2 provides an overview of 30 FBOs with CHPs and in which countries they are located. A total of 208 faith-based CHPs were identified. Of the 168 FBOs researched, 36 did not have current websites, 20 did not have an email address listed or a "Contact Us" widget, and a further 11 emails were invalid or undeliverable.

See **Table 2** on the following page.

Table 2

Number of Community Health Programs per FBO (As of February 2024)

Faith-Based Organization	Number of CHPs	Countries Served
Africa Christian Health Associations Platform (ACHAP)	6	Kenya, Uganda, Ivory Coast, Zimbabwe, Sierra Leone, Malawi, Central Africa Republic, Madagascar, Sierra Leone, Rwanda
Africa New Life Ministries	3	Rwanda
AMOS Health & Hope	4	Nicaragua
Cameroon Baptist Convention Health Services (CBCHS)	6	Cameroon
CAPNI Christian Aid Program	10	Iraq
Christian AIDS Bureau for S.A (CABSA)	4	South Africa
Christian Health Association of Ghana (CHAG)	2	Ghana
Christian Health Association of Kenya (CHAK)	27	Kenya
Christian Health Association of Liberia (CHAL)	2	Liberia
Christian Health Association of Malawi (CHAM)	5	Malawi
Christian Health Association of Nigeria (CHAN)	4	Nigeria
Christian Health Association of Sierra Leone (CHASL)	6	Sierra Leone
Christian Hospitals Association of Pakistan (CHAP)	4	Pakistan
Christian Medical Association of India (CMAI)	2	India
Churches Health Association of Zambia (CHAZ)	31	Zambia
CMMB	8	37 countries
Emmanuel Hospital Association	43	India
Espoir de la famille	4	Benin
Heal Africa	3	Democratic Republic of Congo
Helping Children Worldwide	4	Sierra Leone
Human Development and Community Services	4	Nepal
Impact Ministries	2	Guatemala
International Care Ministries	2	Philippines
LAMB Hospital	3	Bangladesh
Nepal Leprosy Trust – Lalgadh Leprosy Hospital and Services Center	4	Nepal
OMF International	Unknown	Multiple countries
SANRU	6	Democratic Republic of Congo
When It Needs Doing (WIND)	1	Guatemala
World Hope International	3	Sierra Leone
World Renew	3	Multiple countries
Total	**208**	**26+**

Table 3 provides a summary of the thematic focus areas or "the what" for the CHPs for a sample of 21 FBOs for which descriptive CHP data was available. CHPs were divided into 11 categories: health education, infectious diseases, nutrition, non-communicable diseases (NCDs) services, community services, disability services, mental health, family planning services, maternal and child health, COVID-19, and WASH. Examples of each category are listed in the methods section. Community services, maternal and child health, and disability services were the three largest categories of CHPs. Some CHPs fell under multiple categories but were only listed under the primary category. (No CHPs were counted twice).

Table 3

Overview of the Thematic Focus Areas for the CHPs by Organization

CHP Focus Area	Number of CHPs
Health Education	9
Infectious Diseases	11
Nutrition	10
Noncommunicable Disease Services	8
Community Services	25
Disability Services	13
Mental Health Services	7
Family Planning Services	4
Maternal and Child Health	20
COVID-19	9
WASH	9
Total	**125**

Table 4 shows the type of CHP intervention or "the how" for the same sample of 21 FBOs referenced above. These categories are education, health worker visits, campaigns, and outreach (system navigation and continuous care). Examples of each category are listed in the methods section. Outreach (continuous care) and education are the two largest categories of CHPs.

Some CHPs fell under multiple categories but were only listed under the primary category. (No CHPs were counted twice).

Table 4

Type of Intervention FBOs Used to Implement Their CHP

Type of Intervention	Number of CHPs
Education	42
Health worker visits	9
Campaigns	8
Outreach - system navigation	17
Outreach - continuous	49
Total	**125**

DISCUSSION

While many FBOs were contacted and reviewed, this is not an exhaustive list, and additional FBOs and their CHPs will continue to register their data in the **live CHAMC database.** This brief examines a sample of CHPs offered across multiple platforms: small vs. large organizations, rural vs. urban, clinic vs. hospital, faith-leader-led vs. clinician-led, and across multiple continents. Some FBOs have a diverse range of CHPs, while others focus on a small area. For instance, When It Needs Doing (WIND) solely focuses on nutrition - providing meals, teaching gardening, and crop rotation. Emmanuel Hospital Association had the highest number of CHPs of the FBOs in this sample (43 in total) and had a large breadth across 9 of the 11 categories with a strong emphasis on child marriage, human trafficking, disability services, and mental health services.

This research was limited by a few factors. First, descriptive data for each CHP was often not listed online. It was also difficult to find, research, and contact FBOs based in low- and middle-income countries, as many had a minimal online presence.

Furthermore, security concerns for individuals operating CHPs may limit the ability to contact them. Some annual reports were not updated or did not discuss their CHPs. We also found that the larger the organization, the less likely they were to have a centralized database of the CHPs.

CONCLUSION

A substantial portion of health services are provided through faith-based community health programs. The paucity of information online and response to requests for information highlights the need for high-quality data on faith-based CHPs. This information will also help FBOs and other global actors know who is operating near them, what type of programs they run, and improve partner collaboration.

Further research on the scope and breadth of CHPs is needed. For this research to be feasible, we need local NGOs and FBOs to register data on local programs and global coalitions of FBOs to help facilitate this. The frameworks developed here to categorize CHPs are only a starting point to understanding the impact of faith-based CHPs. As we learn more about CHPs, categories should be added and removed as needed. Additionally, the connection between increased information and funding, utilization of CHP resources, and the ability of FBOs to learn from and share each other's CHPs should be investigated. CHWs and CHPs are critical health assets and an important part of global healthcare, and they deserve an equal amount of research, funding, and transparency.

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