30 x 30

CCIH HEALTH SYSTEMS INITIATIVE

ANNUAL PROGRESS REPORT 2021

CCIH
Christian Connections for International Health

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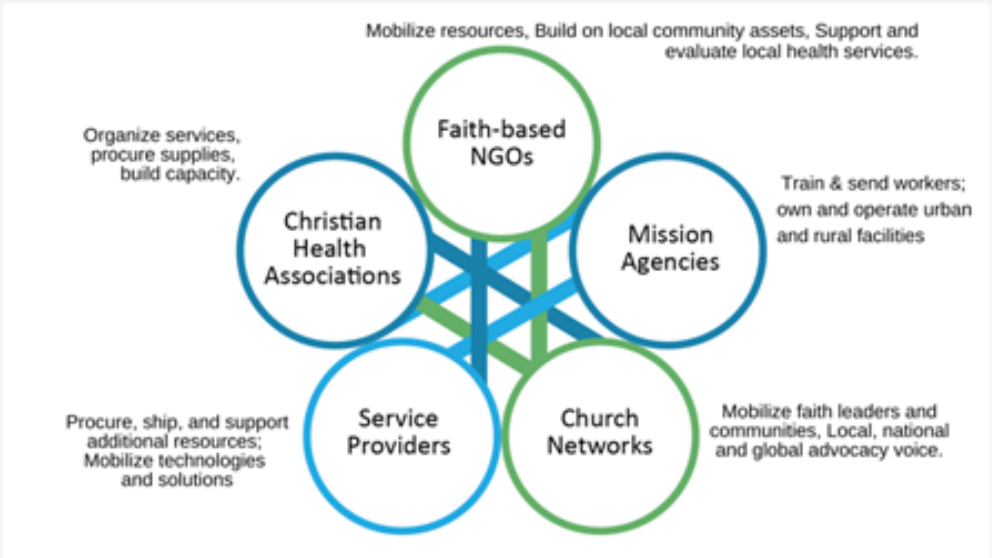
BACKGROUND

The 30x30 Health Systems Initiative, which was launched in 2019 by Christian Connections for International Health (CCIH), aims to strengthen 30 health systems across the world within which faith-based health services operate by 2030. Faith-based organizations (FBOs) play a substantial role in health care delivery in low and middle-income countries, working in complex health systems alongside governments and private providers (1). They are involved in provision of preventive, promotive and curative services, and are often the only health services available to communities at the economic margins in both rural and urban settings. There are multiple types of organizations in the faith-based health services space, which play different roles as illustrated in Figure 1. 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



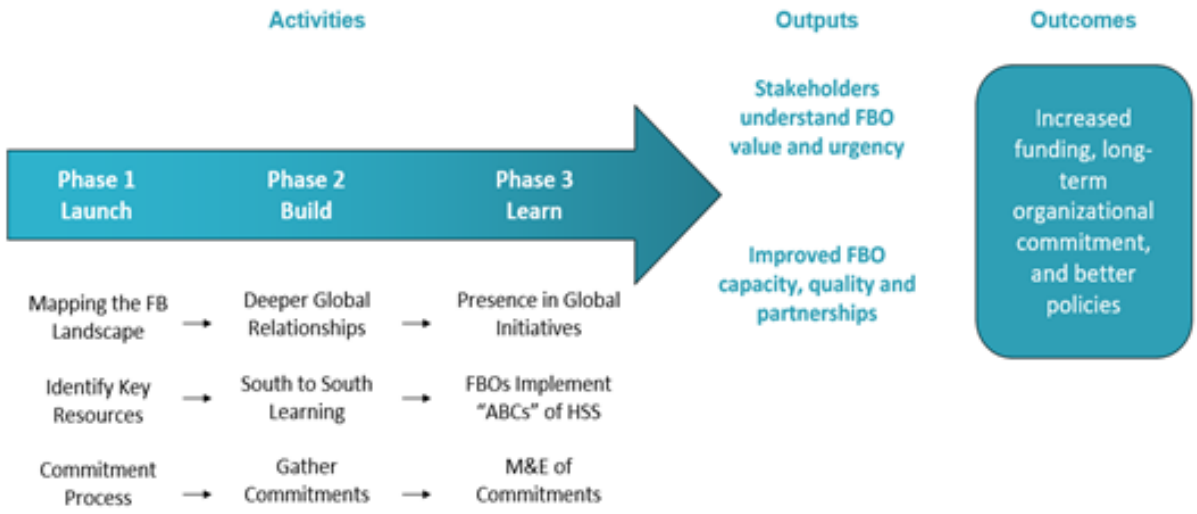
In view of the substantial role faith-based health services play in complex health systems, the 30x30 initiative seeks to describe and measure the efforts of faith-based health services in various health systems across the world between 2020 and 2030. The 30x30 initiative exemplifies CCIH's commitment to work through individual members, affiliates and other organizations to improve one or more of the World Health Organization's (WHO) health systems building blocks, namely health workforce, leadership and governance, service delivery, access to essential medicines and supplies, health information systems and financing. In addition to this, 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 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, dialogue will be promoted, facilitating south-to-south learning and increasing the presence and visibility of faith-based health services in global initiatives. This should, in turn, translate to better capacity among faith-based organizations (FBOs) to deliver quality services, stronger partnerships among FBOs and between FBOs and other sectors. Additionally, external stakeholders will gain a deeper understanding of FBO's value and the potential impact of investing in FBO work (Figure 2).

