

30
X
30 **CCIH**
HEALTH
SYSTEMS
INITIATIVE

ANNUAL
PROGRESS
REPORT
2022



CCIH
Christian Connections
for International Health

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BACKGROUND

The 30x30 Health Systems Initiative, launched in 2019 by Christian Connections for International Health (CCIH), aims to strengthen 30 health systems globally within which faith-based health services operate by 2030. Faith-based organizations (FBOs) frequently collaborate with governments and private providers to deliver healthcare across complex health systems in low- and middle-income countries (1). They contribute towards the provision of preventative, promotive, and curative services, and are often the only health services available to economically marginalized groups in both rural and urban settings. As shown in Figure 1, there are various types of organizations that provide faith-based health services, each of which plays a distinct role. Similar to other health sectors, FBOs are often faced with health systems challenges including capacity building, governance and infrastructure.

Figure 1: Types of FBOs and their key activities



The 30x30 initiative seeks to describe and measure the efforts of faith-based health services to strengthen health systems throughout the world between 2020 and 2030. The 30x30 initiative demonstrates CCIH's commitment to working through individual members, affiliates, and other organizations to improve one or more of the World Health Organization (WHO) health systems building blocks, namely health workforce, leadership and governance, service delivery, access to essential medicines and supplies, health information systems, and financing. Additionally, CCIH includes “community services” as an additional block, recognizing that a strong health system is contingent on the interconnectedness between the community and health facility.

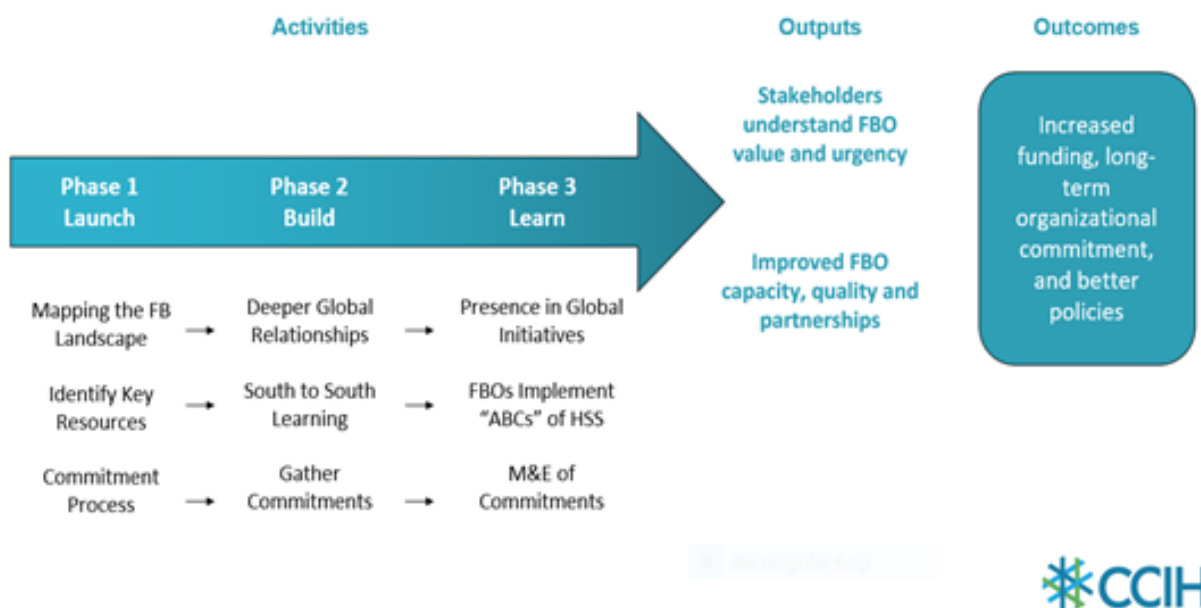
At the core of the 30x30 initiative is the “commitment”, a public statement made by organizations, where they commit to work with CCIH and report data to measure progress of their planned or ongoing activities.

The key objectives of the 30x30 initiative are to:

- Increase global attention to the work of faith-based health services.
- Work alongside faith-based health services to improve resource mobilization, and improve programs and policies.
- Gather evidence of stronger health systems for FBOs.

CCIH anticipates that through the process of making public commitments and measuring commitment makers' planned or ongoing activities, we will promote dialogue that facilitates learning exchanges and increases the presence and visibility of faith-based health services in global initiatives. This should, in turn, translate to stronger partnerships among FBOs and between FBOs and other sectors through strengthened capacity to deliver quality services. Additionally, external stakeholders will gain a deeper understanding of FBOs' value and the potential impact of investing in FBO work. This Theory of Change framework is demonstrated in Figure 2.

Figure 2: Theory of Change

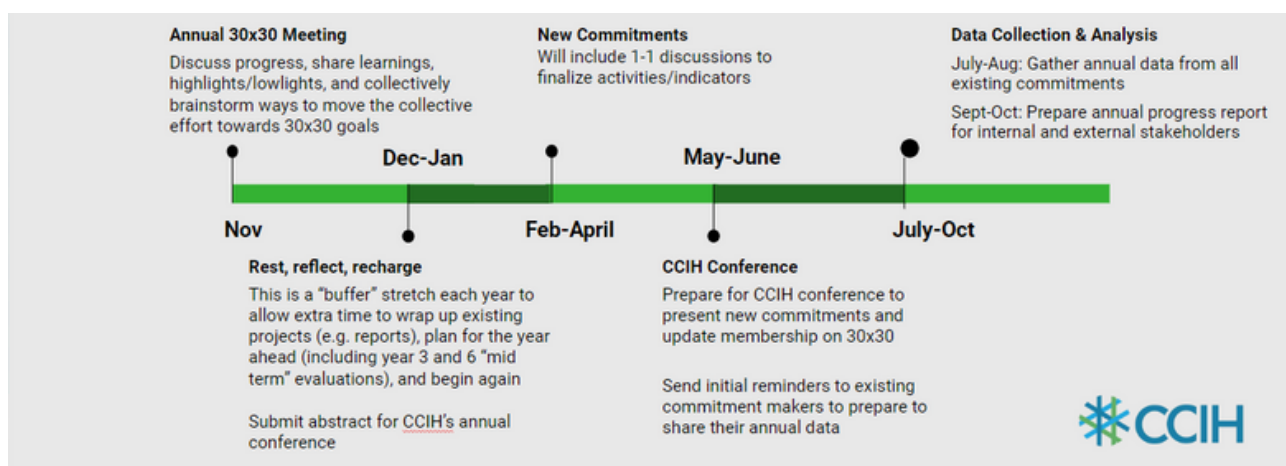


PROGRESS THUS FAR

Call for Commitments

Following the launch of the initiative, CCIH issued the first call for commitments from member organizations and affiliates in late 2019. This first cohort of commitments (Y1 cohort) were published in a report in April 2020. The second and third calls for commitments were made in January 2021 and 2022, respectively, and these were added to the [commitment report](#) in June 2022 (Y3 cohort). Moving forward until 2027, a call for commitments will be made annually at the beginning of each year, as depicted in the timeline in Figure 3.

Figure 3: 30X30 Timeline



COMMITMENT REFINEMENT

After commitments were submitted, they underwent a review process by the CCIH 30x30 team. During this stage, the CCIH 30x30 team worked with commitment makers to clarify and refine the goals, objectives and specific activities of each new commitment maker. In addition, the CCIH 30x30 team worked with each commitment maker to develop and refine the program indicators for the planned activities.

Building on this experience, the CCIH 30x30 team developed a [document of common indicators](#) for each health systems strengthening block which will be a reference document for future commitment makers. This indicator document was included in the commitment submission form for years 2 and 3, referred to as the Y2 and Y3 cohorts of commitment makers. It guided the commitment makers to select the right indicators during the submission stage itself, facilitating a streamlined commitment making process. Thus, the commitments, activities, and indicators were all reviewed by the 30x30 team in a singular submission, and then refined through individual sessions with the commitment makers.

TECHNICAL SUPPORT BY CCIH 30X30 TEAM

To date, roughly 900 hours have been spent by project staff in refining project activities, selecting indicators, and analyzing the impact and outcomes of the public commitments. This represents a large capacity building component of the 30x30 initiative as technical training and resource sharing is undertaken by the stakeholders. Furthermore, in order to ensure the quality of data and ensure uniform understanding among the commitment makers in the data submission process (outlined below in 2.4), a Monitoring, Evaluation, and Learning (MEL) forum was conducted in July 2022, which was attended by 37 participants from 21 organizations out of the 33 commitment makers. The event focused on providing guidance and building the capacity of commitment makers on data collection, collation and submission processes in the online data submission platform.

DATA SUBMISSION

All commitment makers submitted their annual performance indicators (July to June) in the online database platform that was launched in September 2021, and all three cohorts (Y1-Y3) of commitment makers used this platform to submit data in 2022. In addition to quantitative data, optional qualitative data was also requested from the Y1-Y3 cohort commitment makers in 2022.

PURPOSE AND OBJECTIVES

The purpose of this report is to present a summary of the progress made through the 30x30 initiative towards achieving the intended objectives of the project since its launch in 2019. The specific objectives of this report are:

- To present the health systems strengthening efforts by faith-based health services.
- To summarize the scale, scope and reach of 30x30 since the launch of the initiative.
- To assess the key gaps and challenges in the implementation of 30x30 and recommend strategies for upcoming years of the initiative.

METHODOLOGY

The report is based on the analysis of quantitative and qualitative data submitted by the commitment makers. Data from all three cohorts of commitment makers (Y1-Y3) was used for analysis.

DATA ANALYSIS

The submitted data that includes the geographic focus, health system strengthening areas, and annual achievements were downloaded, collated and analyzed using Microsoft Excel to describe the characteristics of the commitments and trends of progress of the initiative since the inception of the initiative. The indicators for each of the commitments were aggregated, by identification of common activities and further grouped into sub-categories of activities. Common activities were generated by one of the CCIH 30x30 team members, and reviewed and verified by a second team member for coherence. A given indicator cannot be assigned to more than one common activity, thus efforts were made to assign indicators to the most appropriate common activity. As some indicators were highly specific to a single activity and couldn't be aggregated, they were excluded from tables/figures, and instead were outlined under the appropriate subheading in the following Key Findings section.

