Malawi Faith-based Organizations
Health Systems Strengthening Mapping Workshop
Thursday, April 25, 2019
Lilongwe, Malawi

CCIH partnered with the Christian Health Association of Malawi (CHAM) to gather 7 Malawi faith-based organizations (FBOs) (African Enterprise, Archdiocese of Lilongwe Catholic Health Commission, CHAM, LifeNet Malawi, Malawi Network of Religious Leaders Living with HIV/AIDS, Partners in Hope, World Relief) to discuss health systems strengthening (HSS) from a faith perspective.

The goals of the meeting and CCIH's new HSS initiative 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 shared with potential donors and partners (longer term).
3. Seek or identify any geo-mapping or electronic lists/data bases of health facilities, programs or related services, or initiatives to create those (longer term).

CCIH's main takeaways included:

- The importance of accountability and transparency and strong governance needs in their structures.
- The need for accountability and follow through to ensure lead positions are filled with staff that can implement and track policies, conduct comprehensive landscape analysis, and execute based on findings.
- Need for cross-collaboration. Participants reported this was the first gathering they had participated in that specifically brought together Christian organizations working in health together to specifically map successes and challenges. For many, they had never met before and were not aware of another Christian organization working in health in the same regions or districts.

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 quality service delivery, standards for their health workforce, and monitoring knowledge/practical supervision of health workforce. Mona Bormet, Program Director for CCIH, facilitated this meeting.

Then the groups went through a variety of interactive prioritizing exercises regarding how FBOs can improve, need help, or do better in each of the six building blocks, in addition to needs in monitoring and evaluation (M&E) 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 areas with the highest need for further work included, but are not limited to:

1. **Leadership and Governance:**
    a. Ensure a strategic policy framework.
    b. Intelligence and oversight - looking at the big picture and all the parts.
    c. Innovation.
    d. Ensuring leadership positions are filled and workload is spread fairly across staff.
    e. Strengthen governance of the network: Board/Developing local board: people and policies and procedures.
    f. Collaborate with other players in the health system (i.e. Involve District Health Office-Ministry of Health in oversight of program).
    g. External partners interference with priorities.
    h. Professional development of our own staff to grow as managers and leaders.
    i. Evidence-based decision making.
    j. Greater transparency and accountability.
    k. Implementation of policies
        i. Guidance - policy guideline priorities.
        ii. Putting in place proper controls and procedures in health system.
        iii. Work regulations.
        iv. Improve on regulations and reinforcement for compliance.
        v. Need to look at the bigger picture of intelligence and oversight (e.g. health reforms).

2. **Financing:**
    a. Financial management that is accountable and transparent and that has a positive outcome and meets goals.
    b. Sustainable financial system/strategy that is evidence based, with cost recovery systems and catastrophic financial protection systems in place.
    c. Resource mobilization.
    d. Skills for domestic resource mobilization so as to not always depend on outside donors.
    e. Advocacy around adequate and equitable financing from local to national.
    f. Equitable sharing of financial resources by FBOs.
    g. Community health insurance. Community schemes/insurance to protect from catastrophic health expenditure.
    h. Poor incentives and salaries for health workers.
    i. Unaffordable health service fees by the majority poor in rural areas.

3. **Service Delivery:**
    a. Ensure quality, safety, and access when delivering services.
    b. Demand Creation.
    c. Engage Health Surveillance Assistants (HSAs)/Community Health Workers (CHW) in programs,
    d. Improve support supervision and mentoring to our vast network of volunteers and staff.
    e. Infrastructure to support service delivery such as buildings, water, power, computers and vehicles.
    f. Engage community committees, local leaders, etc.

4. **Health Information Systems:**
    a. Use of technology and data (basic and advanced).
    b. Data feedback/integrating data into District Health Information Systems /other MoH Health Information Systems (HIS).
    c. Improve data collection skills of staff and volunteers.
    d. Instituting production of annual reports.
    e. Insufficient evidence (need robust M&E system).
    f. Improve adequate capacity/systems to synthesize data and use it to make expedient decisions, communicate health events, and generate research questions.
    g. Quality of data.
    h. Timely sharing and disseminating of data.
    i. Adding specific training on reporting into our systems and programs.
    j. Inadequate resources for data collection.

5. **Access to Essential Medicines:**
    a. Access to essential medicines: easy access to better quality medicines, access in hard to reach areas, and advocacy to government for equitable access to medicines.
    b. Storage of medical products to adhere to recommended WHO protocols to maintain efficacy.
    c. Improving store room infrastructure including cold storage and power to do so.
    d. Safety of essential quality medicines.
    e. Communities not engaged in drug safety, abuse, and effective use.
    f. Procurement:
        i. Need government to prioritize essential medicine procurement to do away with donor reliance.
        ii. Procurement from private sector.
        iii. Where to get medical supplies?
        iv. Pooling of procurement.
        v. Transparency in procurement of essential medicines.
    g. Quantification, procurement and forecasting systems; inventory management.