Figure 2: Theory of Change

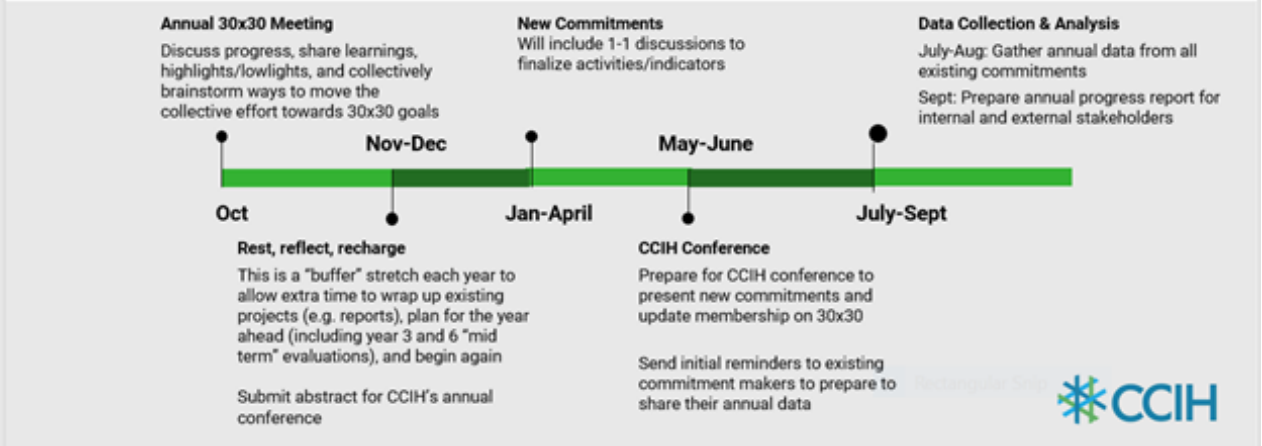


PROGRESS THUS FAR

Call for Commitments

Following the launch of the initiative, CCIH called 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 call for commitments was made in January 2021, and these were added to the commitment report in May 2021 (Y2 cohort). Moving forward until 2029, 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



REVIEW OF COMMITMENTS

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 committed goals, objectives, and activities for clarity and brevity. In addition, indicators to measure each of the planned activities were identified and refined. During the first round of commitments in 2020, the Y1 cohort commitment makers worked with the CCIH 30x30 team to develop indicators retrospectively, after submission of the commitment. Building on this experience, the CCIH 30x30 team developed a document of common indicators for each health systems strengthening block. This indicator document was included in the commitment submission form for year two, referred to as the Y2 cohort of commitment makers. The common indicators document will be included thereafter, facilitating a streamlined commitment making process.

DATA SUBMISSION

The next step involved data collection, where commitment makers submitted data on their chosen indicators. For the Y1 cohort of commitment makers, the submissions of their baseline quantitative data were made using Excel spreadsheets. Following this experience, the CCIH 30x30 team worked closely with partner Christian Medical College, Vellore, India to create a database that streamlines the data submission process. The new database was launched in September 2021 and both Y1 cohort and Y2 cohorts of commitment makers used this platform to submit data in 2021. In addition to quantitative data, qualitative data was also requested from the Y1 cohort commitment makers in 2021.

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 the commitment makers.**
- **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 both the Y1 and Y2 cohorts of commitment makers was used for analysis.