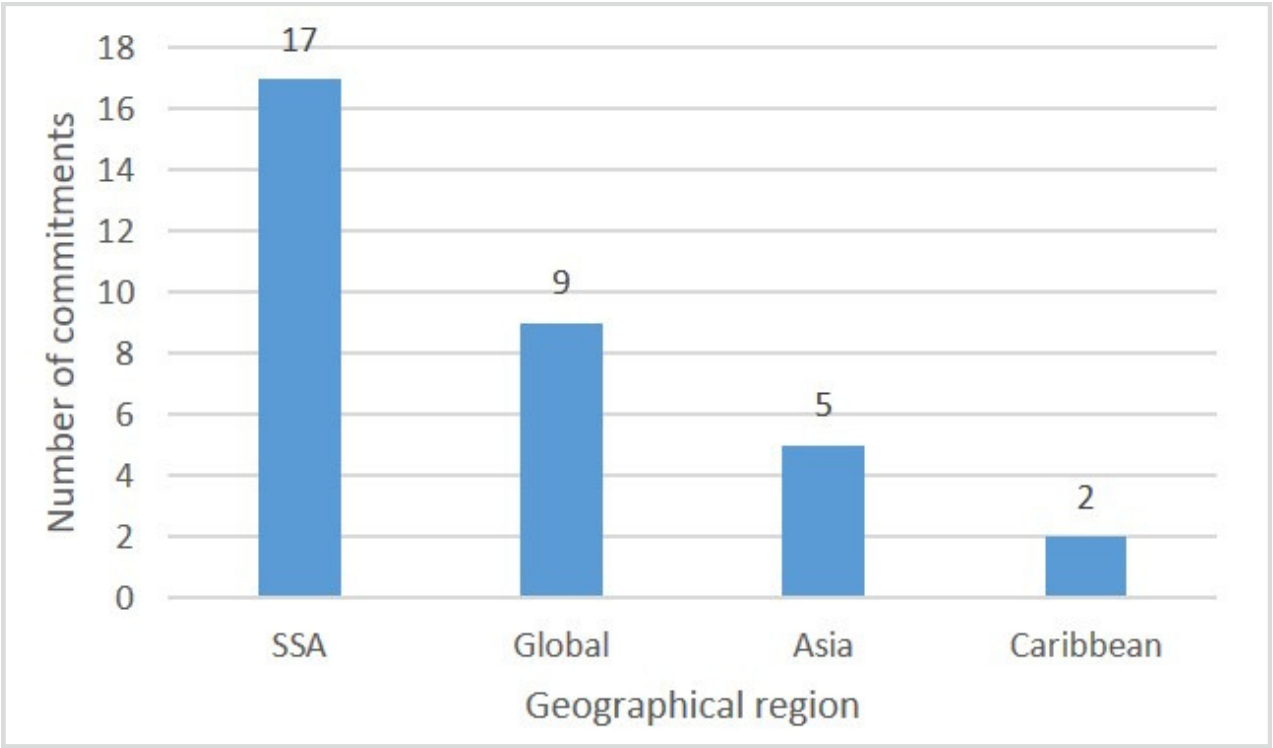
CURRENT STATUS OF COMMITMENTS

Over the past three years, 40 commitments to the 30x30 initiative have been received and accepted: 22 in Y1, 10 in Y2, and 8 in Y3 of the initiative. Two organizations in the Y1 cohort completed their commitments and five other organizations opted to withdraw their commitment. During year 3 of the initiative, all Y1, Y2 and Y3 cohort commitment makers were able to submit 2021-2022 data by the deadline for inclusion in this report—except for one commitment maker, due to the current crisis in their country. Thus, we present a synthesis of 33 commitments in this report.

KEY FINDINGS

As of 2022, the 30x30 health initiative has 33 active commitments from 36 organizations across 35 countries. The sub-Saharan Africa (SSA) region represents the most commitments (17, 49%), followed by the Asian region (5, 14%) as shown in Figure 4 below.

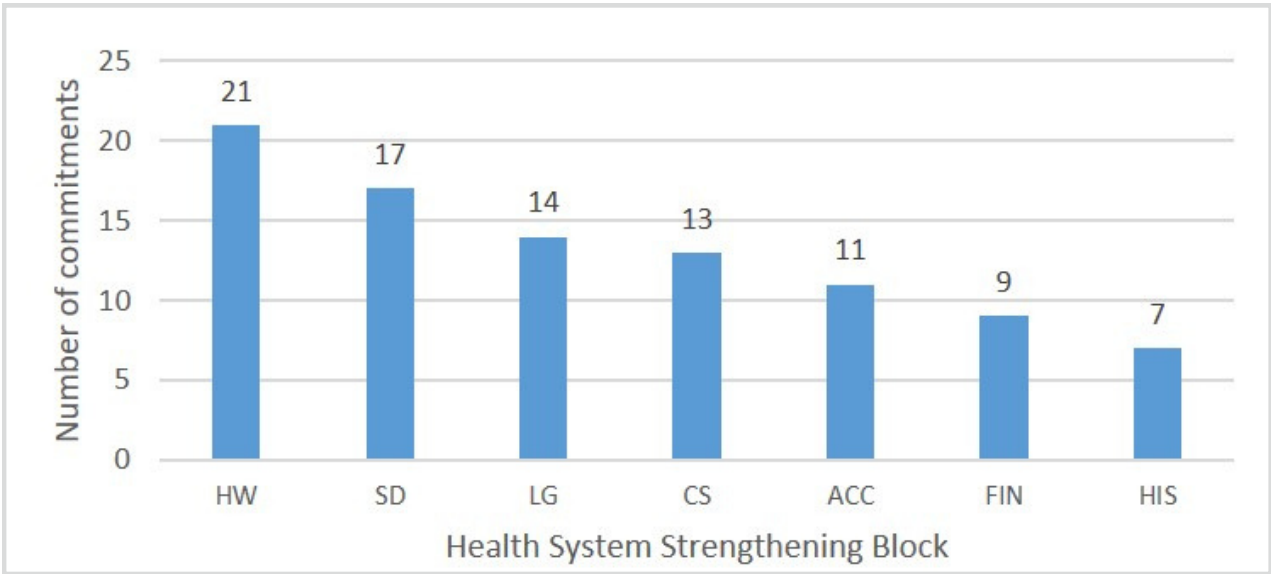
Figure 4: Commitments by Geographical Location



*SSA: Sub-Saharan Africa

The activities and focus areas of the commitment makers were classified under health systems building blocks as defined by the World Health Organization, in addition to our additional category of Community Services. We present in Figure 5 the number of commitments seeking to address each of the blocks. Health workforce was the most common commitment area, with 64% (n=21) of the commitment makers involved in this domain. Service delivery followed, with 52% (n=17) commitments. Leadership and governance was third, with 42% (n=14) commitments. Then community services for 39% (13), access to essential medicines for 33% (n=11), and financing for 27% (n=9). Health information systems was the least common focus area with 21% (n=7) commitments. In Y3 the activities and focus areas of commitment makers were more evenly distributed across the health system building blocks, compared to the previous two years.

Figure 5: Commitments by Health System Strengthening Block



HW: Health Workforce, SD: Service Delivery, LG: Leadership & Governance, CS: Community Services, ACC: Access to essential medicines and supplies, FIN: Financing, HIS: Health Information Systems

Considering the different number of commitments under each of the health systems building blocks, a common public health framework – the socio-ecological model, is used to examine the commitments at a broader level, thus facilitating aggregation of indicators (2).

Analysis of the indicators revealed that commitments were made at multiple levels of the socio-ecological model, targeting individuals, institutions, communities, and the health system as a whole.

INDIVIDUAL-LEVEL

The commitments targeting the individual level were predominantly related to capacity building on a variety of subject areas and improving access and utilization of health services. The specific activities were training programs and provision of health related services through health programs including inpatient services and outpatient services. Each of these were further categorized to define them further.

TRAINING PROGRAMS

In the first three years of the 30x30 initiative, 4,683 training programs were delivered by commitment makers. In Y1, 600 programs were delivered by seven Y1 commitment makers, in Y2, 910 training programs by Y1 and Y2 commitment makers, and in Y3, 3,173 training programs by Y1, Y2 and Y3 commitment makers (Figure 6).

