Strengthening Health Service Delivery by Community-Based Organizations

The Role of Data

Data-informed decision making is the cornerstone of effective health programs. Significant human and financial resources have been invested worldwide in the collection of population, facility, and community-based data. However, this information is often not used by key stakeholders to effectively inform policy and programmatic decisions. In an effort to better understand the common constraints to data collection and use facing community-based organizations (CBOs), a series of in-depth interviews were conducted with members of six organizations in six countries. Information was gathered from a convenience sample of 16 key informants using a semi-structured questionnaire. Key informants were selected by virtue of their decision-making positions within the organization and their roles in data collection and use. The information collected is synthesized in this document.

THE IMPORTANCE OF CBOS IN THE HEALTH SECTOR

As countries strive to achieve multiple health goals to ensure their citizens' access to health care, multiple actors, organizations, and partnerships are needed. In this context, CBOs have become a critical component of the extended health care system in many countries. CBOs are defined as organizations that have arisen within a community in response to particular needs or challenges and are locally organized by community members. As CBOs develop and expand their programs, many register as non-governmental organizations (NGOs) so they can mobilize resources from donors that will fund only organizations that have NGO legal status.[1] CBOs fill an important role in the health care response by providing services outside of the Ministry of Health (MOH) system, advocating for needed services and under-represented populations, engaging in policy and priority setting discussions at a national or sub-national level, and linking the formal health system to the community—the consumers of health services. CBOs are uniquely positioned to provide sub-national support for the implementation of national development projects by working alongside other health actors. Together, they can achieve the scale, range, and sustainability of interventions that are required to reach important health goals.

THE ROLE OF DATA IN STRENGTHENING CBOS

Monitoring and evaluation (M&E) data are critical to the efficient and effective functioning of health programs. Monitoring is the systematic collection and analysis of program data in order to track program progress in meeting pre-determined program objectives and performance targets. Monitoring helps to keep work on track, and can alert management if problems arise. Evaluation measures how well program activities have met expected objectives and/or the extent to which changes in health outcomes and or impacts can be attributed to the program or intervention.

[1] The Global Fund to Fight AIDS, Tuberculosis and Malaria. Community Systems Strengthening Framework, May 2010.

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MEASURE Evaluation

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By prioritizing systematic data collection and use, CBOs can make the most of their limited resources, while simultaneously improving services offered to the communities they serve.

Basic M&E systems can assist CBOs to:
- Determine whether a program is meeting its stated objectives, activities and outputs.
- Determine whether services are meeting the needs of the community and target groups.
- Refine programs and services that are not meeting objectives, targets, and expected outcomes.
- Raise local and national awareness about key issues in the community.
- Advocate for resources to deliver new and/or additional services.
- Target services to geographic regions in need, based on population density and health burden.

Advanced M&E systems can assist CBOs to:
- Identify the priority health needs of a community.
- Track changes in disease prevalence and specific health behaviors.
- Determine the most effective program and policy approaches.
- Facilitate civic engagement in key health priorities.
- Link local data to regional and national-level health information systems.

While the benefit of data-informed decision making to CBO programs is clear, many CBOs struggle to collect and use data in decision making. To understand the common constraints to data collection and use for CBOs, a series of in-depth interviews were conducted.

AN IN-DEPTH LOOK AT CBO DATA COLLECTION AND USE IN SIX COUNTRIES

Methodology

Study Design and Sample

A series of sixteen in-depth interviews were conducted with members from four CBOs and two national umbrella coordinating organizations working with CBOs in six countries. For the purposes of this document, an umbrella coordinating organization is defined as the national organization tasked with providing coordination among CBO programs. While the national coordinating organization is not in and of itself a CBO, it is directly linked to CBOs and plays an important role in M&E issues and data use. The organizations were selected via convenience sample to represent a variety of CBOs in terms of organizational structure (umbrella coordinating organization, multi-site CBO, single-site CBO), the reach of services being delivered (national, regional, community), and the origin/type of funding supporting each organization (multilateral, bilateral, individual donors). For the purpose of presenting the results and discussing their significance, we have grouped these organizations into three categories (see Table A at the end of this document).
- Category 1: Umbrella coordinating organization; Country-wide service delivery; multilateral funding source
- Category 2: Multi-branch CBO; Region-wide service delivery; bilateral funding source/small grants
- Category 3: Single-site CBO; Community-wide service delivery; individual donors