DATA ANALYSIS

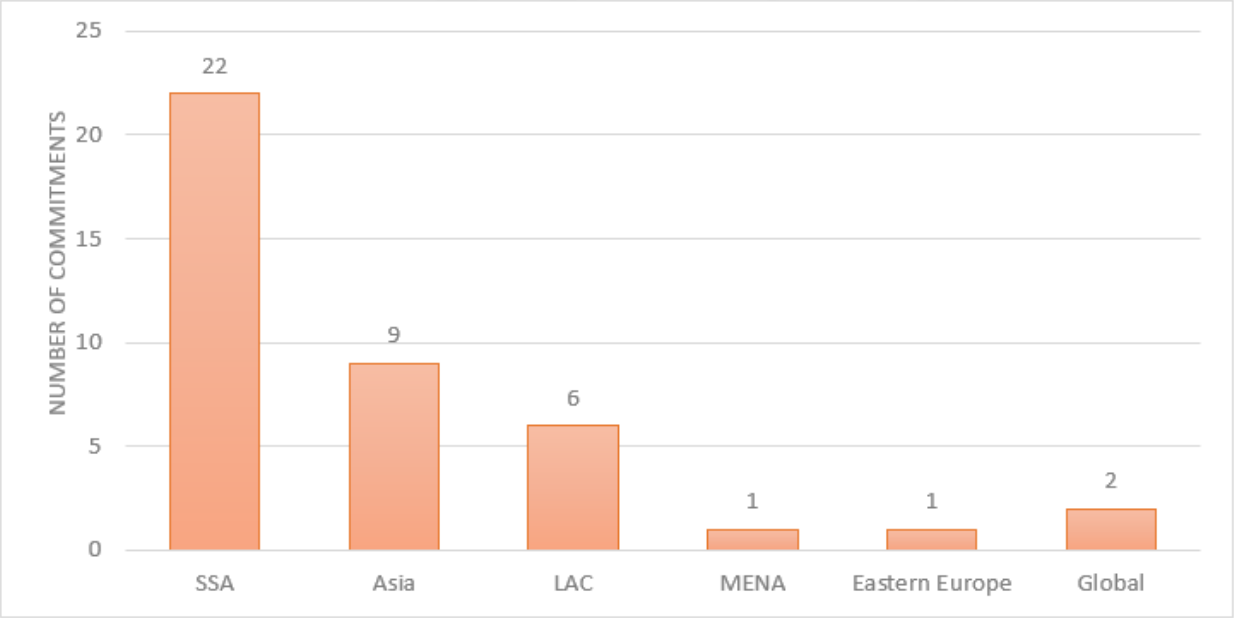
The key details of each commitment - geographical focus and health system strengthening areas - were collated using Microsoft Excel to describe the characteristics of the commitments in the initiative. The indicators for each of the commitments were then aggregated, by identification of common activities, and further grouped into sub-categories of activities. Common activities were generated by one of the CCIH 30x30 team then reviewed and verified by a second team member for coherence. A given indicator could not be assigned to more than one common activity, thus efforts were made to assign indicators to the most appropriate common activity. Some indicators were highly specific to a single activity and organization and, therefore, were not assigned. Common activities and sub-categories of activities were reviewed and refined throughout the analysis process.

Over the past two years, 32 commitments to the 30x30 initiative have been received - 22 in Y1 and 10 in Y2 of the initiative. One organization in the Y1 cohort opted to withdraw their commitment, thus we present a synthesis of 31 commitments. Furthermore, three organizations from the Y1 cohort, and one organization from the Y2 cohort were not able to submit 2020-2021 data by the deadline for inclusion in this report.

KEY FINDINGS

As of 2021, the 30x30 health initiative had 31 Commitments from 36 countries across the world, with the Sub-Saharan Africa region having the most commitments, as shown in Figure 4 below.

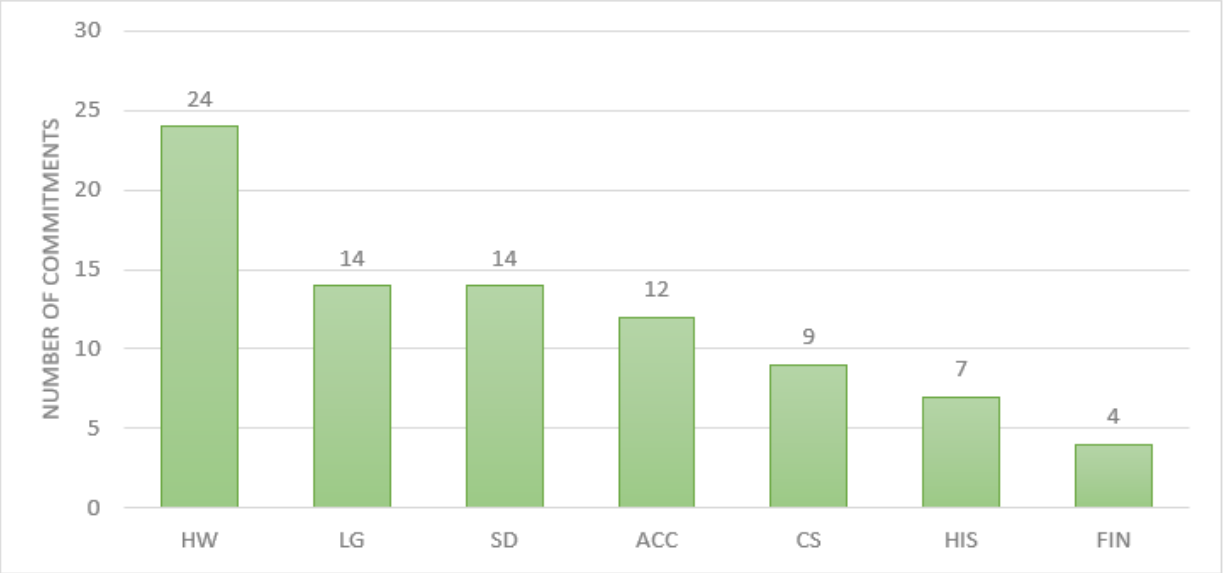
Figure 4: Commitments by Geographical Location