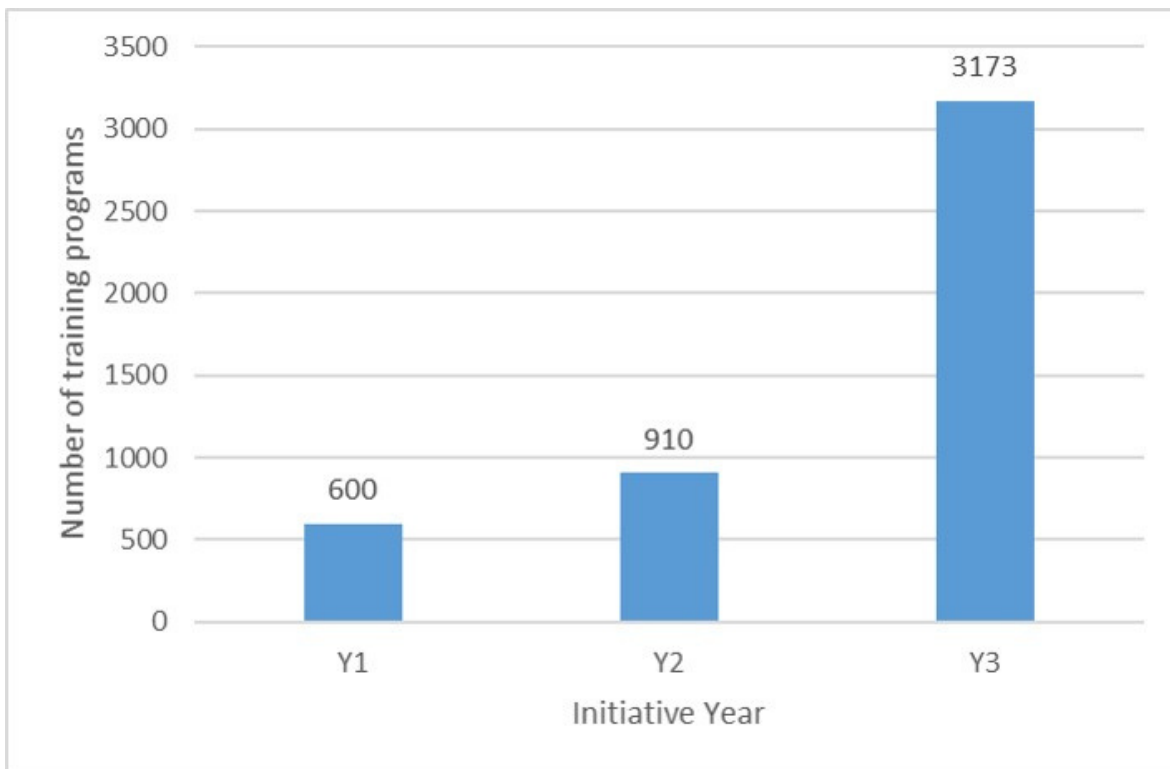
Training programs largely focused on strengthening the health workforce to improve leadership and governance, service delivery, health information systems, health financing and community services. These programs were delivered to a wide range of health care professionals including medical officers, nurses, laboratory technicians, pharmacists, community health personnel and administrators which covered twelve subject areas namely (alphabetically listed):

- Basic/General Health Services
- Clinical Practice,
- Document Management
- Equipment Management
- Financial Management
- Leadership and Governance
- Maternal, Newborn, and Child Health
- Pharmacy Management/Practice

Newly added subject areas in Y3:

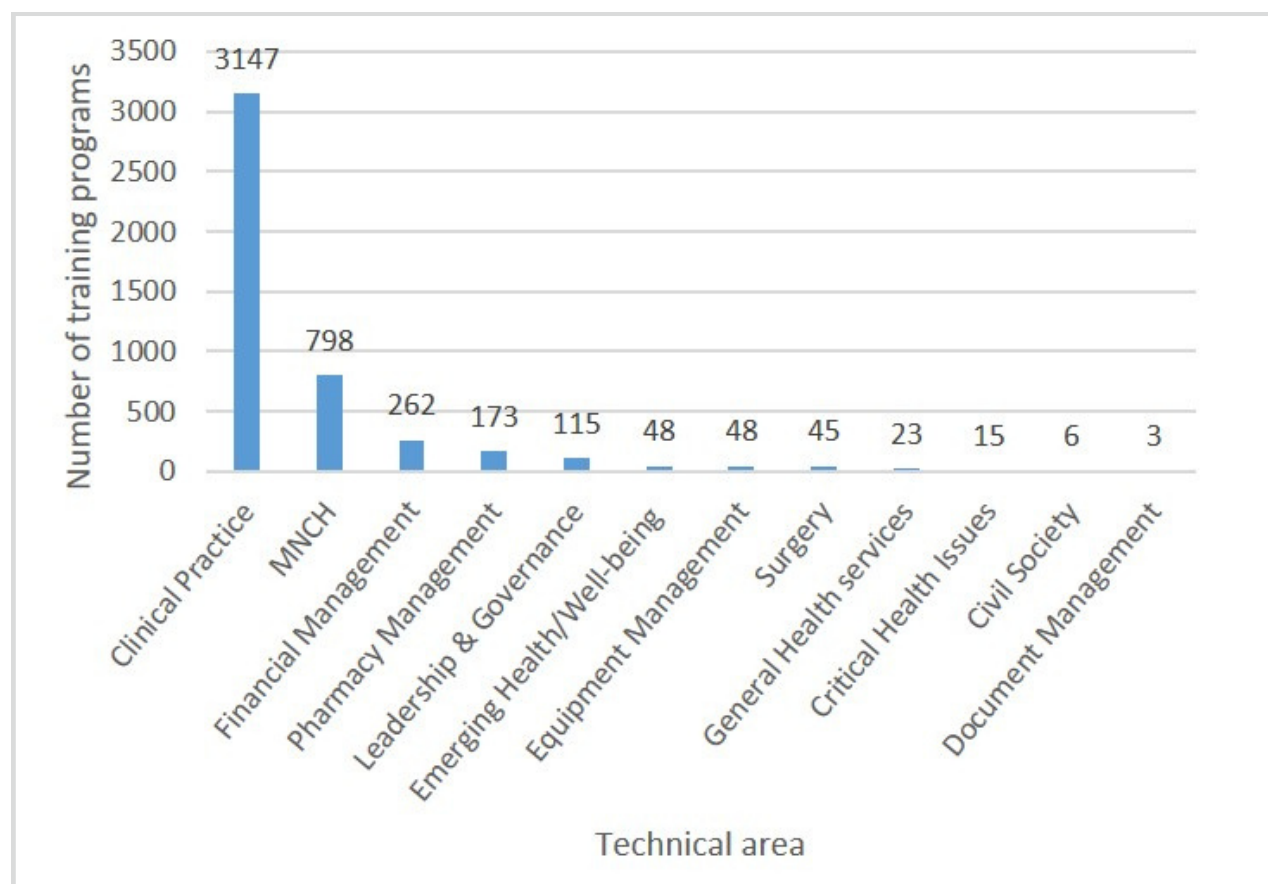
- Civil Society
- Critical Health Issues
- Emerging Health/Wellbeing Issues
- Surgery

Figure 6: Total Training Programs by Year



Y1: Year 1, Y2: Year 2, Y3: Year 3

Figure 7: Number of Training Programs by Category (Cumulative of Y1, 2, and 3)



MNCH: Maternal, Child and Neonatal Care. 'Pharmacy management' includes Pharmacy practice.

The considerable increase in training programs delivered in Y3 (Figure 6) is the result of the training programs delivered by one commitment maker (n=2974). The number of training programs delivered in Y3 would have fallen from 3,173 to 199 if their data had not been included, indicating a considerable decrease in the number of training programs delivered by commitment makers in Y3 compared to the two years prior (Figure 6).

“THE ADVENT OF COVID19 PROMPTED US TO ADAPT TO REMOTE FUNCTIONING VIA THE INTERNET... PHYSICAL MEETINGS WERE SUSPENDED. SUBSEQUENTLY, COORDINATION, MONITORING AND REPORTING ARE NOW ALSO DONE VIA THE INTERNET. TO DO THIS, WE ORGANIZED UPSTREAM TRAINING FOR OUR STAFF AND VARIOUS PROJECT TEAMS ON THE SOFTWARE REQUIRED FOR THIS NEW APPROACH.”

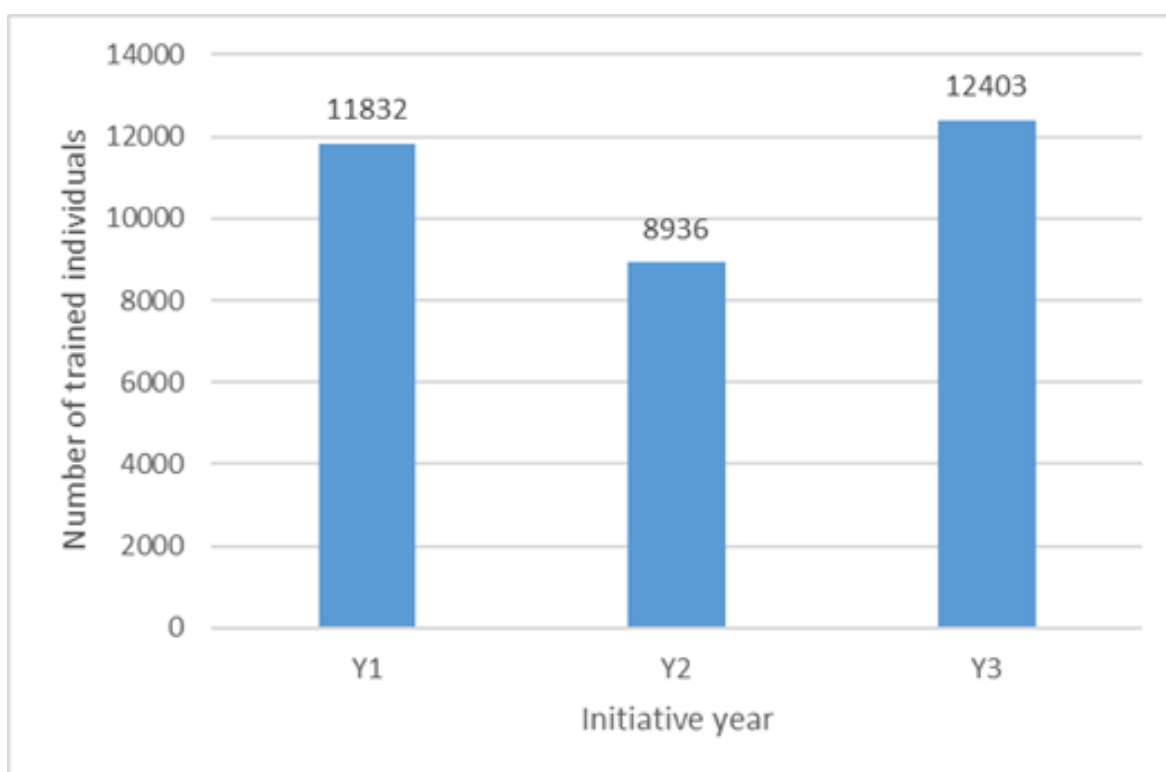
30X30 COMMITMENT MAKER

Additionally, three family medicine and internal medicine-pediatrics residency programs were established by a single commitment maker in SSA, resulting in the enrollment of 57 residents, of which 15 reached program completion. Furthermore, 29 consultants were trained to deliver the residency programs by the same commitment maker.

