



**Kenya Faith-based organizations
Health Systems Strengthening Mapping Workshop
Wednesday, May 15, 2019
Nairobi, Kenya**

Christian Connections for International Health (CCIH) hosted 13 Kenya-based faith-based organizations to discuss health systems strengthening from a faith perspective. These included Adventist Development and Relief Agency Kenya (ADRA-Kenya), Catholic Relief Services (CRS), Christian Health Association of Kenya (CHAK), Coptic Hospital, CURE Kenya, Ecumenical Pharmaceutical Network (EPN), Kabarak University, Kenya Assemblies of God, Mission for Essential Drugs and Supplies (MEDS), Mennonite Central Committee (MCC), Samaritan's Purse, World Relief and World Renew. Mona Bormet, Program Director for CCIH, facilitated this meeting.

The goals of the meeting included:

1. Share and learn through an honest and open dialogue with other faith-based health organizations running health facilities and/or community programs regarding health systems successes and needs.
2. Develop concrete organizational profiles with HSS successes and needs that will be used to share with potential donors and partners (longer term).
3. Seek or identify any geo-mapping or electronic lists/databases of health facilities, programs or related services, or initiatives to create those (longer term).

CCIH's main takeaways included:

- Financial sustainability of the organizations is crucial to continue the work. Creative ways of adding and managing income are to be explored.
- User-friendly ways of data collection and analysis will benefit decision making.
- Communication and branding need to improve to help organizations position themselves well and diversify income streams.

The mapping exercise started with context and successes: CCIH shared WHO definitions of the six HSS building blocks and asked the FBOs to highlight three ways in which they are doing well/succeeding under each building block. Highlights included service delivery successes at the community level engaging community health workers (CHWs); training their health workforce; access to supply chain systems for medicine & supplies; many policies in place related to leadership and governance.

Then the groups went through a variety of interactive prioritizing exercises regarding how FBOs can improve, where they need help, or can do better in each of the six building blocks, in addition to needs in monitoring and evaluation and communications. Issues listed below are in order of participant ranking.

While discussing each of the HSS building blocks, the issues that came forward as the highest needed areas of further work included, but are not limited to:

1. *Financing:*

- a. Reducing the community burden for health costs by finding a balance between charging and providing free services. Sustainable community-based health financing system.
- b. Sustainable organizational financing (systems) and income generating activities that meet audit and donor requirements.
- c. Diversify funds including local resource mobilization and external funding.
- d. Improve cash flow by receiving timely disbursements and avoiding outstanding debts from health facilities.
- e. Reducing waste on irrelevant activities.
- f. Financing for infrastructure and housing development for staff.
- g. Mitigate risk of national health insurance collapse that could weaken a Universal Health Care (UHC) system.

2. *Health Information Systems:*

- a. Use of advanced technology solutions such as mobile data collection and more automated data analysis tools (realtime data).
- b. Improve data sharing with the national health system.
- c. Adequate and sustainable infrastructure (including tools) to support health information systems.
- d. Better use of data for decision making, influence policy and performance monitoring.
- e. There are capacity needs on how to collect, manage, synthesize, analyze and validated data.
- f. Improve data sharing with stakeholders and for feedback to the community.
- g. Build in finance and performance data and analytic tools to generate cost/benefit or cost-effectiveness ratios.

3. *Health Workforce:*

- a. Provide more opportunities for health workers to be trained (develop curriculum, skill sharing, best practices, refresher training, CME's, etc).
- b. Need improvement on staff retention strategies (salaries, terms and conditions) and reduce burnout.
- c. Participate in advocacy activities at both national and county level to improve health workforce.

- d. More elaborate structures and systems to monitor health workforce performance with adequate use of data and regular performance reviews.
- e. Include more trainings for leaders of the community (not just CHWs) as it will create a more sustainable structure.
- f. Improve recruitment and hiring among the highest qualified potential staff, to prevent them taking jobs at better paying facilities.

4. Leadership & Governance:

- a. Evidence-based decision making.
- b. More or better implementation of policies including empowering staff on the policies, such as workplace safety, stigma, and child protection.
- c. Transparency and Accountability from leadership:
 - i. Remaining focused to achieve the organization goals.
 - ii. Have training in leadership and governance for staff.
 - iii. Orientation of boards regarding oversight roles and expectations in the health systems through the lowest level.
 - iv. Succession planning.
 - v. Appraisals and rewarding systems within the organization.
 - vi. Mentorship and coaching.
 - vii. Leadership not necessarily based on skills and experience, which can cause problems.
- d. Partnership and collaborations with (county and national) government and (potential) donors.
- e. Synchronized approach for the organizational health facilities is lacking.
- f. Leadership and governance challenges at health facilities.
- g. Improve policies and enforcement to reduce corruption in public sector and some faith-based outlets.
- h. Improve local ownership and continuation of programs, especially regarding their sustainability when they end.

5. Service Delivery:

- a. Collaboration of providers from government / CSO / private amongst others for referral systems. Currently fear of 'competition'.
- b. Community-level interventions like mobile clinics, prevention etc.
- c. Availability of wide variety of services.
- d. Infrastructure to support service delivery like equipment, ambulances, facilities, housing etc.
- e. Quality - monitoring and standard operating procedures (SOPs).
- f. Improve medicine/supply deliveries to address out of stock issues.
- g. Use of ICT solution to improve on service delivery.
- h. Limited situational assessment regarding demand for services. Partners just decide on a need and a response without sufficient data.
- i. Need adequate motivation for community volunteers.