SSA – Sub- Saharan Africa, LAC – Latin America and the Caribbean, MENA – Middle East and North Africa

The activities within the commitments were classified under health systems building blocks as defined by the World Health Organization, thus 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 77% (n=24) of the commitment makers involved in this domain. Leadership and governance and service delivery followed, with 45% (n=14) commitments. Access to essential medicines and supplies accounted for 39% (n=12) of commitments, community services for 29% (n=9) of commitments, and health information systems for 23% (n=7) commitments. Financing was the least common focus area with only 13% (n=4) commitments.

Figure 5: Commitments by Health System Strengthening Block



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

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

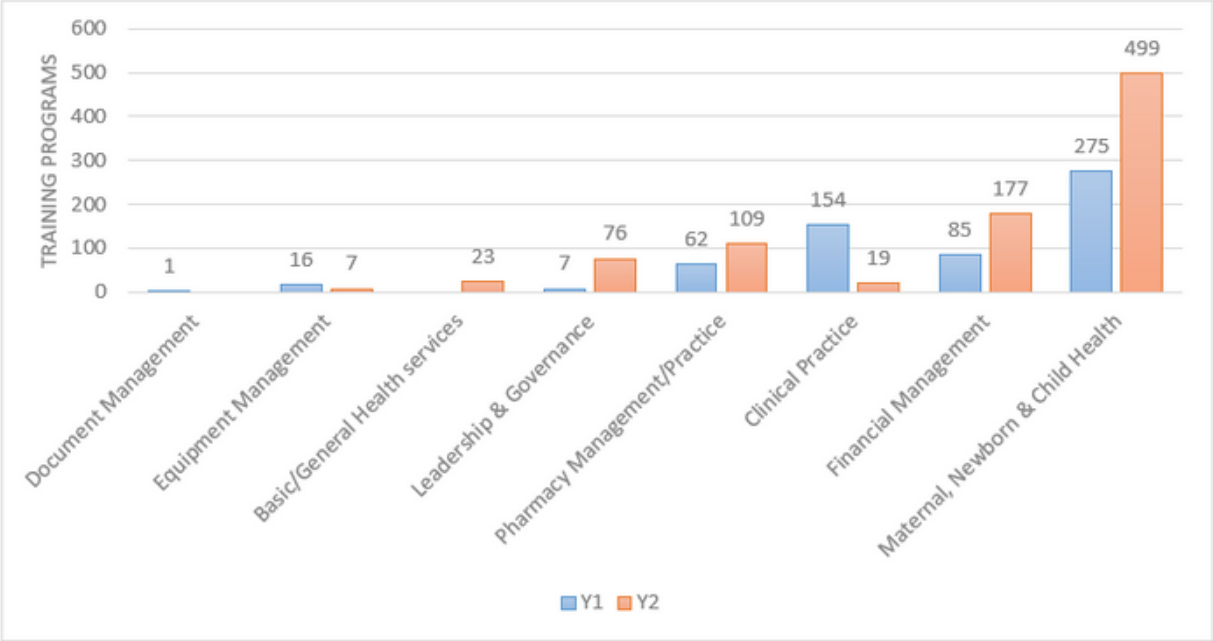
The commitments targeting the individual level were predominantly related to capacity building on a variety of subject areas and improving access and utilization of health services. The main activities targeted at the individual level included capacity building of individuals through various training 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 two years of the 30x30 initiative, 1,510 training programs were delivered by commitment makers. In Y1, 600 programs were delivered by seven Y1 cohort commitment makers, while 910 programs were delivered by ten Y1 cohort and Y2 cohort commitment makers in Y2 (Figure 6). Training programs largely focused on strengthening the health workforce to improve leadership and governance, service delivery, health information systems 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 and they covered eight subject areas namely:

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

Figure 6: Training Programs by Year



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PERSONNEL TRAINED

Commitment makers trained personnel with a view to strengthen the health workforce, largely on leadership and governance in their various areas of expertise. In the first two years of the initiative, 20,768 personnel were trained, of which 11, 831 personnel were trained by 16 Y1 cohort commitment makers in Y1, and 8,937 personnel trained by 23 Y1 cohort and Y2 cohort commitment makers in Y2 (Table 1). Personnel, who belong to various health care professional cadres, were trained on a wide range of 19 subject areas (Table 1).