PERSONNEL TRAINED

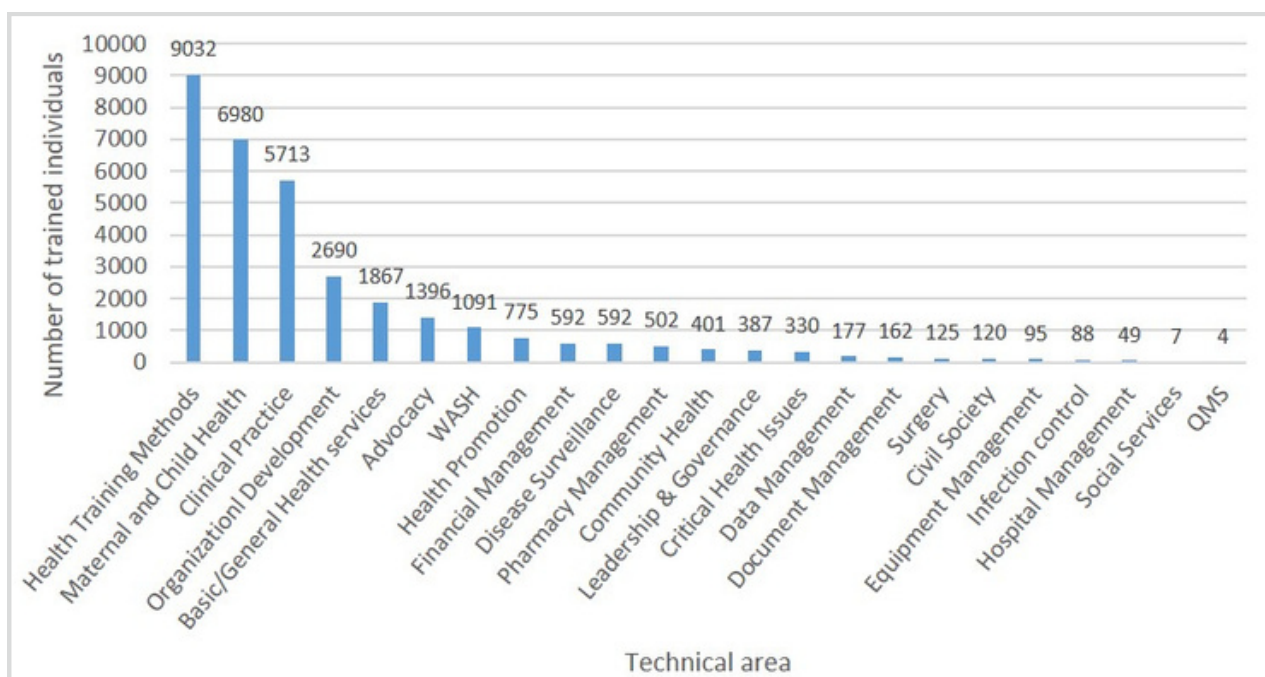
Commitment makers trained personnel with a view to strengthen the health workforce in different technical areas. In the first three years of the initiative, 33,175 personnel were trained; of which 11,832 personnel were trained by 16 Y1 commitment makers in Y1, 8,936 personnel were trained by 23 Y1 and Y2 cohort commitment makers in Y2, and 12,403 personnel were trained by 21 Y1, Y2, and Y3 commitment makers in Y3 (figure 7). Personnel, who belong to various health care professional cadres, were trained on a wide range of 24 subject areas (Figure 8, Table 1).

Figure 7: Number of Personnel Trained by Year



Y1: Year 1, Y2: Year 2, Y3: Year 3

Figure 8: Number of Personnel Trained by Category (Cumulative of Y1,2&3)



'Pharmacy management' includes Pharmacy practice.

QMS: Quality Management System

The number of personnel trained in health training methods (trainees trained to become trainers) accounts for the highest proportion of personnel trained across the three years of the initiative (Figure 8), despite being carried out by a single commitment maker. Leadership & Governance and MNCH services were found to be the most common training subject areas across all commitment makers, delivered by three commitment makers.

Table 1: Number of Personnel Trained by Year

People trained	Y1	Y2	Y3	Total
Health Training Methods	5876	1182	1974	9032
Maternal and Child Health	1435	1673	3872	6980
Clinical Practice	3061	498	2154	5713
Organizational Development	54	2632	-	2690
Basic/General Health services	656	516	695	1867
Advocacy	-	573	823	1396
WASH	-	92	999	1091
Health Promotion	106	326	343	775
Disease Surveillance	80	326	186	592
Financial Management	188	404	-	592
Pharmacy Management/Practice	199	291	12	502
Community Health	115	141	145	401
Leadership & Governance	29	76	282	387
Critical Health Issues	-	-	330	330
Data Management	30	80	67	177
Document Management	1	-	161	162
Surgery	-	-	125	125
Civil Society	-	-	120	120
Equipment Management	-	29	66	95
Infection control	-	88	-	88
Hospital Management	-	-	40	40
Hospital administration	-	-	9	9
Social Services	-	7	0	7
QMS	2	2	-	4
Total check	11832	8936	12403	33175

The symbol [-] denotes that no data was available in that given year.

Over three years, the percentage coverage of trained personnel was reported by two commitment makers. One commitment maker provided training in pharmacy management/practice to 35% of personnel, and another commitment maker was able to provide training in general health services and key skill areas to all health personnel.

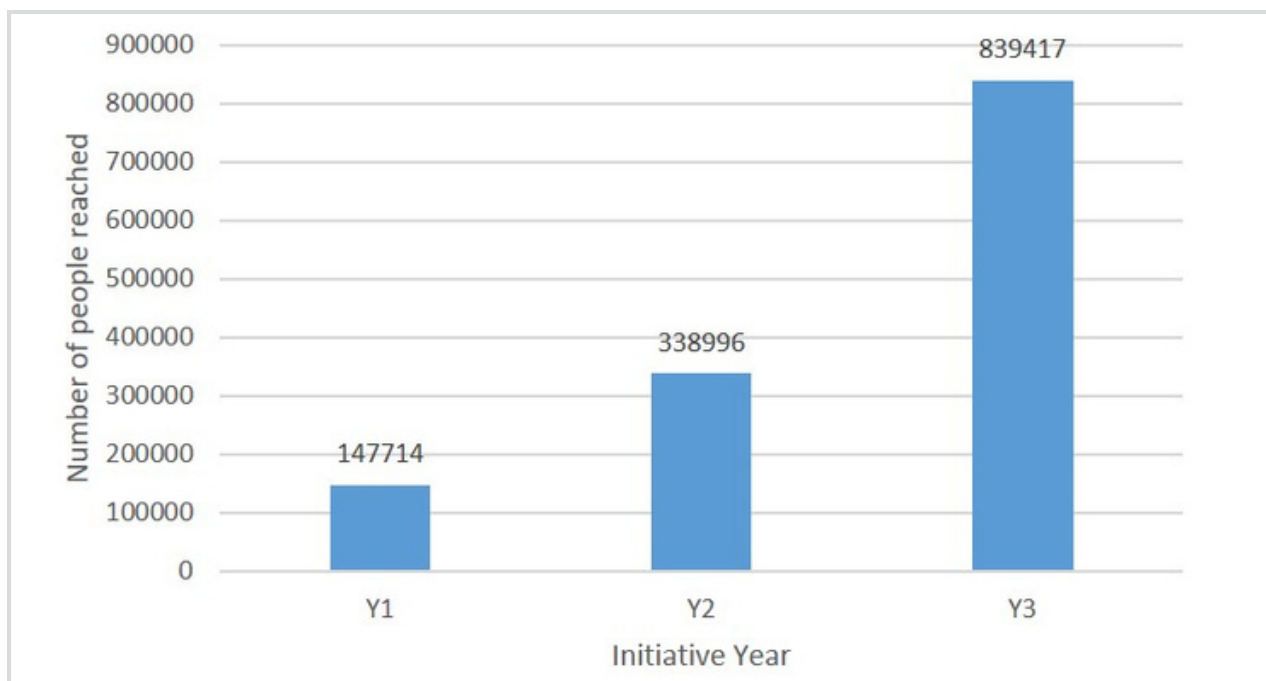
GRADUATES FROM OUR AFFILIATED PROGRAMS CONTINUE TO TAKE ON LEADERSHIP ROLES SUCH AS LEAD PROGRAM COORDINATORS OF RESIDENCIES, CLINICAL SERVICES DIRECTOR AND CEOS OF PARTICIPATING TEACHING HOSPITALS."

