STRONGER HEALTH SYSTEMS FOR THE DEVELOPING WORLD

BY BRUCE COMPTON

In February, the Pew Internet and American Life Project reported a survey of technology experts who described the hyper-connected Millennial generation, born between 1981 and 2000, as a group of nimble multitaskers who also may "exhibit a thirst for instant gratification and quick fixes, a loss of patience, and a lack of deep-thinking ability" due to what one expert called "fast-twitch wiring." (Find the report at pewinternet.org/Reports/2012/Hyperconnected-lives.aspx)

I would suggest the report describes not just a specific generation but modern American culture. We seek ways to fix things fast; ways that are based on our way of life and capabilities. Our ways, however, may not be in line with the realities faced by women, men and children in the developing world.

The Pew report called to mind several questions directly related to my work in international outreach and a new initiative CHA is undertaking with Catholic Relief Services (CRS) and the University of Notre Dame:

- How will the Internet continue to affect how we relate to individuals in the developing world?
- With our cultural tendency to seek instant gratification, will we be able to create and sustain the processes and initiatives needed to strengthen health systems in countries that aren't wired — places where few to no Internet access points currently exist?
- Facebook campaigns allow potential donors to "like," then support our organizations. Posting our organizations' contact information online means people in the developing world with Internet access are able to individually request donations or services. But do these kinds of swift, direct digital connections overshadow or negate vital but more cumbersome processes — such as collaboration in seeking solutions to larger problems, then undertaking slow but sustainable improvement?
- Will those who participate in our ministry's international mission activities not merely meet the needs of the moment, but dedicate themselves to others with heartfelt concern, as Pope Benedict XVI urged, enabling them to experience the richness of their humanity?

These are probing questions I ask myself in my own work, and they apply, as well, to our "Strengthening Faith-Based Health Systems" partnership, a new, 10-year initiative that gives our ministry the means to collaboratively seek sustainable solutions. Will we as a ministry have the will to carry it through?

On behalf of the partnering organizations, guest columnist Karen Moul, CRS communication officer, describes on the following page the pilot program that will launch the project.

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A New Collaborative Effort Seeks to Change Lives

GUEST COLUMN BY KAREN MOUL

It's an incredible time to work in health care. Our ability to prevent and treat illness grows every day with new drugs, amazing technology and complex research at our disposal. Yet in the face of unprecedented medical advances and innovative new technologies, poor health outcomes and deep inequities persist in many parts of the world. Wealthy nations enjoy a sophisticated array of effective and affordable alternatives, while poor countries lack the strong health systems needed to deliver these interventions reliably, consistently, cost effectively and at scale. They simply don't have the funding,

infrastructure and trained personnel to serve patients in need.

The new partnership between CHA, Catholic Relief Services and the University of Notre Dame is a 10-year collaboration that will strengthen faith-based health care systems in 10 countries so that they can meet the health needs of the poorest and most vulnerable people.

CRS will be responsible for implementing the initiative overseas and leading the consortium of core partners in the U.S., while CHA will mobilize and coordinate the response from U.S.-based

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Catholic health care systems and facilities. The University of Notre Dame will act as the primary research partner and manage activities such as monitoring and evaluation, strategic planning, health analytics, mathematical modeling and decision analysis. As the initiative progresses, Notre Dame could also lead a U.S.-based, Catholic university health consortium involving medical and nursing schools to provide critical support while also providing faculty and students with opportunities to get involved.

After consultation with CRS country programs around the world, the project has selected the following six countries for pilot initiatives. In general, these are locations where CRS already has established relationships with Catholic and other faith-based health facilities that have the capacity to provide services and to absorb technical assistance and other inputs.

Ghana — CRS has a history of more than 50 years in Ghana, an African country in which faith-based organizations provide 42 percent of health services nationally. The Catholic presence is significant, for the National Catholic Health Service represents 70 percent of the membership of the Christian Health Association of Ghana, an umbrella group of organizations. The Health Systems Strengthening Project will focus on the country's East Mamprusi District, the site of a current CRS maternal and child survival project.