Table 1: Number of Personnel Trained by Year

Personnel trained	Y1	Y2	Total
Health Training Methods	5876	1182	7058
Clinical Practice	3061	498	3559
Maternal and Child Health	1435	1673	3108
Organizational Development	54	2632	2686
Basic/General Health services	656	516	1172
Financial Management	188	404	592
Advocacy	-	573	573
Pharmacy Management/Practice	199	291	490
Health Promotion	106	326	432
Disease Surveillance	80	326	406
Community Health	115	141	256
Data Management	30	80	110
Leadership & Governance	29	76	105
WASH	-	92	92
Infection control	-	88	88
Equipment Management	-	29	29
Social Services	-	7	7
Quality Management Systems	2	2	4
Document Management	1	-	1

The symbol – denotes that no data was available in that given year

The importance of standardized training processes was recognized by several commitment makers in the qualitative reports. One commitment maker described existing gaps in their system: "Most of them are learning by practice. There is no common platform for their sharing of good practices which would facilitate standardizing the processes".

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 two years of 30x30, nearly half a million (n=486,710) people were reached by health programs. In Y1, 147,714 people were reached by nine commitment makers and 338,996 people were reached by 15 commitment makers in Y2 (Table 2). The types of programs covered a range of subject areas, as laid out in Table 2.

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

People reached through health programs	Y1	Y2	Total
Disabilities	78,495	72426	150921
Advocacy	-	103224	103224
Maternal, Newborn & Child Health	250	91276	91526
General Health Services	22982	23899	46881
Health Promotion	13096	31696	44792
Cervical Cancer	13480	12392	25872
Insurance	13096	-	13096
Diabetes	3500	1285	4785
Surgery	2021	2056	4077
Leprosy	794	687	1481
Early Child Development		55	55

The symbol – denotes that no data was available in that given year

INPATIENT AND OUTPATIENT SERVICES

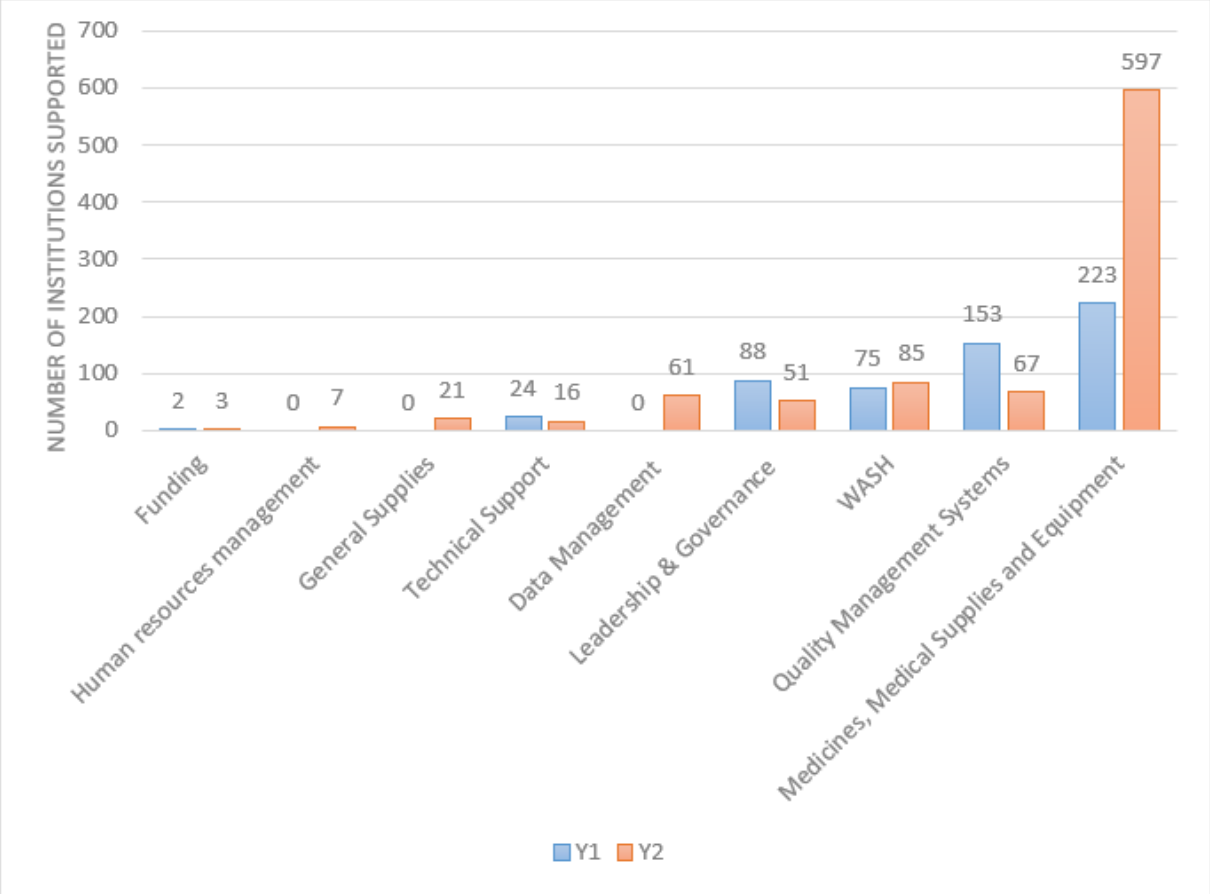
In the first two years of the initiative, 1,152 inpatients and 159,815 outpatients were provided clinical services by commitment makers. In Y1, 858 inpatients and 125,544 outpatients were provided services by a commitment maker. In Y2, 293 inpatients and 34,271 outpatients received clinical services from two commitment makers. Most impatient and outpatient services were related to leprosy and general health services, and focused on enhancing service delivery at health facilities in Asia and Sub Saharan Africa.