CBOs Interviewed
- Réseau Rwandais des Associations des Personnes Vivant avec le VIH—Rwanda
- Network of People Living with HIV/AIDS in Nigeria
- I Choose Life—Kenya
- Education Fights AIDS International—Cameroon
- Escuela de la Calle—Guatemala
- MeHiPro—Ecuador

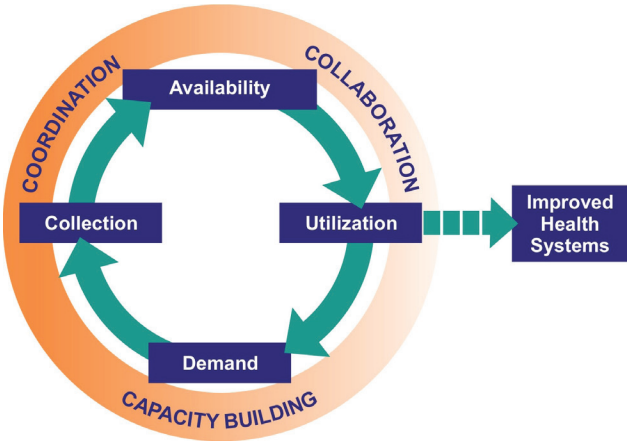
Information from each organization was gathered via snowball sampling of key informants. Recommendations for subsequent interview candidates were based on decision-making positions within the organization and roles in data collection and use. The sample size was based on the scope and budget of the research activity.

Data Collection and Analysis

An open-ended, semi-structured questionnaire was used to collect information from individual informants. Detailed notes were taken during the interviews and follow-up/probing questions were

asked to fill in gaps where additional clarification was needed. The information collected was synthesized and then grouped under the themes outlined in the MEASURE Evaluation Data Demand and Use (DDU) conceptual framework. The themes include: data demand, data collection, data availability, and data use (see Figure 1). According to this conceptual framework, data-informed decision making is enhanced by a sound demand for health information, the collection and analysis of quality health data, making information available to decision-makers, and finally, from facilitating use of information to improve health system performance. There is a cyclic connection between the four elements represented in the DDU conceptual framework. It is critical for each element in the framework to function effectively for data use to occur.[2]

FIGURE 1: MEASURE Evaluation Data Demand and Use Conceptual Framework



Limitations

The information presented in this study is limited due to a number of methodological challenges. First, the study sample—both in terms of the number of organizations included and the number of participants interviewed—is small, which limits generalizability of results beyond the organizations interviewed. Second, the sample may be biased due to inherent biases introduced by snowball sampling where individual participants are chosen based on colleague recommendations. Lastly, considering the respondents' possible desire to please the interviewer, response bias may have been introduced.

[2] Data Demand and Information Use in the Health Sector: Conceptual Framework (1998).

Results—Common Constraints That CBOs Face Demanding, Collecting, Accessing, and Using Data

The findings presented represent constraints to data use that were reported by two or more organizations regardless of which category they originated from. Barriers reported by just one CBO, regardless of category are not included. All results are presented according to the MEASURE Evaluation Data Demand and Use (DDU) conceptual framework.

Data Demand

In order for decision-makers to place the proper value on data, they need to have incentive or motivation to use it. Motivation to use data, results in decision-makers actively requesting and seeking out data. According to the DDU framework, Data Demand reflects the value that decision-makers place on data. Without prioritizing data in an organizational structure, the probability that it will be collected, made available, and used is low. Each of the 16 study participants interviewed reported that CBOs do not prioritize data collection in the functioning of the CBO.

Furthermore, all interviewees stated that many key CBO stakeholders do not understand the importance of data and how it can be used to improve service delivery or advocate for funding, and therefore do not demand it. Still, participants from Category 1 and 2 organizations recognized the value of systematic data collection and use. In response to requirements from their funders and/or Board of Directors, Category 1 and 2 organizations included M&E systems into their projects and are required to collect data from their member associations and/or community programs.

However, Category 1 and 2 organizations also point out that the associations and programs they support tend to focus their efforts on service delivery, resulting in unreliable and/or inconsistent M&E efforts and limited data use at the community level. Category 3 CBO participants, on the other hand, reported difficulty in prioritizing data collection and use in general due to insufficient resources for activities outside the scope of their daily service delivery. In the absence of such data, there is limited evidence-based decision making.