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PEOPLE REACHED THROUGH HEALTH PROGRAMS

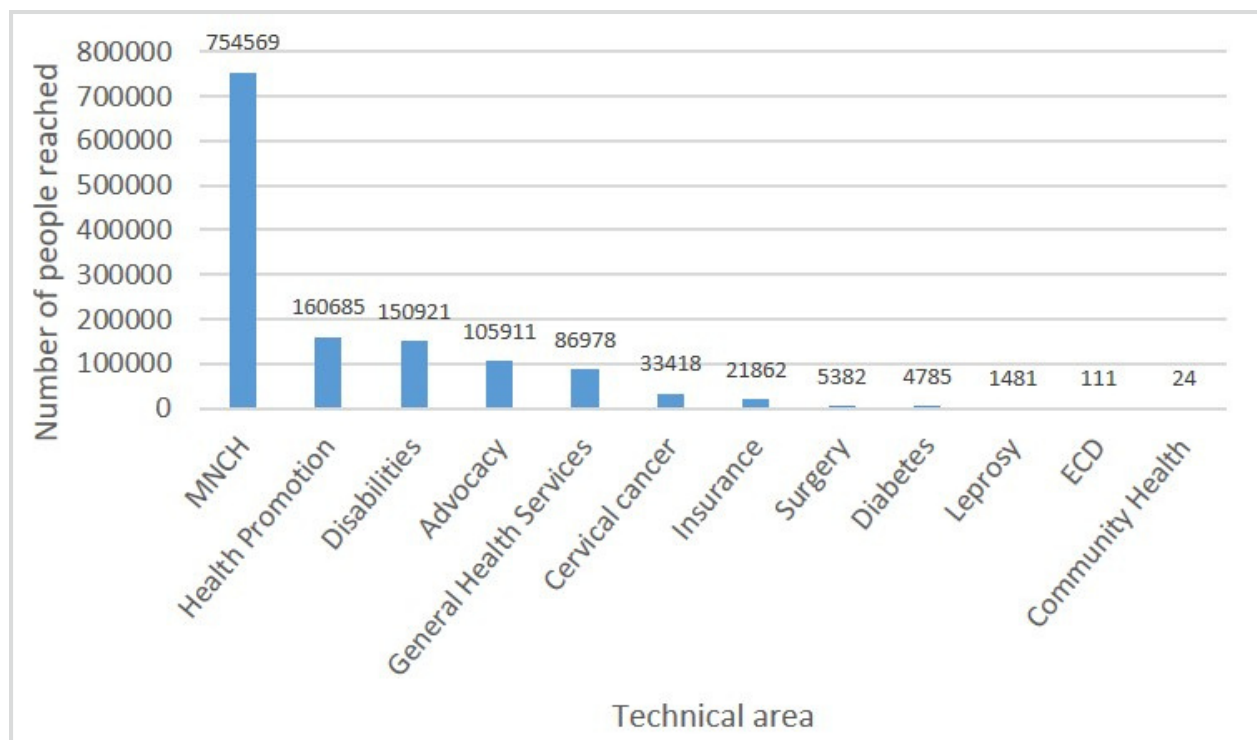
Commitment makers delivered various health programs to improve the access and utilization of health services primarily, with a few programs also seeking to strengthen community services. During the first three years of 30x30, more than a million (n=1,326,127) people were reached by various health programs. In Y1, 147,714 people were reached by Y1 commitment makers, 338,996 people were reached by Y1 and Y2 commitment makers in Y2, and 839,417 people were reached by Y1, Y2, and Y3 commitment makers (figure 9). The types of programs covered a range of subject areas, as laid out in Table 2.

Figure 9: Number of People Reached Through Health Programs by Year



Y1: Year 1, Y2: Year 2, Y3: Year 3

Figure 10: Number of People Reached Through Health Programs by Category (Cumulative of Y1, 2, and 3)



MNCH: Maternal, Child & Neonatal care, ECD: Early Childhood Development

Table 2: Number of People Reached Through Health Programs by Year

People reached through health programs	Y1	Y2	Y3	Total
Disabilities	78,495	72426	-	150921
Advocacy	-	103224	2687	105991
Maternal, Newborn & Child Health	250	91276	663043	754569
General Health Services	22982	23899	40097	86978
Health Promotion	13096	31696	115893	160685
Cervical Cancer	13480	12392	7546	33418
Insurance	13096	-	8766	21862
Diabetes	3500	1285	-	4785
Surgery	2021	2056	1305	5382
Leprosy	794	687	-	1481
Early Child Development	-	55	56	111
Community Health	-	-	24	24

The symbol [-] denotes that no data was available in that given year.

Percentage growth in the coverage of health activities were also reported. In Y3, there was a 96%, 72% and 6% increase in MNCH program coverage from three separate commitment makers, and a 63% increase in Surgery program coverage from a single commitment maker.

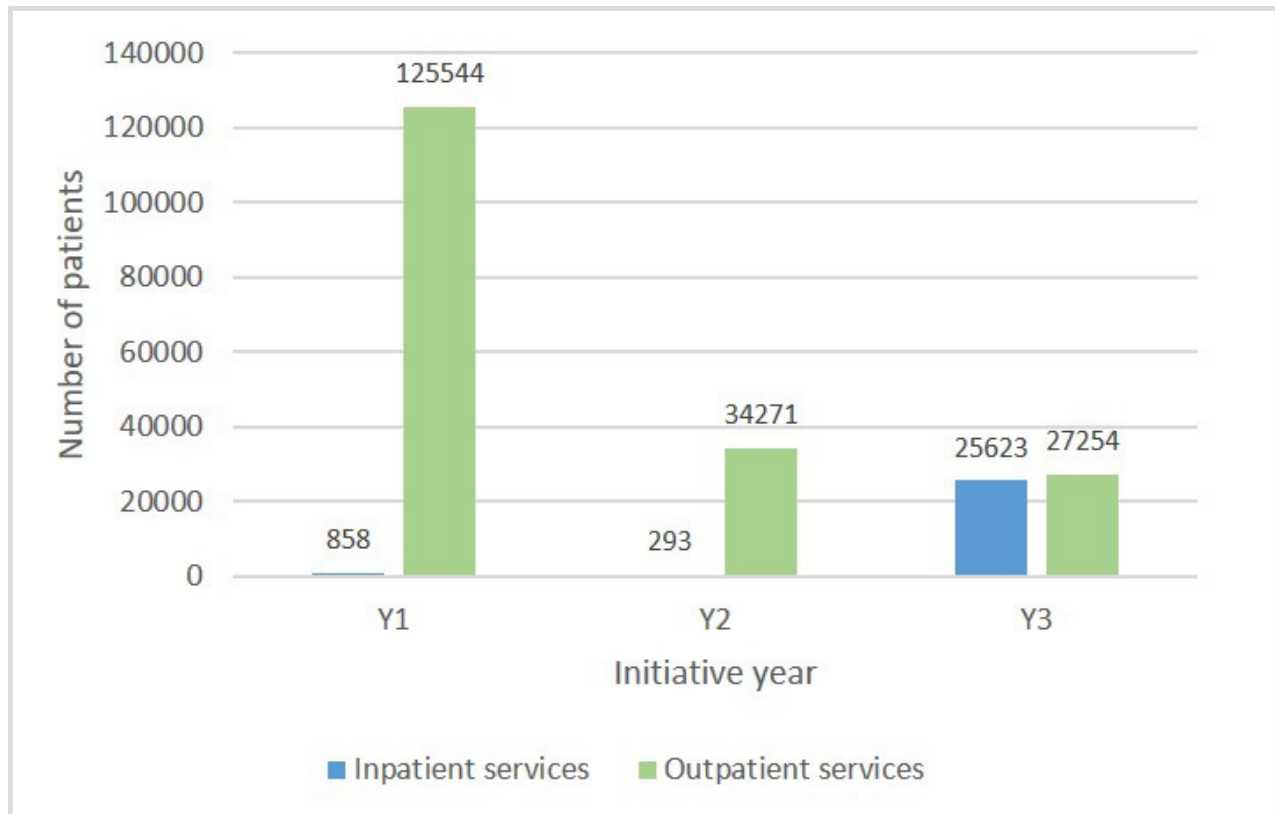
Additionally, indicators on the number of households and schools reached by health programs, and the number of individuals impacted by health programs have been reported in Y3. 33,071 households were reached by MNCH Programs, and one school was reached by early childhood development programs during the three years of the program. About 160,010 people were reported to have benefitted from MNCH and Health promotion programs. Moreover, specific measurements of health activity impact were provided—with two commitment makers measuring an 87% (pharmacy management/practice) and 100% (advocacy) increase in improved human resource practice.

Furthermore, 251 individuals affected by leprosy and lymphatic filariasis, and 22,860 households benefited from leprosy/neglected tropical disease (NTD) targeted health programs by one commitment maker working in Asia.

INPATIENT AND OUTPATIENT SERVICES

In the three total years of the initiative thus far, 26,774 inpatient and 187,069 outpatient services were provided by two commitment makers. In Y1, 858 inpatient and 125,544 outpatient services were provided by one commitment maker. In Y2, 293 inpatient and 34,271 outpatient services were delivered by two commitment makers. In Y3 25,623 inpatient and 27,254 outpatient services were delivered by one commitment maker (figure 11). An additional commitment maker delivered a total of 7,024,809 inpatient/outpatient services in Y3 (not reflected in the graph). All inpatient and outpatient services were related to general health services, and focused on enhancing service delivery at health facilities in sub-Saharan African regions.