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 six building blocks of the WHO framework, with access to essential medicines and supplies being the most popular area, followed by leadership and governance. There were 1,473 institutions supported – 565 in Y1 by 14 Y1 cohort commitment makers and 908 in Y2 by 21 Y2 cohort commitment makers (Figure 7). Support was provided over a range of nine subject areas namely:

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

Figure 7: Institution Support Provided by Year



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COMMUNITY-LEVEL

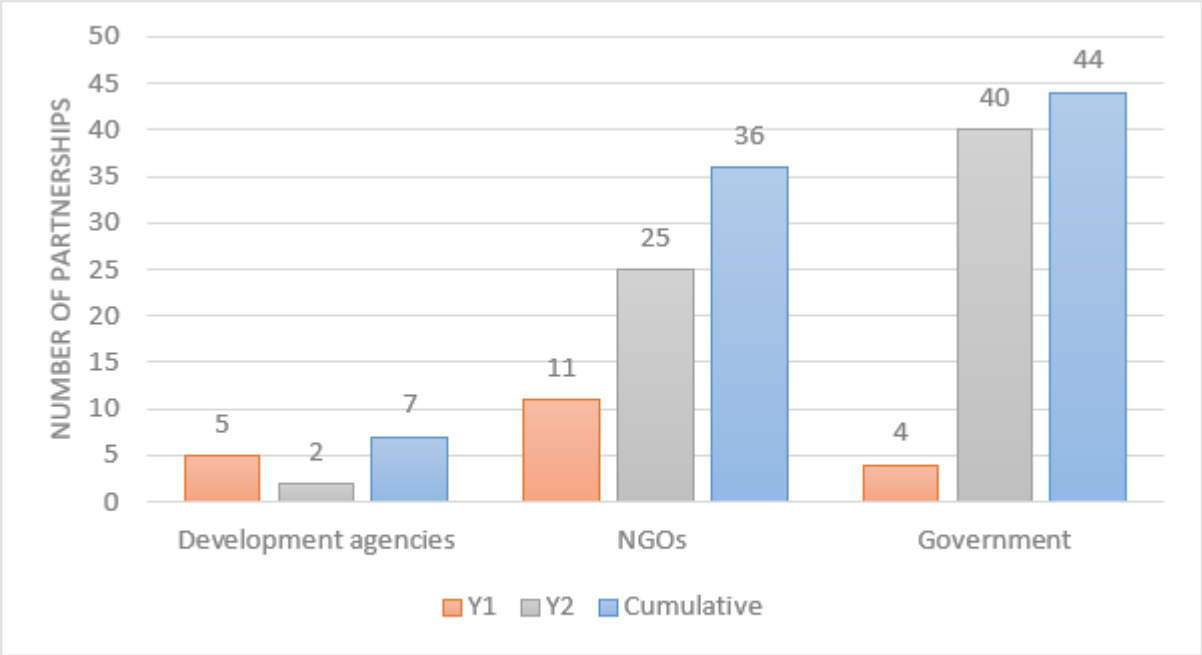
A few commitment makers focused their activities at the community level, seeking to strengthen the community services building block of the health system. Community activities included health promotion of general wellbeing, nutrition and increasing awareness and reducing stigma around communicable diseases. To achieve this, commitment makers established community groups, church groups, and trained them on various health related activities. For instance, 539 community groups were trained by one of the commitment makers during the first two years of the initiative. In addition, two commitment makers involved 1,629 church groups in health-related activities in the community over the first two years of the initiative.