6. Access to Essential Medicines:

- a. Partner with (county) government to get medicines for FBOs.
- b. Counterfeit and substandard medicines in the market; need for quality medicines and supplies.
- c. Irrational prescribing and use, amongst other over-the-counter sales.
- d. Reliable and user-friendly supply chain with adequate, affordable medicines and supplies, reducing stock-outs to all communities.
- e. Adequate quantification and forecasting.

Organizational Communications: outward facing communications is important for partners, donors and for the community to know how you are promoting yourself and the actual mission, vision and work of your organization. Organizations were successful on organizational and programmatic factsheet/brochures, website, social media and mapping of activities.

Vital components of communications that need attention, based on the discussions, are:

- a. Specific assigned communication staff with clear job description.
- b. More use of radio/tv/newspapers.
- c. Branding of the organization and its programs to be more visible, including visibility of implementing partners.
- d. Translation of materials / adverts in local languages.
- e. Ensure the website is up to date.
- f. Be more intentional regarding communication and less ad hoc.
- g. Need factsheets on programs.

Monitoring & Evaluation could be considered part of the Health Information Systems or Governance and Leadership building blocks, but M&E issues are brought to the forefront often when it comes to faith-based organizations. In general most of the organizations do well in the following parts of M&E: searchable and shareable databases of staff and projects, support supervision, internal reports and external reports, sharing of reports to headquarters, paper and electronic records.

Below are specific components of M&E that were mentioned as critical areas for FBOs to improve:

- a. Organizational Theory of Change and Logframe are not always in place.
- b. Impact assessment, including feedback mechanisms from the beneficiaries.
- c. Sustainability of projects and an exit plan for when the project ends.
- d. Gender analysis.
- e. Control measures to measure the work plan versus the actual, but also to ensure quality and timelines (Gantt chart).
- f. Having a dedicated staff for M&E and/or ensuring that the M&E staff is not implementing the project as well. Seven organizations indicated they have M&E staff members, but they are not dedicated to M&E and mostly help implement projects as well.
- g. Collaboration and sharing of data and information.

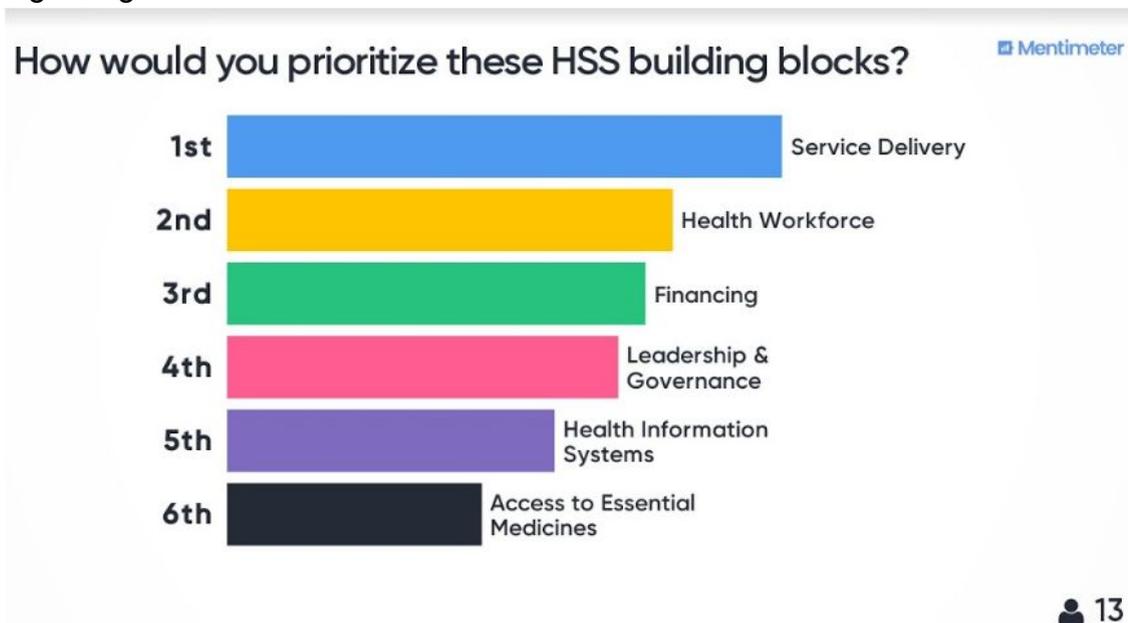
h. Conducting research with ethical approval.

The mapping exercise concluded with two priority-setting exercises at the end of the day. Each participant was asked to write down what they think their organization's top three HSS priorities should be (knowing that these are not official as they have not had any organizational official discussions). It was interesting to see that people included Communication and M&E under the HSS priorities.

Tallied in order of importance based on a written mapping activity:

1. Financing: 9
2. Health Information Systems: 6 (tied with Communication, but people listed lots of challenges under Health Information Systems)
3. Communication: 6
4. Health Workforce: 5
5. Leadership & Governance: 4
6. Service Delivery: 3
7. Access to Essential Medicines and Supplies: 3
8. M&E: 3

Then, in another priority mapping activity using the online system mentimeter.com, the participants were asked to rank the HSS building blocks 1-6 from most to least important, and the ranking was a little bit different than above. Service delivery scored ranking #1 (most important), while in the needs exercise it was ranked #6. The situation was similar with Health workforce; it ranked #2 regarding importance but only #4 regarding needs. Finances ranked #3 regarding importance but #1 regarding needs.



CCIH is grateful for all organizations that contributed to the meeting and hope the discussion and findings bear fruit in collaboration among Kenyan FBOs and other partners to strengthen their health systems. The results from this mapping have contributed to the content of CCIH's 30x30 HSS initiative that will be launched at the CCIH 2019 annual conference.