



## **Working Group Issue Paper: Health System Strengthening**

Rev. May 2019

### **Preamble**

Each of CCIH's four thematic working groups (integration of faith and health, health system strengthening, community-based primary care and health of women and children) was invited to develop an 'issues paper' to serve as an agenda for CCIH action. This is one of the four resulting papers. Working groups are developing action plans based on these at the CCIH Annual Conference in June 2019. Suggestions and contributions are always welcome.

### **Background**

The Health Systems' Strengthening Working Group (HSS WG) of CCIH ascribes to the World Health Organization's building blocks of health systems. These building blocks include: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance with an additional component focused on community. The CCIH HSS WG seeks to strengthen the capacity of members to improve these systems in low- and middle-income countries, including fragile states. Strengthening health systems of under-resourced countries is a high priority for CCIH members, and has become a critical issue for the rest of world. To date, most health system strengthening efforts focus on supporting the public sector health sector. Faith based health systems have a long history of caring for the most vulnerable in the population and also need greater support to continue to achieve their mission in a rapidly changing global health and development landscape. Christian organizations are already an indispensable part of many health systems supplying a significant amount of healthcare globally.

According to the current CCIH Strategic Plan developed in 2015 for 2016-2021,

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<sup>1</sup> \*Defined by WHO's Health Systems Framework or "building blocks":  
[http://www.wpro.who.int/health\\_services/health\\_systems\\_framework/en/](http://www.wpro.who.int/health_services/health_systems_framework/en/)

CCIH is well placed to explore how faith-based institutions relate to, and can have a positive impact on health systems. CCIH should be framing and finding answers for the following questions:

- How can faith-based organizations strengthen health systems?
- What lessons can faith-based organizations teach non-FBOs, and vice versa?
- How can public institutions, secular NGOS, and faith-based institutions work together more effectively to strengthen health systems?
- How can CCIH facilitate sharing information among CCIH members in the health systems strengthening space?
- What is CCIH's role in ensuring members have access to and utilize the best available evidence – from faith and secular sources – on how faith-based organizations can address social and health challenges?
- How can CCIH involve a variety of faith entities (including pastors and church-based groups) in health outreach and programming?

## Goals

It is the objective of this issue brief to respond to the strategic plan findings in 2015 and assessments conducted since then to (1) prioritize key issues and areas of strategic focus for the Health Systems Strengthening Working Group of CCIH; (2) define key recommendations that the power of the CCIH network can be utilized and leveraged to solve and (3) add to the global body of evidence on how faith based institutions relate to, and can have a positive impact on health systems.

## Current Global Health and Development Landscape

According to Oleg Kucheryavenko, MD, MPH, a Senior Consultant at the World Bank, the “golden age” of global health financing is no longer the current reality. Investments from national treasuries (primarily the USA and UK), philanthropies, and development agencies have led to a 40% reduction in under-five child mortality, 35% reduction in the incidence of HIV, and almost halved mortality from malaria. However, since 2000, the investments from these traditional sources of funding began to stymie and a paradigm change occurred. Innovative financing resulted in the increase in public-private sector engagement and investment for global health where an increased focus on programs that deliver results and a desire to support collaboration between the public and private sector is the new reality. With that said, it is critical that the faith-based health services consider and are prepared for these changes to ensure their sustainability. The reality of documenting, measuring and demonstrating their reach, scope and impact is increasingly critical, not simply for external funding, but for quality of care, internal sustainability, growth, development and most importantly serving the communities with greatest need based on their needs and assets regardless of external funding mechanisms. Faith-based health systems must be able to speak to their national leaders demonstrating their work and reach to ensure social accountability for their country’s health and well-being. It is widely known that on the continent of Africa, faith-based health services provide between 40-70% of individual countries’ health delivery, yet the data that demonstrates their impact is not easily accessible. Increasing resources to support data collection, communities of practice and documentation of

learned lessons for members are clear opportunities recognized both within the CCIH constituency as well as globally.

## Primary Concerns to Our Members

Based on current member feedback, organizational capacity and the current global health landscape and financing changes, we focused our attention on 3 strategic areas:

1. **WHO ARE WE & WHERE ARE WE?** Identifying, understanding, and connecting the current landscape. The primarily anecdotal evidence of the reach, scope and impact of faith-based healthcare in LMICs is insufficient to effectively sit at the global health and development table where decisions are made within the input of these critical partners.
2. **SELF-DIRECTION IS CORE.** Leadership, Management, Governance & Strategic Data Use: Implementing any large-scale change will fall short of desired outcomes without quality, committed leadership with strong management and governance capacity, and the tools to make informed decisions. We see this as a ubiquitous challenge facing the vast majority of faith-based organizations working around the world. We see it as an area that is currently getting very little attention.
3. **COMMUNITY ENGAGEMENT.** Addressing society and church leaders to encourage the community to use church health services is only one component of community engagement. We believe that demonstrating the power of faith-based institutions to connect communities as members of civil society through shared ownership and governance for better health is also an area of needed sharing and documentation.