The commitment makers perceived community linkages through local volunteers and groups as critical elements for supporting them with their activities. It indicates the need for community ownership in dealing the local issues, as quoted by one of the commitment makers Quotin, “These groups represent their own communities and issues”. The value of these linkages were felt and highlighted during the COVID-19 pandemic, where they were leveraged to support sensitization and community education efforts. Engagement of the community before undertaking activities was also emphasized.

SYSTEMS-LEVEL

At the systems level, commitment makers focused on establishing partnerships and mobilizing resources. 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 cohort commitment makers, and 67 partnerships were fostered by 11 Y1 cohort and Y2 cohort commitment makers in Y2 (Figure 8). Partnerships were largely with government, NGOs and development agencies. Qualitative responses emphasized the value of partnerships to expand commitment maker activities and service delivery. One commitment maker shared a caution with partnerships as well: “Because we have partnered with…we were vulnerable to their potential collapse”.

Figure 8: Types of Partnerships across the years



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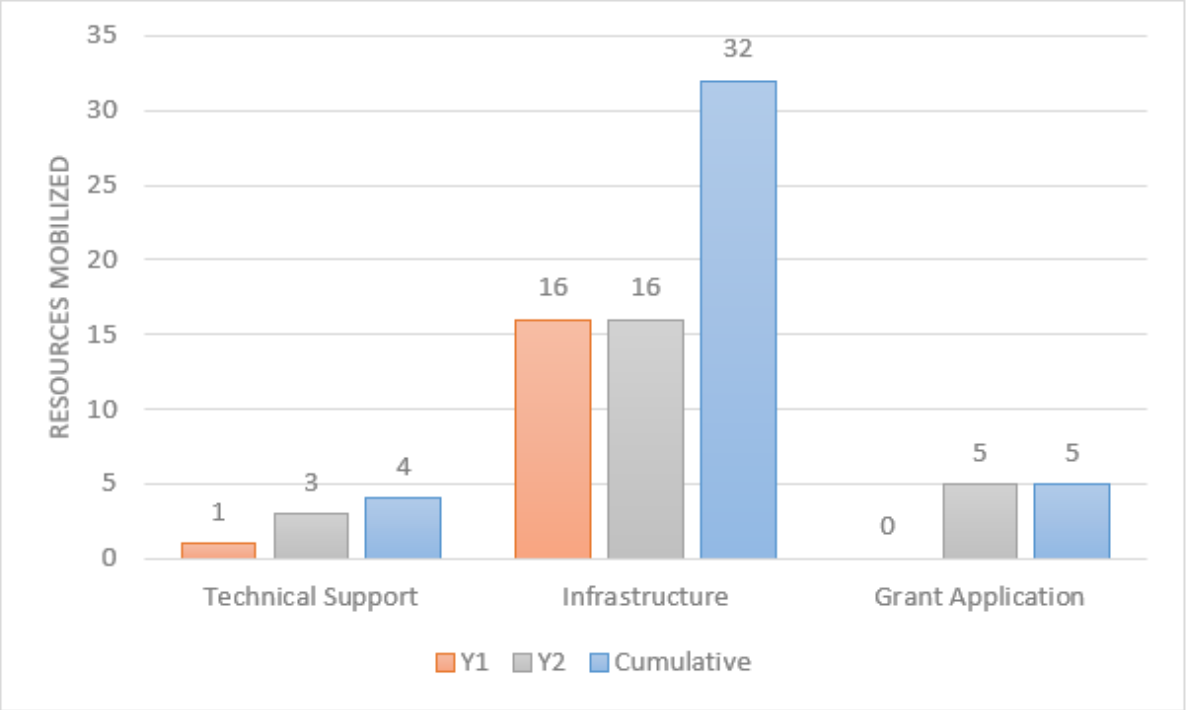
In addition, there were 17 resource mobilization efforts by two Y1 cohort commitment makers in Y1 and 24 efforts to mobilize resources by four Y1 cohort and Y2 cohort commitment makers in Y2 (Figure 9). Resource mobilization efforts were both direct and indirect, whereby technical support was provided through development of advocacy documents (indirect), funding infrastructure projects at health facilities (direct) and applications for grants to support programs (direct).