6. **Health Workforce:**
    a. Training colleges have good graduates, but then qualified nurses are unemployed. Need to get them into the workforce.
    b. Poor incentives to health workers.
    c. Training and education of staff/building capacity.
    d. Provision of scholarships.
    e. Insufficient staff to support community-level initiatives.
    f. Lack of financial sustainability plan beyond donor-funded projects. No allowances to staff/Inadequate funding to meet needs, challenges, and standards of health workers/costing when donors are no longer there.
    g. Poor monitoring of health worker performance and needs.
    h. Mentoring of health workforce.
    i. Lack of transformative trainings to staff for mindset change over poverty alleviation.
    j. Delays in recruitment.
    k. Involving HSAs/CHWs in trainings.
    l. Advocacy at national level and involving district health office.

Monitoring & Evaluation could be considered part of the Health Information Systems or Governance & Leadership building blocks, but M & E issues are brought to the forefront often when it comes to faith-based organizations. Below are specific components of M&E that are critical for FBOs to improve:

- Database of Projects/Members (that can be searched and shared).
- Database of staff (that can be searched and statistics shared).
- Report to national reporting systems.
- Paper records transferred to electronic records.
- Theory of Change/Log Model/Logical Framework.
- Program reports are sent from the field to headquarters.
- Support supervision to improve compliance and delivery.
- Internal reports (created and shared among staff).
- External reports (created and shared outside the organization to donors, partners, etc.).
- Annual reports developed.
- Quality reports - make sure we are telling the proper story of successes and reporting and explaining statistics.
- Timeliness - ensure we are reporting on time and are prepared to do so.

Organizational Communications: outward facing communications is **i**mportant for partners, donors and for the community to know how you are promoting yourself and the actual mission, vision and work of your organization. Vital components of communications:

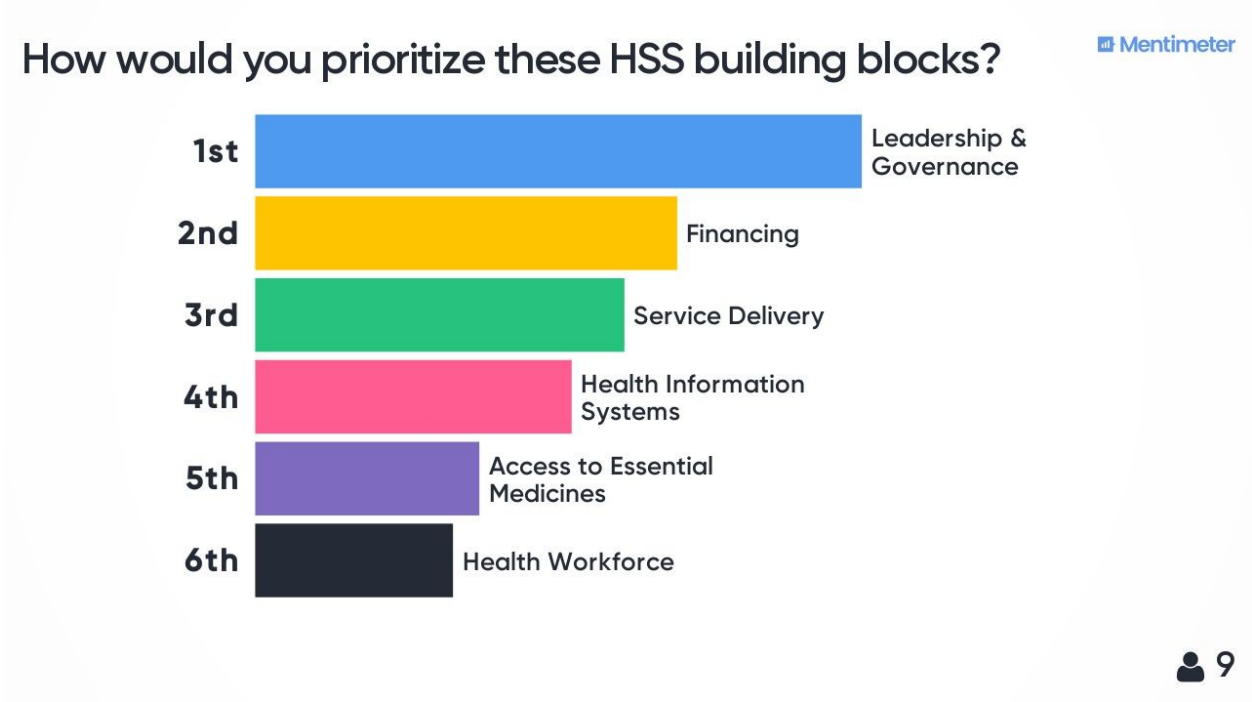
- Fact Sheet/Brochure on your organization (that is less than 3 years old)
- Fact Sheet on specific programs
- Story collection/photo collection/video collection (includes permission from people featured to be shared publicly)
- Website
- Social Media
- Visual map of your country programs
- Communications budget/staff person

The mapping exercise concluded with two mapping exercises at the end of the day which focused on priority setting. 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).

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

- Leadership & Governance: 8
- Service Delivery: 6
- Financing: 5 (tied with HIS, but people really struggled with the Financing piece)
- Health Information Systems: 5
- Health Workforce: 2
- Access to Essential Medicines and Supplies: 1

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 to them, and the ranking was a little bit different than above. Leadership & Governance still stood out as the #1 area in which focus is needed; service delivery and financing switched places between #2 and #3 rankings.



CCIH is grateful for CHAM's assistance in this meeting and hope the discussion and findings bear fruit in collaboration among Malawi 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.