Figure 11: Number of Inpatient/Outpatient Services Provided by Year



Y1: Year 1, Y2: Year 2, Y3: Year 3

INSTITUTION-LEVEL

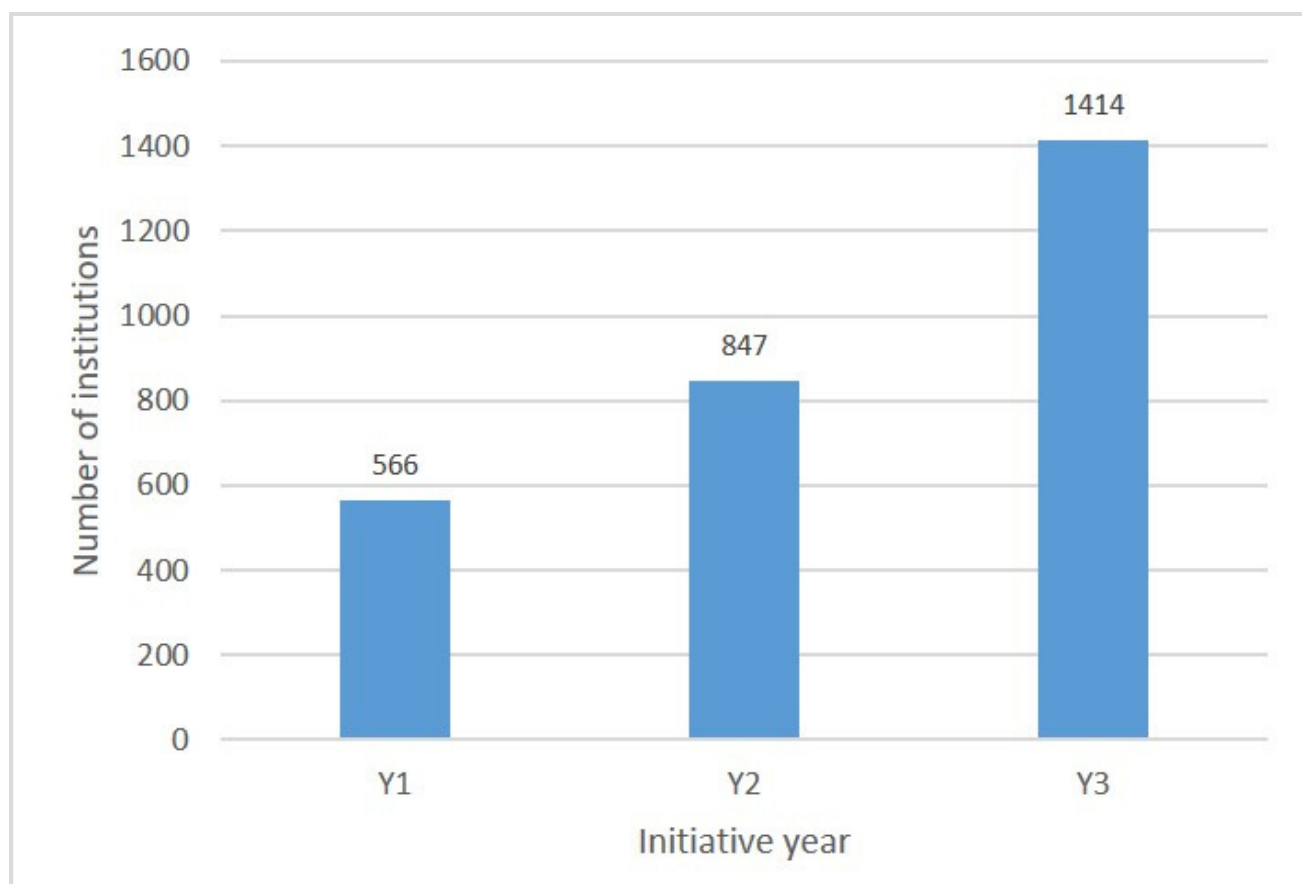
At this level, commitment makers focused on supporting institutions, including health facilities, drug supply organizations and non-profit organizations. Efforts to support institutions were undertaken with a view to strengthen all seven building blocks of the CCIH adapted WHO framework for health system strengthening, with access to essential medicines and supplies being the most popular area, followed by financial management. There were 2,834 institutions supported – 541 in Y1 by 14 commitment makers, 892 in Y2 by 21 commitment makers, and 1,400 in Y3 by 13 commitment makers (figure 12). Support was provided over a range of nine subject areas namely (alphabetically listed):

- Data Management
- Funding
- General Supplies
- Human Resource Management
- Leadership and Governance
- Medicines, Medical Supplies, and Equipment
- Quality Management Systems (QMS)
- Technical Support
- Water, Hygiene, and Sanitation (WASH)

Newly Added Subject Areas in Y3:

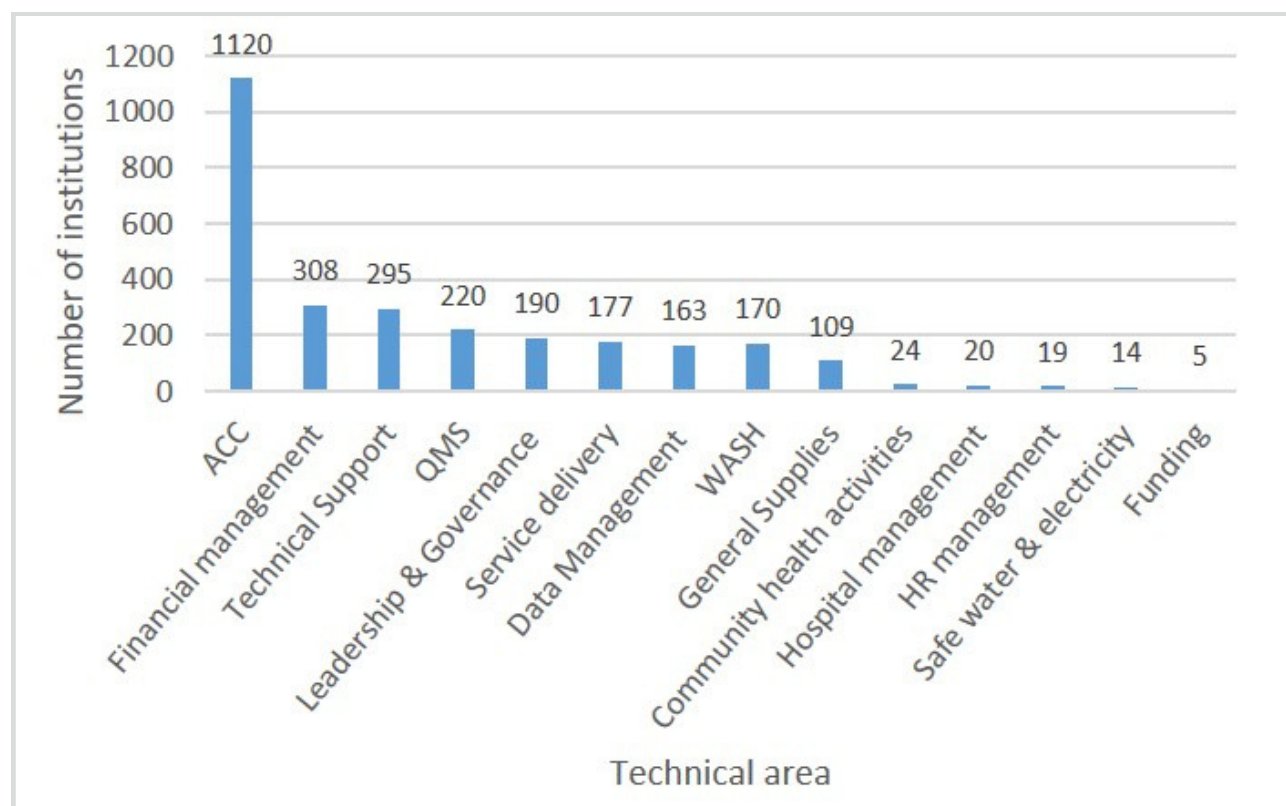
- Community Health Activities
- Financial Management
- Hospital Management
- Safe Water and Electricity
- Service Delivery (specifically to vulnerable populations)

Figure 12: Total Number of Institutional Support Provided by Year



Y1: Year 1, Y2: Year 2, Y3: Year 3

*Figure 13: Institutional Support by Category
(Cumulative of Y1, 2, and 3)*



ACC: Access to medicines, medical supplies & equipment, QMS: Quality Management System, WASH: Water, Sanitation and Hygiene, HR: Human Resources

Table 3: Institutional Support Provided Over the Years

Institutions supported	Y1	Y2	Y3	Total
Access to medicines, medical supplies & equipment	223	597	300	1120
Financial management	-	-	308	308
Technical support	24	16	255	295
Quality management system	153	67	40	220
Leadership & Governance	89	51	50	190
Service delivery			177	
WASH	75	85	24	170
Data management		61	102	
General supplies	-	21	88	109
Community health activities	-	-	24	24
Hospital management	-	-	20	20
Human resource management	-	7	12	19
Safe water & electricity	-	-	14	14
Funding	2	3	-	5
Total	566	847	1414	2827

The symbol [-] denotes that no data was available in that given year.