Data Collection

Data collection is the next element in the DDU continuum. The term Data Collection describes the methods and tools used to collect data and address information gaps. Appropriate data collection methodology leads to obtaining reliable, quality data, which in turn facilitates evidence-based decision making. All organizations collected data on the services they deliver, or in the case of those in Category 1, on the services delivered by their member organizations; however, the quantity and quality of the data collected varied, as did the methodologies used. Study results highlight that CBOs face many obstacles to data collection. The main obstacle, mentioned by all organizations, was that CBO staff often have limited experience and/or skills in data collection and M&E. Furthermore, in Category 3 CBOs, there often are no resources designated in the budget to train CBO staff in M&E or hire an outside consultant to do the work.

Category 1 (as well as one CBO from Category 2) reported that each of their donors have specific reporting requirements and fund specific data collection activities. Therefore, data collection often stops or changes when funding from a particular donor is terminated. This inconsistency makes it difficult for Category 1 and 2 organizations to consistently monitor indicators for services provided by their member associations.

A more specific obstacle to data collection mentioned by one CBO each in Categories 2 and 3 was that low literacy among local CBO workers negatively affects the quality of data collected and compiled. Meanwhile, when data collectors are employed from outside the community they struggle to obtain reliable data due to community reluctance in divulging personal information to an outsider. Finally, respondents from Categories 2 and 3 mentioned that determining appropriate incentives to engage community members in research activities proves to be challenging.

Data Availability and Access

Once data have been collected and analyzed, the next element in the MEASURE Evaluation conceptual framework is Information Availability or data sharing. It is during this step that data and information are disseminated and made publicly available in a format that is understandable and useful to those who access it. All organizations reported that they share the data they collect with either their funders or their government's Ministry of Health. Both Category 2 CBOs reported informal sharing of their data with other NGOs working on health-related issues in their country, and Category 3 CBOs reported not having the infrastructure or capacity to share data they have collected beyond their required reporting. Furthermore, Category 3 CBOs reported that CBO staff lack skills in data analysis, interpretation, presentation, and communication. Category 1 organizations reported sharing their information beyond the MOH and funders when engaged in advocating for their member CBOs.

When asked about obstacles related to accessing data external to the CBO, a number of issues were reported. Among the smaller Category 3 CBOs, the main difficulties included the fact that CBO staff are unaware of existing data sources. Moreover, they often lack formal training in data search techniques, including simple data/information searches on the Internet. Additional obstacles, mentioned by Category 1 and 2 CBOs, were that service delivery data collected by the national Routine Health Information Systems (RHIS) are not readily available and that data from other CBOs are not directly shared. Furthermore, regional/local data do not always exist, are not up-to-date, or are unreliable, and accessing certain data sets requires permission or costs money. Lastly, Category 1 organizations reported that accessing new research data proves to be challenging.

Data Use

Once data have been collected, analyzed and made available, the next step in the DDU cycle is Data Use. It is at this point in the information cycle when data are used beyond reporting and translated into policies and program improvements.

When asked how data are used, all 16 organizations said that they primarily use the information they collect to solicit new funding and update current donors on program activities. Category 1 organizations also reported using data to inform national advocacy efforts and to raise awareness

about key issues. When asked specifically about the obstacles to using data to monitor and improve their programs, Category 1 organizations (along with one CBO in Category 2) reported that due to the requirements attached to their funding sources, the data they are asked to collect do not always align with the information they need to make internal program and service delivery decisions. Furthermore, participants from Category 1 organizations reported that due to weaknesses in the M&E infrastructure of the CBOs they coordinate/support, the data they receive are often of poor quality, late, or incomplete. As a result, they are challenged to determine how and if they can use the information in decision making.

Respondents from Category 3 organizations and (with one respondent from Category 2) mentioned that local staff do not have the experience and skills to translate data into practice, meaning that they do not understand what programmatic action should or should not be taken based on the data. These CBOs also reported that their local staff do not value the importance of using data in their organization's program planning/strategic planning process. Finally, every organization—regardless of their category—mentioned difficulties in incorporating data into decision making at the community level, where there is limited time and capacity to focus efforts on anything other than service delivery.

DISCUSSION

Results from this analysis underscore the fact that CBOs face many obstacles to incorporating data in decision making, and that many of these obstacles are common among specific categories of NGOs. Furthermore, the obstacles discussed in this analysis have been shown to mediate the four elements of the MEASURE Evaluation DDU conceptual framework.

When the findings are considered in the context of the framework, the interdependent nature of the barriers are revealed and their impact on limiting data-informed decision making becomes clear (see Figure 1). Because of their interdependent nature, it is challenging to pinpoint the most limiting barrier to data use; however, many of the obstacles seem to originate from insufficient demand for data.

