



In Kitwe, Zambia, pharmacist William Mwiinde prescribes medication to Mary Mwewa. *Jake Lyell for CRS*

Health Networks and Associations in Low and Middle Income Countries:

KEY FACTORS FOR SUSTAINABILITY

The study identified key characteristics shared by successful networks and associations, with the aim that young networks in low and middle income countries could use this information in their planning and be more sustainable and valuable to their members as a result.

STUDY PURPOSE

In 2014, Catholic Relief Services Haiti and the University of Notre Dame Eck Institute for Global Health conducted a study to identify key characteristics related to the success of long-standing health facility networks in low and middle income countries. The information gathered in this study was used to provide a summary of successful practices to support the recently formed

Réseau d'Institutions Chrétiennes de Sante d'Haiti (RICSH) or the Haitian Network of Christian Health Institutions in Haiti.

As little information has been documented on health facility networks and associations in resource-limited settings, the study included an analysis of various organizations' management, finances, membership

and services in low and middle income countries. The study identified key characteristics shared by successful networks and associations, with the aim that young networks in low and middle income countries, such as the RICSH network, could use this information in their planning and be more sustainable and valuable to their members as a result. RICSH was used as a case study for this study.

BACKGROUND

RICSH, started in 2009 with nine health facilities, is considered a relatively new network compared to other longer-lived health facility networks elsewhere in the world, and is currently facing a number of challenges, including:

- **Lack of accreditation:** Most of the RICSH health facilities are not yet accredited with the Haitian Ministry of Health. Without individual facility accreditation, the network cannot become a recognized and legal entity in Haiti. It also cannot apply for funds through public donors.
- **Member dissatisfaction:** RICSH members feel the network has not generated enough benefits for its members in the five years since it informally banded together.
- **Varying levels of functionality and quality:** RICSH members are at varying levels of functionality and quality, so each health facility has its own unique challenges and priorities.
- **Limited human resources:** Health facility administrators are the acting representatives for each health facility within the network. They run high demand, resource-challenged health centers, making it difficult for them to find time to govern the network.
- **Insufficient funding:** RICSH is funded through a short-term, single funding stream with no plans for additional funding.

STUDY OBJECTIVES

This study looked at the following objectives:

1. Developing an understanding of different funding mechanisms used by health facility networks to cover the networks' or associations' operating costs.
2. Documenting the current governance structure of health facility networks and roles of member health facilities within the network

3. Documenting information about network membership including what types of services are offered to network health facilities

STUDY METHODOLOGY

Research consisted of a desktop review and key informant interviews to gather information from twelve health facility networks or associations. The interviews included questions about finances, governance, membership, and services offered. Networks were purposefully selected in this study based on relevance to the RICSH network and some basic inclusion criteria. All existing networks in Haiti were interviewed as well as select faith-based networks in other countries.

Box 1: Networks or Associations Interviewed

- CHAK:** The Catholic Health Association of Kenya
- CHAM:** The Christian Health Association of Malawi
- CHAG:** The Christian Health Association of Ghana
- CHAZ:** The Churches Health Association of Zambia
- ZACH:** The Zimbabwe Association of Christian Hospitals
- AMCES:** l'Association des Œuvres Médicales Privées Confessionnelles et Sociales au Bénin
- ACHAP:** The Africa Christian Health Associations Platform (unique from the other associations in that it is an "association of associations")
- AVESSOC:** La Asociación Venezolana de Servicio de Salud de Orientación Cristiana
- CHAS:** The Christian Health Association of Sudan
- CHN:** The Cap Haitian Health Network
- AHPH:** l'Association des Hopitaux Privés d'Haiti
- CPHRN:** The Central Plateau Health Resource Network (Haitian)

FINDINGS

The study identified several common core characteristics shared by health facility networks or associations, which likely contribute to the long-term sustainability of these networks:

- **Organizational Structure:** A structure which includes a Secretariat, Board of Trustees, and General Assembly.
- **Paid staff:** Successful networks have non-member paid staff running the networks.
- **Multiple sources of outside funding:** Outside funding enables networks to both hire staff to manage network activities and to provide services to health facility members.



Box 2: Timeline of Association or Network Start Dates

- **Membership fees:** Buy-in from network health facilities, while more complex than this study can measure, can be partially understood by looking at the contributions made by members. Eight of the networks studied collect membership fees from their members.
- **MOU and accreditation with the government:** Long-standing networks have MOUs with the local government and are accredited (both individual facilities and the network)
- **Mission and vision statements:** The older, more established networks studied have clearly defined mission and vision statements.
- **Variety of services tailored to member health facilities:** The networks that have been around longer tend to offer a wider variety of services.

KEY RECOMMENDATIONS FOR YOUNG OR NEW HEALTH FACILITY NETWORKS IN LOW AND MIDDLE INCOME COUNTRIES

RECOMMENDATION #1: ESTABLISH A SECRETARIAT

Secretariats are a key part of successful networks. The secretariat serves as the engine of the network, managing the day-to-day logistics of the network and ensuring that member health facilities are receiving relevant services through their participation in the network. It is important that the secretariat is comprised of staff, ideally paid, who are not health facility member staff due to their time constraints.

RECOMMENDATION #2: BUILD THE CAPACITY OF THE NETWORK TO SEEK OUTSIDE FUNDING

A network can only do so much with limited funds, so it needs to build its capacity to seek its own funding— tasks which are traditionally handled through a Secretariat. This can be accomplished through capacity building activities, such as training on the grant application process for Secretariat staff. Funding from entities such as USAID, CDC, UN, and World Bank may be considered as the networks studied in this report have had success in obtaining funding through these channels.

Another potential source of funding is network membership fees. Membership fees, perhaps on a sliding scale model, could be introduced once the network is able to demonstrate a true benefit for its members and once members are invested in the network. While many of the networks interviewed reported that membership fees did not comprise a large percentage of the overall network budget, they help improve network member buy-in and contribute to a sense of ownership.

RECOMMENDATION #3: SEEK ACCREDITATION

Networks should seek to be accredited or somehow formally recognized through relevant government entities. For example, this could be done by acquiring accreditation as a health network or by establishing NGO status. Government involvement and support can help networks establish more legitimacy, allowing them to be more competitive for international grants.



The health networks studied share several core characteristics that likely contribute to their long-term sustainability. *Sarah Ju for CRS*

RECOMMENDATION #4: ADD A BOARD OF TRUSTEES

Once a Secretariat is functioning, networks should seek to add a Board of Trustees made up of influential community members, church leaders, government officials, health professionals or other potential donor/technical expertise bodies, and other stakeholders. Without partners, ideally local partners, willing to fight for the network's success, it will not be sustainable. Older networks in this study had a local "champion," such as a church body or the government, who realized the importance of the network and the needs it could fill and who advocated for it to be successful. Adding a board comprised of influential community leaders may prompt the community to take more ownership of the network and to push for its success. Additionally, it will add internal accountability.

CONCLUSION

Key challenges for networks include identifying the right structure through which the network can adequately support its members and developing the necessary funding channels to support the network structure. By adapting some of the successful practices identified in this study, networks may be able to increase the benefits, resources and knowledge available to members, and increase the network's power to advocate to the government.

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