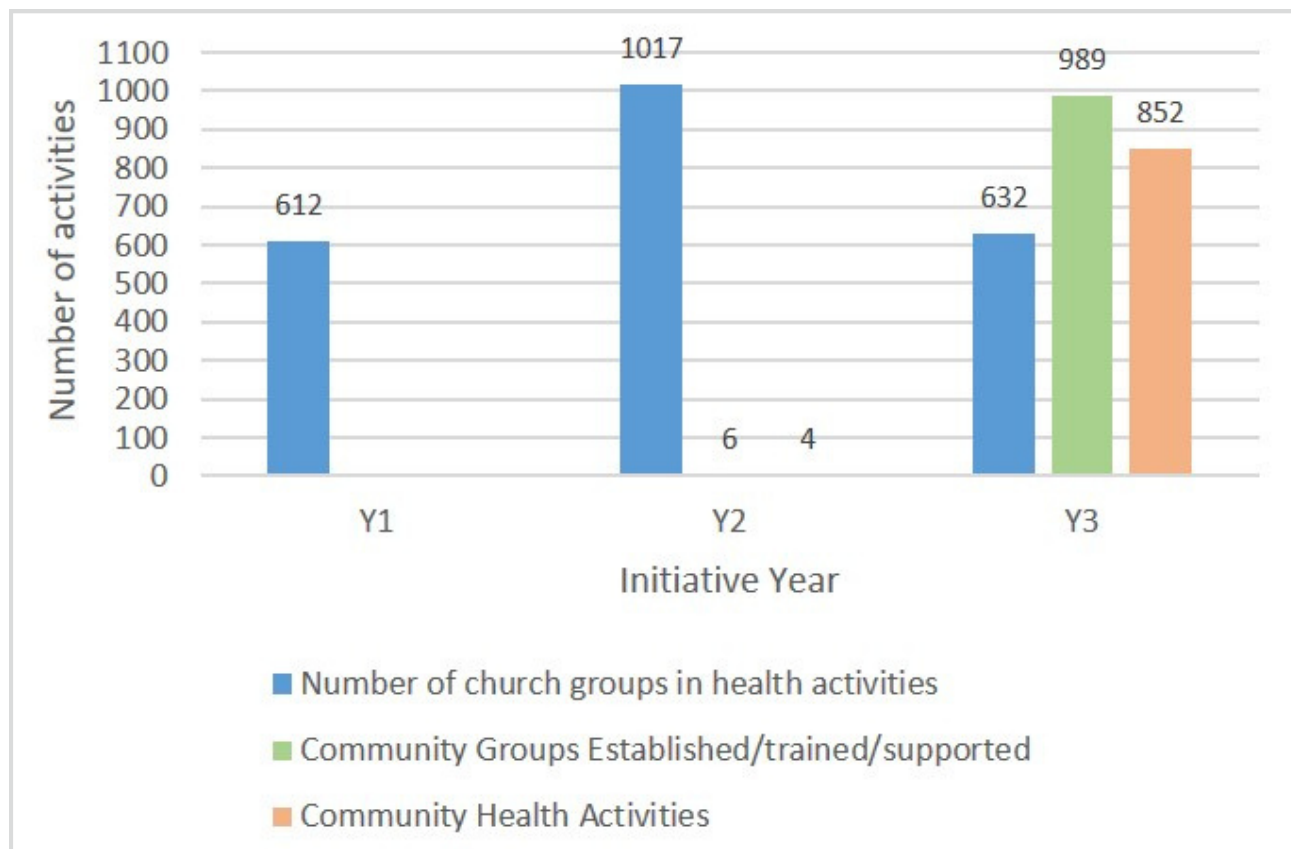
COMMUNITY-LEVEL

In Y3, ten commitment makers focused their activities at the community, seeking to strengthen the community services building block of the health system. Community activities included health promotion of general wellbeing (NCD prevention, maternity care, child immunizations, nutrition promotion), increasing awareness/reducing stigma around communicable diseases, vaccine awareness/provision, and community leadership development. To achieve this, commitment makers established community groups, church groups, and trained them on various health related areas. For instance, 985 community groups were trained by one of the commitment makers during the three years of the initiative. In addition, three commitment makers provided support to create 2,261 church groups for health-related activities in the community over the three years of the initiative.

"A BIG CHANGE DUE TO OUR COMMUNITY HEALTH ACTIVITIES IS THAT HUSBANDS ARE NOW MORE INVOLVED IN CARETAKING OF THEIR CHILDREN AND BEING SUPPORTIVE PARTNERS DURING ANTENATAL CARE AND CHILDBIRTH, AND IN MANY COUNTRIES, THEY ARE IDENTIFIED AS "CHAMPIONS" IN SUPPORTING THEIR WIVES IN PREGNANCIES."

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Figure 14: Number of Community Level Activities by Year



Y1: Year 1, Y2: Year 2, Y3: Year 3

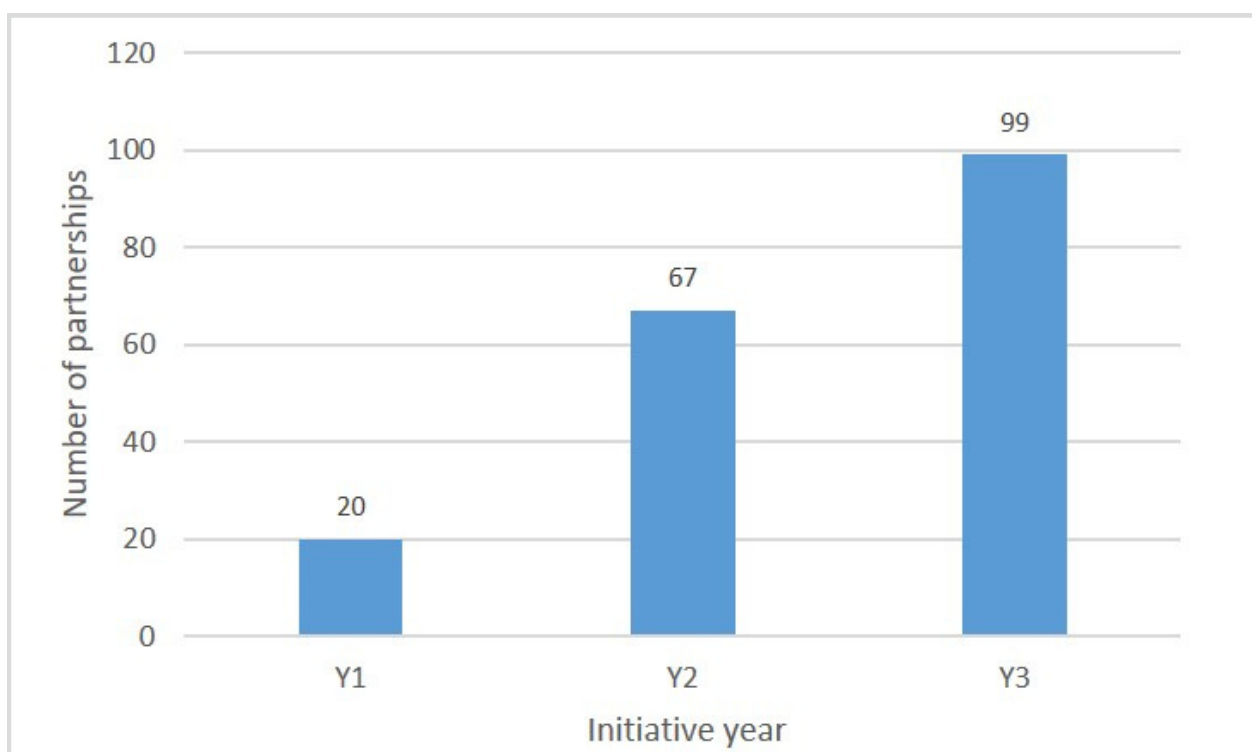
"[OUR] COVID-19 VACCINATION AWARENESS AND MOBILIZATION WORK HAD A PROFOUND IMPACT. STAFF OF ONE OF THE THREE CENTERS OF OUR ORGANIZATION, VISITED A TRADITIONAL CONVENT DURING A STRATEGY SESSION WHERE AFTER TEACHING AND EDUCATION, THE CONVENT'S HEAD WITCH DOCTOR AND HIS FOLLOWERS ADHERED TO THE IDEA OF VACCINATION AND ACCEPTED TO BE VACCINATED ON THE SPOT IN PUBLIC. THIS IS THE FIRST TIME THAT A VACCINATION TEAM HAD ENTERED SUCH A TRADITIONALLY SACRED PLACE. THIS VERY BOLD AND SUCCESSFUL MOVE GARNERED APPRECIATION FROM THE COUNTRY'S HEALTH AUTHORITIES."

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SYSTEMS-LEVEL

At the systems level, commitment makers focused on establishing partnerships and resource mobilization initiatives. These efforts were largely to strengthen leadership and governance, with a few targeting financing, service delivery, and health information systems of the health system blocks. In Y1, 20 partnerships were established by seven Y1 commitment makers. In Y2, 67 partnerships were fostered by 11 Y1 and Y2 commitment makers, and in Y3, 99 partnerships were fostered by seven Y1, Y2, and Y3 commitment makers (Figure 15). Partnerships were largely with government, NGOs and development agencies as depicted in Figure 16.

Figure 15: Number of Partnerships by Year

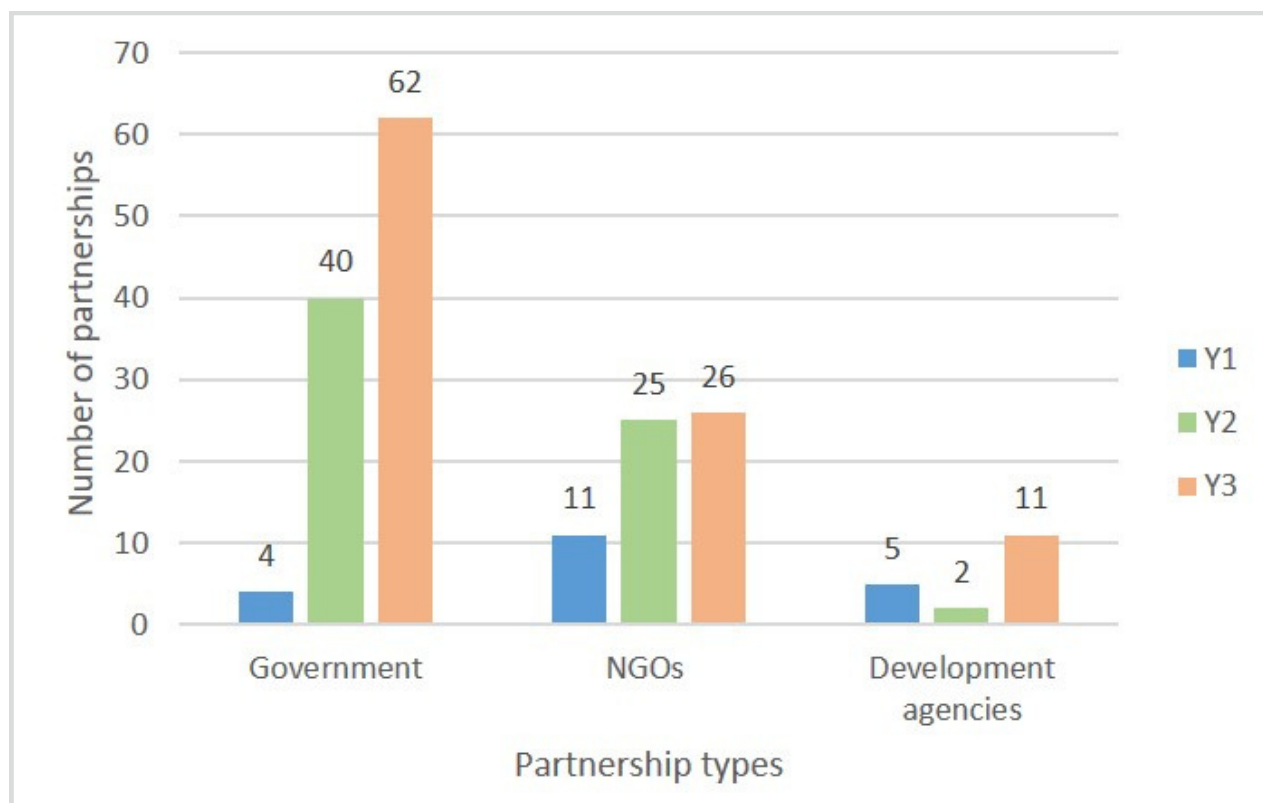


Y1: Year 1, Y2: Year 2, Y3: Year 3

“THIS YEAR, WE STRENGTHENED OUR COMMUNICATION CHANNELS THAT FACILITATED FREQUENT INTERACTIONS BETWEEN OUR HEADQUARTERS AND OTHER ORGANIZATIONS ACROSS THE COUNTRY REGIONS, AND MORE INTERACTION WITHIN THE REGION ITSELF. THIS LED TO A SENSE OF SYNERGY AND JOINT WORKING TOWARDS A COMMON PURPOSE.”