Results reveal that it is often challenging for CBOs to prioritize M&E equally with service delivery and community support activities. Although all of the organizations in this analysis collected data on the services they deliver, the data were of varying quantity and quality. Respondents reported that CBOs often do not fully understand how data can be used to inform programs, policies and advocacy messages and, therefore, do not consider M&E to be a priority undertaking. In these contexts, M&E activities do not receive the financial and human capacity commitments necessary to make them function well. Even when CBOs recognize the value of information, they are limited by insufficient resources and do not have the staff to dedicate to activities other than delivering health services.

In the instances where data collection is prioritized (Category 1 and 2 organizations), the demand for data often stems from the need to show program success and to continue and/or expand funding from donors. Donors often require CBOs to collect a predefined set of indicators, which often do not align with the decision-making needs of the organization. When donors require collection and reporting of data for continued funding, organizations must comply, and the donor's M&E requirements take precedence. As a result, many CBOs do not develop their own indicators or identify the information that will inform their own decision-making needs. In this context, the culture of M&E becomes one focused on reporting versus monitoring the delivery of services, identifying and evaluating problems, and making program and policy decisions based on evidence.

In addition to the discrepancy between reporting data versus using data in decision making, there is an evolution of data use within CBOs as they grow and become more complex. As Category 1 organizations take on more CBOs, and Category 2 CBOs expand their service delivery to additional sites and geographic areas, the management of the expanded programs becomes decentralized and more difficult to oversee. As a result, it becomes increasingly important to have data in order to monitor and evaluate satellite and member activities. Category 1 and 2 organizations, indicated that the "headquarters office" appreciates the value of data more than the CBOs/member groups. The satellite sites do not

necessarily share the same value of the data they collect as do the members of their coordinating "headquarters." Without a shared value and demand for data, information is often collected haphazardly at the community-level, thereby hampering the availability and use of data in decision making. This finding also relates to Category 3 organizations. As a single site organization that is more easily managed through day to day interactions with service providers, the demand for data is not great.

It is also worth noting that each organization in our analysis shared their data with their funder or their national Ministry of Health. However, only Category 2 organizations mentioned sharing their information with other CBOs working in the same field. While the reasons for the lack of data sharing were not investigated by this research study, it is posited that this finding is related to a lack of demand for and prioritization of data from other organizations, little incentive to share data and potential competition among CBOs for funding.

Also illuminated by the findings is that accessing data external to the CBO, such as topic specific research study data or national RHIS data, was challenging. The poor availability of RHIS and secondary data may also contribute to the CBO's low demand for data. It is hypothesized that without a culture of information sharing and information availability, requests for information will not be met and therefore negatively affect future demand for information.

The cyclic nature of the MEASURE Evaluation Data Demand and Use conceptual framework makes it difficult to distinguish which element in the framework functions as the 'tipping point' for data use. It is often unclear if a high demand for data leads to use of data or if regular use of data leads to a high demand for data. Without this precision, it is also challenging to identify where to intervene to improve data informed decision making. Fortunately, in the CBO contexts investigated by this study, the data suggest that the lack of demand for data is driving the low levels of data-informed decision making. While the study found that there are multiple barriers to data use, the majority of them can be traced back to an insufficient prioritization of M&E activities. Without demand for data, resources to improve M&E data collection systems and adequately staff the functions associated with them, will not be prioritized or realized.

Recommendations to Facilitate Data Collection and Use

In order to improve data-informed decision making, the demand for data needs to be strengthened among all CBOs interviewed in this study. Globally, there is growing interest from national governments and some donors in strengthening community-based information systems. CBOs can engage in this dialogue to ensure that their voices are heard and to strengthen advocacy efforts to ensure that the commitment to M&E is continued. Within their own organizations, CBOs can also improve data collection and use. Possible initiatives are listed below by CBO Category.

Umbrella Coordinating (Category 1) Organizations

As the national-level coordinating body for issue-specific CBOs, Category 1 organizations have a significant responsibility to lead the effort to improve data-informed decision making. Specifically, they can:

- Advocate to governments and donors to prioritize the support of CBO M&E activities. Specifically, the development and maintenance of good data systems, the regular review of data, and the consideration of data during decision making.
- Fundraise/solicit funds specifically for internal M&E systems, dedicated staff and other activities, as well as for member CBOs.
- Provide technical assistance to CBOs on M&E and data use.
- Assist member CBOs/satellite sites with the development of meaningful programmatic indicators that are linked to decision making.
- Share aggregated data with member CBO and other relevant stakeholders
- Facilitate the sharing of relevant secondary data results (research, surveys, or national RHIS) with member CBOs.
- Foster partnerships among member CBOs that have established M&E systems and skills with those that don't to develop a mentoring relationship that builds M&E capacity and systems.
- Provide networking opportunities among CBOs to share experiences and lessons learned on successful M&E systems and data-informed decision making.