There are four key areas of intervention:

- Improve community-based access to health care by supporting mobile medical outreach teams and medical extension days
- In a part of the world where many women give birth at home, engage traditional home-birth attendants to refer mothers to clinics and improve birthing services and equipment at health facilities
- Ghana, like almost all developing countries, suffers from a crisis of human resources. Include remuneration packages for paramedics and initiatives that would shift tasks from doctors to nurses and from nurses to paramedics
- Improve quality of health services by rolling out mobile technologies, improving supply-chain management, strengthening patient transportation and referral systems and installing quality improvement teams in facilities

Honduras — This Central American country represents an opportunity to build a national faith-based health network from the bottom up. All Catholic health services are managed at the diocesan level without any national coordination. Therefore, the first step will be to map faith-based health services and develop local capacity to advocate to the government on health policy issues. There is a need for minimum standards for procurement, handling and use of medical supplies as well as collaboration with medical training institutions for internships at Catholic health facilities. From a health financing perspective, program managers hope to investigate micro-insurance schemes to provide access to health care for the poor.

India — India's National Rural Health Mission formed a network of over 825,000 women who serve as volunteer community health workers. They facilitate access to health services and promote healthy practices and behaviors in their communities, especially for women and children.

CRS has helped pilot a mobile phone-based pregnancy checklist that helps these volunteers raise awareness among rural women and their families of the need for full antenatal care, good nutrition, birth preparedness, institutional delivery and recognition of danger signs. The CHA/CRS program will expand both the technical scope and scale of the program in collaboration

with Indian health authorities. Key interventions will include:

- Contributing to sustained improvements in maternal, newborn and child health outcomes and survival
- Developing a postnatal checklist that will promote early and exclusive breastfeeding, complementary feeding and routine immunization
- Strengthening village health and sanitation committees

Because CRS works with several faith hospitals in the northeast part of India where health services are traditionally under-resourced, it plans to expand its current work in this area of the country to increase the quality of existing health care services offered by local church partners.

Kenya — Faith-based organizations provide 30 percent of all health care in Kenya and as much as 50-60 percent in rural areas. Overall, 47 percent of faith-based health facilities are Catholic. CRS has strong relationships with the national Catholic and Protestant health organizations, having worked in the African country since 1965. The project will focus on rural areas but also on the vast slums found in Kenya's bustling capital city, Nairobi. Key efforts will include:

- Strengthening local networks of faith-based organizations to build institutional capacities in healthy board governance principles and practices, financial policies and procedures and inventory systems to monitor pharmaceutical stocks
- Strengthening links between communities and the formal health system, using communication networks such as mobile phones to increase access to care and improving transportation for patients who must often travel long distances for health care services.

Nigeria — The most populous country in Africa, Nigeria has faith-based organizations providing up to 60 percent of health care for its 170 million residents. The Catholic Church is the single largest provider of faith-based health care, with 300 health institutions. The CHA/CRS collaboration will focus on the Diocese of Makurdi, which operates a network of 45 health facilities, and the Diocese of Kano, which collaborates with the Daughters of Charity to manage two primary health care facilities and 16 village outposts in the poorest part of the country.

Efforts will focus on developing a "hub and spoke" model of health service delivery in both dioceses that will include providing key medical equipment to hub hospitals. Lab equipment will be a priority. Other specific areas in need of strengthening include human resources, governance and management, supply chain, health management information systems, quality assurance systems and increased engagement with the government for long-term health care funding sustainability.

Zambia — Faith-based facilities provide 30 percent of all health services in Zambia, with 50 percent in the African country's rural areas. The project will target two hospitals in rural Monze Diocese and one hospital in Ndola Diocese that serves a peri-urban population. Another key partner will be the Churches Health Association of Zambia (CHAZ), an umbrella organization composed of faith-based member facilities and networks. Efforts to improve health care management will include establishing a governance and leadership unit at CHAZ, developing community advisory boards at the facility level, creating a facility advocacy network, strengthening human resources and improving access to quality information for decision-making. There are also plans for a distance learning program for neglected tropical diseases and non-communicable diseases.

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