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Figure 16: Types of Partnerships Across the Years



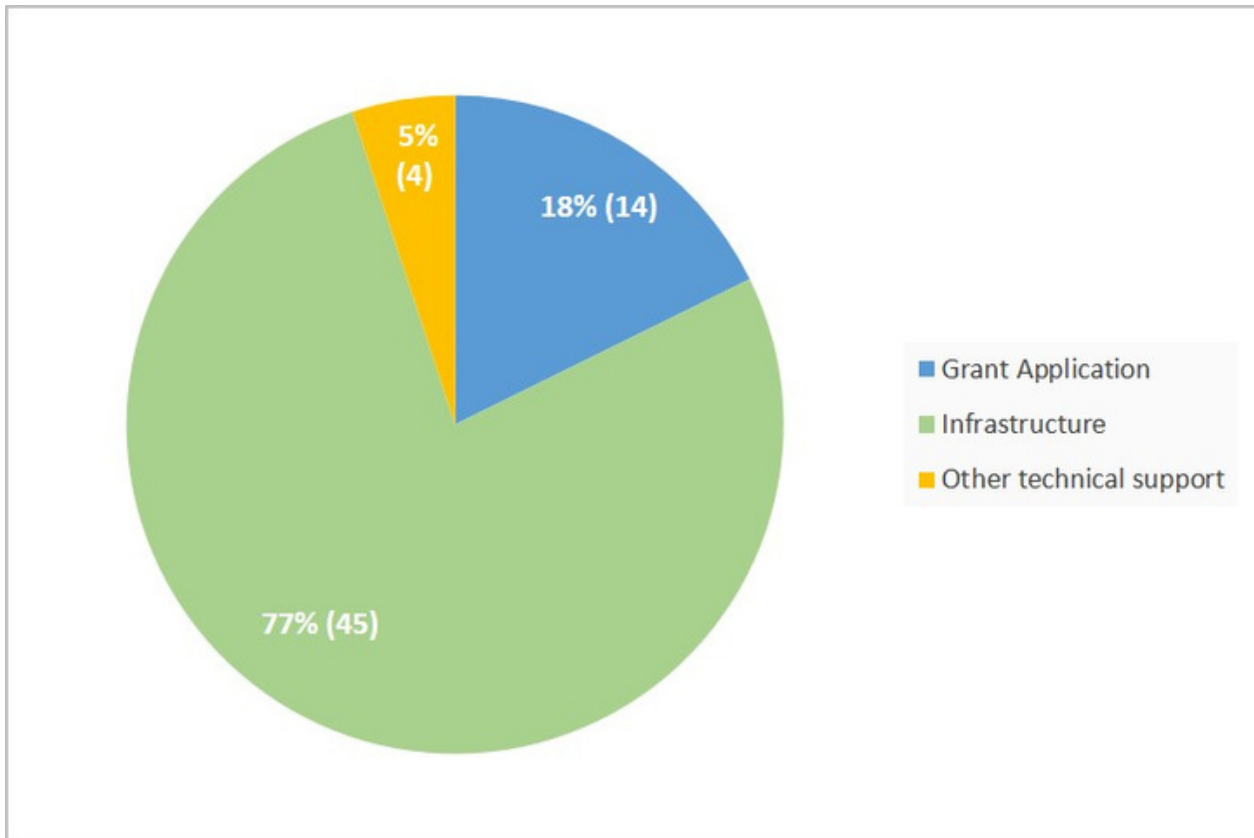
NGO: Non-Governmental Organization; Y1: Year 1, Y2: Year 2, Y3: Year 3

Additionally, in Y1 there were 17 resource mobilization initiatives by two commitment makers. In Y2 there were 24 resource mobilization efforts by four commitment makers. In Y3 there were 38 efforts to mobilize resources by three commitment makers (Figure 17). Resource mobilization efforts were carried out through funding infrastructure projects at health facilities (providing direct technical support) in Y1, Y2 and Y3. They supported applications for grant programs to assist programs (indirect technical support) in Y1, Y2 and Y3, and supported other technical areas in Y1 and Y2. Throughout the three years of the initiative, resource mobilization efforts have addressed the Service Delivery and Health Financing health system building blocks.

“OUR ORGANIZATION HAS WORKED CLOSELY WITH OUR PARTNER ORGANIZATION IN DEVELOPING A GRANT PROPOSAL SUBMITTED TO A FOUNDATION FOR COVID-19 VACCINATION WORK, PLUS CAPACITY-STRENGTHENING OF CHRISTIAN HEALTH ASSOCIATIONS (CHA) FOR FUTURE HEALTH EMERGENCIES, THAT RESULTED IN MAKING APPROXIMATELY \$1.4M AVAILABLE TO OUR PARTNER ORGANIZATIONS.”

30X30 COMMITMENT MAKER

Figure 17: Types of Resource Mobilization Efforts Across the Years



“WE HAVE BECOME INCREASINGLY ENGAGED AND ARE THANKFUL TO BENEFIT FROM THE COALITION THAT OUR PARTNER ORGANIZATION (A 30X30 COMMITMENT MAKER) HAS BUILT—EVEN IN THE MIDST OF THE PANDEMIC AND POLITICAL AND SOCIAL UNREST IN HAITI.”

PARTNER ORGANIZATION OF A 30X30 COMMITMENT MAKER

GAPS, CHALLENGES, AND RECOMMENDATIONS

MONITORING AND EVALUATION CAPACITY

- **Challenge:**
 - Commitment makers had varied levels of experience and capacity for monitoring and evaluation of their activities. Hence, the CCIH 30x30 team worked closely with them to finalize commitments and refine appropriate indicators. Some FBOs did not have formal processes for data collection and reporting, and therefore had not instituted such a process for their 30x30 commitment. This made defining indicators and submitting data for the annual report on time challenging.
- **Recommendations:**
 - CCIH will continue to work with commitment makers to ensure that activities included in their commitment can be measured with quantitative indicators.
 - CCIH will continue to provide technical assistance to build the MEL system and capacity of commitment makers.

DATA MANAGEMENT LOGISTICS

- **Challenge:**
 - As the initiative expands in scope, some commitment makers had challenges accessing and navigating the online database, requiring extra support from the CCIH 30x30 team.
- **Recommendations:**
 - A video tutorial document may be developed and shared with commitment makers. This will supplement the written database user guide that includes screenshots with navigation instructions.
 - The database will be refined based on feedback from commitment makers and the CCIH 30X30 team for a smoother data submission process in upcoming years.
 - CCIH will seek technical assistance from the database creator to support data management and program coding.

COMMITMENT MAKER INTERACTION

- **Challenges:**
 - Connecting 30x30 commitment makers in strategic ways to exchange ideas about successes, challenges, and key learning.
 - Commitment makers in Y1 and Y2 have requested more opportunities to connect and learn from each other. In March of Y3, the CCIH 30x30 team started the 30x30 Google Group to create a forum for exchange. It has been useful for the CCIH 30x30 team to share updates and reminders about the program, but commitment makers have not used it to share and connect with each other.
- **Recommendation:**
 - CCIH 30x30 to facilitate a brainstorming session as part of the 30x30 annual meeting in December of Y3 to discuss methods of engagement that would interest commitment makers and encourage shared learning.

THE WAY FORWARD

One of the key objectives of the 30X30 Health System Initiative is to capture comprehensive information about the planned and ongoing activities of CCIH members and affiliates in health systems strengthening. Findings from this report indicate that over the first three years of the initiative, 30X30 commitment makers have prioritized strengthening of the health workforce, expansion of service delivery, and leadership and governance.

To map the way forward, we assessed the progress of the 30x30 initiative towards its objectives thus far.

- Increase global attention to the work of faith-based health services
 - Through submission of a public commitment that includes planned and ongoing efforts to strengthen the health systems in which they work, the commitment makers have highlighted the work of faith-based health services. Furthermore, the summary of their efforts in this report emphasizes the scope, scale and reach of FBO work in health systems.
 - Moving forward, the CCIH Communications team will publicize the report among various stakeholders, including those external to the faith-based space.
 - An advocacy plan has been developed with support of the CCIH Advocacy team, with the plan to review quarterly with various stakeholders.

- Work alongside faith-based health services to improve resource mobilization and improve programs and policies.
 - The CCIH 30x30 team worked closely with commitment makers to refine the commitments and discuss the MEL system including the finalization of indicators to measure their program activities, thus indirectly improving the monitoring and evaluation of programs and systems. In addition, the publishing of commitments and this annual report may indirectly facilitate resource mobilization. The suggested strategies to achieve the objective include:
 - Regular convening of meetings where commitment makers can share experiences, lessons learned and best practices, which may facilitate planning of better policies and programming, with CCIH as the convening body.
 - Identification of health systems blocks that may require more efforts and sharing of existing CCIH resources related to the health system blocks to support organizations in their programming. For instance, referral to the CCIH Community Based Prevention and Care technical working group.
- Gather evidence of stronger health systems for FBOs.
 - Development of the online database and annual tracking of performance of the commitment makers, provide evidence on the contribution of FBOs to the local health systems and population. As it has been institutionalized and streamlined, it will be a key resource to establish FBOs role in health system strengthening across the world. However, this database access is limited to the CCIH 30x30 team and commitment makers.
 - In the future, the CCIH team may consider ways to translate and appropriately publicize the evidence collected through this process.

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For more information about the 30x30 CCIH Health Systems Initiative, visit our [website](#) or email us at 30x30@ccih.org.