Multi- and Single-Branch (Category 2 and 3) Organizations

While the mandate of Category 2 and 3 organizations is to focus on delivering services at the community level, the lack of data to inform decision making will eventually impede their ability to effectively and efficiently do so. These organizations can begin to prioritize M&E and data use by:

- Prioritizing M&E systems, staff, and activities in the organization's yearly operational plan and budget, and in program/project budgets.
- Building staff skills in M&E and data use. Access on-line and print resources for this purpose (see resources section below).
- Prioritizing services and selecting a subset of regularly monitored indicators that will inform decision making related to priorities.
- Initiating quarterly data review meetings to monitor trends and discuss data quality.
- Coordinating data collection activities and sharing data with other CBOs in the community/region.
- Including key community members in the data collection process in order to foster trust and open communication.

IMPROVING DATA COLLECTION AND USE: RESOURCES FOR CBOS

Global Initiatives

The Global Fund to fight AIDS, Tuberculosis and Malaria has developed the CSS Framework in collaboration with other stakeholders to clarify the range of community strengthening activities the Global Fund is mandated to support.

- For overview see: http://www.theglobalfund.org/documents/rounds/8/r8css_factsheet_en.pdf
- To join the Community systems strengthening discussion listserv send an e-mail to: Join-cssframeworkconsult@eforums.healthdev.org

Capacity Building

Online Courses

The Global Health eLearning Center, developed by the USAID Bureau of Global Health, offers a menu of free online courses that learners can use to expand their knowledge in key public health areas, and to access important up-to-date technical information. MEASURE Evaluation has collaborated with USAID and their partners to develop the following courses: (1) M&E Fundamentals, (2) M&E Frameworks for HIV/AIDS Programs, and (3) Data Use for Program Managers. Visit: http://www.globalhealthlearning.org/learnmore.cfm

These courses can also be accessed at the MEASURE Evaluation web site. http://www.cpc.unc.edu/measure/training/online-courses

Assessing Community Health Programs: A Trainer's Guide to Using LQAS for Baseline Surveys and Regular Monitoring

This guide is intended for managers, field supervisors, and others who plan, monitor and evaluate community health programs. The guide provides a raining approach in a simple and rapid method for collecting data to use for planning, monitoring and evaluating community health programs.

- For the trainers manual visit: http://www.coregroup.org/storage/documents/LQAS/Intro.pdf
- For the participant's manual visit: http://www.coregroup.org/storage/documents/Workingpapers/LQAS_Participant_Manual_L.pdf

Malawi Community-Based Organizations M&E Curriculum

This two-module curriculum was developed for the National AIDS Commission in Malawi as a generic monitoring and evaluation curriculum and training guide. The curriculum was used by various national umbrella NGOs, who worked with NAC in the field of AIDS services, to train members of community based organizations (CBOs) in basic M&E techniques.

- Module 1 can be found at: http://gametlibrary.worldbank.org/FILES/146_M&E%20Curriculum%20for%20CBOs%20-%20Malawi%20Module%201.pdf
- Module 2 can be found at: http://gametlibrary.worldbank.org/FILES/147_M&E%20Curriculum%20for%20CBOs%20-%20Malawi%20Module%202.pdf

The Global HIV M&E Information Web site

This web site is designed for M&E specialists supporting HIV/AIDS initiatives in countries, headquarters, regional organizations, and communities. For specific capacity building training opportunities and resources visit: http://www.globalhivmeinfo.org/CapacityBuilding/Pages/Default.aspx

The PCMi online learning M&E course

A four-week interactive workshop designed for individuals who are new to the field of M&E and for those who wish to formalize their existing understanding of the process. Tuition payment required. For more information visit: http://pcmitraining.com/course/category.php?id=2

My M&E

My M&E is an interactive WEB 2.0 platform to share knowledge on country-led M&E systems worldwide. In addition to being a learning resource, My M&E facilitates the strengthening of a global community, while identifying good practices and lessons learned about program monitoring and evaluation in general and on country-led M&E systems in particular. Visit: http://www.mymande.org/?q=wikimehome