## We Plan to Address These By:

1. **Mapping through member engagement (to address “WHO ARE WE & WHERE ARE WE?”):**
  - a. Identify current scope of work of all CCIH members, connect all CCIH members, and support the CCIH 30 x 30 Campaign of improving 30 health systems by 2030. This would leverage and strengthen existing geographic networks and identify new ones, integrating the faith-based healthcare delivery system.
    - i. Determine members who have already conducted mapping exercises and partner to determine insights and additional components to add to data or how to be complimentary
    - ii. Utilize available technologies to create visual platform with parameters to support global use amongst CCIH membership
  - b. Identify other facets of faith-based healthcare in their geographies through asset-based mapping
  - c. Maintain ongoing communications for networking, resource mobilization and action planning for members
  - d. Why: Mapping data is crucial to convince donors of the breadth and value of FBOs in health care service delivery, prevention, etc.

2. **Strengthening knowledge transfer capacity especially for low- and middle-income countries, including fragile settings (to address “SELF-DIRECTION IS CORE”):**
  - a. Sharing of expertise amongst members through conference calls, online document sharing
    - i. Offer targeted information/resources for organizations to use. Overall the goal is to see faith-based organizations not only survive, but thrive and lead by example with excellence. This would include Monitoring and Evaluation coaching, efforts to improve strong leadership and organizational governance, staff management and development, sustainable financing models, etc.
      1. Sharing of specific strategic planning sessions/workshops of members who provide these services
      2. Sharing of evidence-based global health and development practices, events and information
  - b. Foster practitioner, researcher, faith leadership, financing collaborations
    - i. provide opportunities through webinars and conferences for collaborations
  - c. Document faith-based innovations in health systems through
    - i. issue briefs
    - ii. presentations at annual conference
    - iii. white papers and other published articles
    - iv. peer-reviewed articles
3. **Providing thought leadership in the areas of faith-community health and community engagement (to address “COMMUNITY ENGAGEMENT”):**
  - a. Assessment of current faith community health and community engagement successes and gaps
    - i. Identify best methodology (ies) to collect data using both qualitative and quantitative processes:
      1. consider photovoice projects
      2. consider various implementation research studies, case studies etc
  - b. Highlight locally driven promising practices, scaled practices and learned lessons:
    - i. issue briefs
    - ii. presentations at annual conference
    - iii. white papers and other published articles
    - iv. peer-reviewed articles
    - v. social media and online channels (blog, youtube etc.)

## Conclusion

The Declaration of Alma Ata in 1978 was a bold statement that aimed to set the world on a path to eradicate disease, create healthy communities and strong systems of integrated care. Unfortunately, due to several competing factors, including short term funding mechanisms, and vertical disease goals, this hope has not yet been realized. We are now 40 years post Alma Ata,

and engaged in the Astana Declaration and Universal Health Coverage with the goal to ensure access to quality care without financial devastation especially to those most vulnerable. It behooves the CCIH community to be on the forefront defining quality of care, consideration of human dignity, meeting the needs of the poor in the communities they live, work, play and pray. Without the voice, strategy, experience-informed approaches, community-informed engagement and critical data of the faith-based health perspective, the current global campaigns and declarations becomes increasingly unlikely. As such the CCIH HSS WG recommends CCIH focusing on the following three areas to most effectively meet the needs of its members and advocate on behalf of its membership in the larger global health and development landscape. The three areas include (i) mapping; (ii) strengthening communities of practice and, (iii) increasing capacity around community engagement.

There is much to learn, with lessons from all perspectives that should be incorporated for health and wholeness of communities around the world. CCIH membership has a unique voice and opportunity to engage with other stakeholders on the strengthening of health systems.

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### About CCIH

CCIH seeks to mobilize and empower our network to promote global health and wholeness from a Christian perspective. Our goal is to share information and provide a forum for dialogue, networking, advocacy, capacity building and fellowship to the ever-increasing spectrum of organizations and individuals interested in how transformational Christian faith has a positive impact on health around the world.