Figure 9: Types of Resource Mobilization Efforts Across the Years



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GAPS, CHALLENGES, AND RECOMMENDATIONS

TIMELY DATA SUBMISSIONS

- Challenge:
  - The 30x30 timeline does not always align with all the commitment makers' timelines of collecting and reporting data on their programmatic work internally, thus some data could not be included in this year's report.
  - It is also likely that commitment maker activities and submissions were affected by the ongoing COVID-19 pandemic. For instance, two commitment makers reported substantial disruption in their activities due to the pandemic.
- Recommendations:
  - Data missing from this report can be included in subsequent annual reports.
  - The CCIH 30x30 team will request data submissions three months in advance of the deadline to give commitment makers ample time to gather and prepare data submissions, or communicate inability to meet the deadline.
  - Inclusion of data in the annual report that will be publicized may also be an incentive for commitment makers to submit the data by the deadline.

MONITORING AND EVALUATION CAPACITY

- **Challenge:**
  - **Commitment makers had varied levels of experience and capacity for monitoring and evaluation, so 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 difficult.**
- **Recommendation:**
  - **CCIH hopes to be able to provide these commitment makers technical support to put stronger processes into place for future years.**
  - **CCIH will continue to work with commitment makers to ensure that activities included in their commitments can be measured with quantitative indicators.**
  - **Building M&E capacity is a positive (albeit unintended) outcome of this initiative. This was recognized by one of the commitment makers as a valuable take away from their engagement with the initiative.**

COMMUNICATION LOGISTICS

- **Challenge:**
  - **Some FBOs have had staff turnover translating to disconnect in communication when the initial contact person leaves the institution. Furthermore, CCIH's 30x30 team is largely comprised of consultants, thus communication has been handled by multiple parties as the initiative progresses. In view of this team structure, communication with commitment makers has been limited to an "as needed" basis, when requesting for data or responding to queries.**
- **Recommendations:**
  - **CCIH needs to ensure there are multiple points of contact for the 30x30 initiative from each commitment maker to allow for smooth transitions following staff turnover.**
  - **CCIH may distribute quarterly updates on technical areas of importance, to all commitment makers to ensure regular contact throughout the year - in addition to one-on-one communication as needed.**
  - **CCIH may encourage commitment makers to submit abstracts to the annual conference to present on their commitments' progress.**
  - **CCIH may organize regular webinars on various technical aspects emerging as gaps from the 30x30 initiative.**

DATA MANAGEMENT LOGISTICS

- **Challenge:**
  - **In the first year of the initiative, data was collected using Microsoft Excel Spreadsheets via email. As the initiative expands in scope, CCIH opted to set up a database to streamline data submissions. The process of setting up the data management system took longer than anticipated due to several factors, including COVID-19, which required attention of consultants. Furthermore, additional challenges emerged with synchronizing the database to CCIH's web interface. While the team anticipated starting data collection in July, they were not able to begin until mid-September. In addition, some commitment makers had challenges accessing and navigating the database, requiring extra support from the CCIH 30x30 team.**
- **Recommendations:**
  - **A CCIH consultant created a database user guide with screenshots to guide navigation (completed).**
  - **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.**

THE WAY FORWARD

One of the key objectives of the 30X30 health system initiative is to capture evidence of the ongoing and planned activities of CCIH members and affiliates in health systems strengthening. Findings from this report indicate that over the first two years of the initiative, 30x30 commitment makers have prioritized strengthening of the health workforce, leadership and governance and expansion of service delivery.

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.**
- **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 select indicators to measure their planned or ongoing activities, thus indirectly improving the monitoring and evaluation of programs and policies. In addition, the publishing of commitments and this annual report may indirectly facilitate resource mobilization. Despite this, there have been no direct efforts by the initiative towards addressing this objective.**

- Moving forward, strategies to operationalize achievement of this objective should be developed including:
  - Regular convening of meetings where commitment makers can share lessons and best practices which may facilitate planning of better policies and programming with CCIH as the convening body.
  - Development of an advocacy plan to ensure that this common platform can be better leveraged for resource mobilization for faith-based health services.
  - Identification of health systems blocks that may require more strengthening efforts, such as community services and financing, and sharing of existing CCIH resources to support organizations in their programming to address these. For instance, referral to the CCIH Community Based Prevention and Care technical working group.

- Gather evidence of stronger health systems for FBOs
  - Through the development of a database for reporting of data, the measurement of FBO activities to strengthen health systems has been institutionalized and streamlined. Database access is limited to the CCIH 30x30 team and commitment makers.
  - Moving forward, the CCIH team may consider ways to translate and publicize the evidence collected in the dashboard.

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1. Christian Connections for International Health (CCIH). Market share of Faith Based Organizations (FBOs) in the health care of developing countries [Internet]. Washington, DC; 2018 [cited 2021 Nov 18]. Available from: http://dx.doi.org.ezproxy.liberty.edu/10.1371/journal.pone.0128389
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For more information about the 30x30 CCIH Health Systems Initiative, visit our website or email us at 30x30@ccih.org.