Resources and Tools

CLPIR Tool Kit

The Community-Level HIV/AIDS Program Information Reporting Tool Kit (CLPIR Tool Kit), developed by MEASURE Evaluation, is intended for users at the national, sub-national, and community levels to assess existing community-level information systems, harmonize national reporting requirements for community-level programs, and strengthen the capacity of community-level programs and service providers to collect, report and use information. To access the Tool Kit visit: http://www.cpc.unc.edu/measure/tools/hiv-aids/clpir

Participatory M&E of Community-and Faith-Based Programs

To improve the impact of community-based HIV/AIDS interventions, the CORE initiative developed a step-by-step guide for implementing participatory M&E of community-and faith-based programs. For materials visit: http://www.ccaba.org/resources/Participatory%20Monitoring%20and%20Evaluation%20of%20HIV-AIDS%20Programs%20-%202nd%20edition.pdf

Conceptual Framework

To support evidence-based decision making, MEASURE Evaluation has developed a conceptual framework and set of tools to aid policymakers and stakeholders in implementing data demand and use strategies. In this framework, there is a clear and consistent link between the use of health information and the commitment to improving the quality and availability of data. For materials visit: http://www.cpc.unc.edu/measure/approaches/data-demand-and-use/

Strengthening Information Systems for Community-Based HIV Programs

In order to develop a way forward to strengthen information systems for community-based HIV programs, a meeting was convened with representatives from multinational agencies, international profit and nonprofit organizations, and local implementing partners. The meeting generated a report that outlines the group consensus. For the full report visit: http://www.cpc.unc.edu/measure/program-areas/hiv-aids/technical-consultation-on-community-based-hiv-programs-report

Assessment of Data Quality

Quality data is critical to making evidence-informed decisions. For a Tool Kit to assist in the assessment of data quality visit: http://www.cpc.unc.edu/measure/tools/monitoring-evaluation-systems/data-quality-assurance-tools/Routine%20Data%20Quality%20Assessment%20Tool-June%202008.xls/view?searchterm=data quality

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Table A: CBO Categories Defined

Category	Organization	Estimated Annual Budget	Population Served	# Paid Staff	Key Activities
1	**Rwanda** Réseau Rwandais des Associations des Personnes Vivant avec le VIH	$789,400	1,051 associations and cooperatives of PLHIV and affected people (74,861 members)	28	1) TB/HIV—community education 2) Nutrition and health—healthy nutrition education, cooking demonstrations, community cooperative gardens 3) OVC support 4) Democracy, decentralization, and good governance activities 5) PEARL (Peer Educator, Adherence, Referral, and Linkages) 6) M&E
1	**Nigeria** Network of People Living with HIV/ AIDS	$2.5 million	600 PLHIV support groups across 36 states	24	1) Establishment, capacity building, and coordination of PLHIV support groups 2) National level PLHIV advocacy 3) Grants administration to community groups for: stigma reduction, treatment adherence support, home-based care to the chronically ill, and income generation.
2	**Kenya** I Choose Life	$1.5 million	Out of school youth and youth in institutions of higher learning (approximately 20 institutions, including high school) throughout the country. Trained approximately 100,000 youth.	60	1) HIV prevention and sexual reproductive health education 2) Peer education training program—equip youth with life skills (reducing sexual partners, preventing drug use, etc.)
2	**Cameroon** Education Fights AIDS International	$70,000	5 associations (72 active members) for youth less than 35 years of age infected or affected by HIV, in 5 communities in northern Cameroon	3	1) Life skills training and education 2) Youth network to reduce HIV stigma and lead communities towards social change
3	**Guatemala** Escuala de la Calle (EDELAC)	$100,000	Approximately 90 families and 200 at-risk children between the ages of 5-14 in the community of Quetzaltenango.	16	EDELAC School 1) Primary education Hogar Abierto (Open Home) 1) Transitory home & nourishment 2) Educational/job support 3) Primary medical attention and mental health services Community Social Work/Parents' School 1) Health education workshops to community parents (topics—disease, sexual health, mental health, self-esteem, gender equity, nutrition, etc.)
3	**Ecuador** MeHiPro	$65,000	One rural health clinic that serves approximately 6,000 people living in Mache-Chindul Reserve, Esmeraldas Ecuador	5	1) Primary health care services 2) Health education and service delivery outreach 3) First aid and preventative healthcare training for rural community outreach workers