PARTICIPATORY HEALTH SYSTEMS STRENGTHENING

REFLECTIONS FROM MALAWI AND KENYA
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**INTRODUCTION**

Systems thinking is a phrase development practitioners and funders hear often, but isn’t always aligned with the day-to-day experiences of local actors. It does not have to be that way.

Systems thinking is not about big shifts and changes and reinventing strategies. Small tweaks that often require limited resources and short timelines can have a big impact as long as they are grounded in a deep understanding of the context and its dynamics. Nearly all local organizations and governments have a systems thinking approach, even if they may not call it that.

Systems thinking is a philosophy — a way of thinking, being and doing. It helps us become aware of all the contextual elements that drive complex problems — such as relationships of power, patterns of behavior, mental models and perceptions. Systems thinking reveals multiple reasons for a problem and multiple solutions. We believe systems thinking is an approach that can help uncover structural factors underlying a problem.

Global Integrity came to this project to learn about the value and limitations of applying a participatory systems thinking approach (PSTA) that could contribute to better health outcomes, by sparking small, and incremental changes in the system. We wanted to answer the following questions:

- What are the critical components in systems thinking to address health service delivery challenges?
- How would it be to engage with civil society and grassroots organizations to implement systems thinking in a short period of time and with limited resources?
- To what extent is systems thinking for everyone? What would result from it?
- What could our partners change within their radar and sphere of control?

### SYSTEMS THINKING PRINCIPLES

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<th>Principle</th>
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<tr>
<td>1</td>
<td>Seeing and understanding the bigger context surrounding the problem</td>
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<td>2</td>
<td>Viewing the problem from multiple perspectives</td>
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<td>3</td>
<td>Understanding the problem to have multiple causes and multiple effects</td>
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<td>4</td>
<td>Thinking critically about the problems’ root causes and how they are interconnected</td>
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<td>5</td>
<td>Identifying multiple leverage points and pathways to change</td>
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<td>6</td>
<td>Considering short-term and long-term consequences of any action or intervention including their unintended consequences</td>
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<tr>
<td>7</td>
<td>Innovating and adapting interventions in response to changes, feedback and experience</td>
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In many countries around the world, people are not able to access the health services they need, leading to disappointing and inequitable health outcomes. For example, in Kenya, there has been a significant reduction of HIV cases amongst adults, but the rates are still surprisingly high amongst adolescents and youth. In Malawi, safe post-abortion services can be provided if you have the right network and resources but care for most women in rural areas has to be delivered by other women in their community without the right training and precautions.

The reasons why countries struggle to deliver health services effectively vary. Regardless of the specific challenges that countries face, both health outcomes and the patterns of service delivery that contribute to those outcomes are shaped by the interplay between multiple actors in complex systems. When this system of actors — patients, medical staff, hospital administrators, pharmaceutical companies, politicians, regulatory authorities, finance ministries, development partners, and civil society watchdogs — works well together, health service delivery can improve; when they don’t, it doesn’t.

The dynamics of these systems are shaped by a variety of factors which range from the more technical (rules, regulations and the availability of resources) to those that relate more closely to the political economy aspects of the system (power, capabilities, incentives, and relationships). But while these differences exist there are common principles we can apply across different systems and contexts, effective approaches to addressing complex, systemic, and context-dependent challenges that stand in the way of better health outcomes.

Global Integrity believes that local actors should take the lead to address the challenges that they are facing in their communities, but this doesn’t mean that they have to do it alone. Under this project, funded by the Bill and Melinda Gates Foundation, we partnered with the Centre for the Study of the Adolescence (CSA) Kenya and Ipas-Africa Southern Region to test the participatory systems thinking approach, bringing together useful insights, resources, and networks, and making connections across issues, organizations, and geographies. As a learning partner we were able to use methods like the PSTA to strengthen partners’ strategies, along with helping partners use the PSTA as a tool to strengthen their strategies and implementation to improve the public service delivery sector.

Ultimately, our work in leading this approach seeks to promote behaviors of the actors in the systems so they operate in learning-centered and collaborative ways, and strengthen the relationships among them so they are able to bring about the changes that matter to them.
LIMITATIONS

Complex and Inclusive: How Health System Strengthening Approached Systems Thinking

One reason why systems thinking is effective for addressing public systems challenges is that it can incorporate multiple perspectives through inclusive participation of a diverse range of actors operating in the health system into the designing, evaluating and implementing of health policies. As such, key participatory methods can be “mixed” with systems approaches as they are often suitable and complementary.

These studies also found that a systems thinking approach has yet to be practiced widely by local health systems stakeholders operating in low and middle income countries, due to the following challenges (which include but are not limited to):

- The length of time, effort and resources required to engage in mapping the dynamics and root causes underlying problems which includes recurring, iterative work and analysis to generate insights.
- The many insights generated by the approach can be overwhelming — preventing local actors from taking first steps to conceptualize action, implement, test & adapt, particularly without proper guidance.
- It can be easily misconceived as just a ‘philosophical approach’ and as ineffective when it is not followed up with “systems doing” — the implementation of actual interventions.
- It can appear as being too ‘abstract’, making it hard for actors to relate to the conceptual discussions regarding hidden structural dynamics, preferring instead to use approaches that help local actors to identify and grapple with concrete and discrete problems experienced on a daily basis.
- The use of jargon to describe unfamiliar approaches, tools, and methods hinder actors’ capacity to understand and implement systems thinking approaches.
In 2019 we started with a deep dive of systems thinking and health systems literature, conducting comprehensive research on systems thinking approaches that have been applied in health across different contexts and sectors. Our research outputs went beyond merely summarizing the findings and included a degree of analysis, critically interrogating the usefulness and value of the findings to our questions.

Once we were up to speed on what is already known about the value and limitations of using systems thinking to strengthen health outcomes, we focused on designing and planning our own participatory systems thinking approach or PSTA. This approach and our core assumptions on how change would happen were tested in Kenya and Malawi during 2022.

In Kenya we partnered with the Center for the Study of Adolescence (CSA), a leading national organization committed to the promotion of the health and development of young people through research, technical assistance, advocacy, and capacity building to expand choices and improve access to safe, affordable, and sustainable health services.

**What makes PSTA work?**

**Partner selection**

We did not require preexisting knowledge of systems thinking approaches; however, the project partners’ preexisting experience concerning the nature of the problem and the broader health system context was found to be very important for co-designing the PSTA workshops. Our partners did not let their expertise get in the way of being open to receiving relevant information concerning the problem, context, and system dynamics from other health system stakeholders.

It is important that the project partners have internal organizational support, particularly high levels of commitment and buy-in from senior management. Project partners expressed how internal support by their senior management and freedom to make decisions and use organizational resources to apply the PSTA played a critical role in their ability to engage.
CSA chose to apply the PSTA to the Right Here, Right Now (RHRN) II project, for which they serve as the lead partner, as the focus for testing the participatory systems thinking approach. CSA’s RHRN project aims to allow young people (including vulnerable groups, like LGBTQ) to improve their access to comprehensive sex education and youth-friendly sexual reproductive health rights.

In Malawi we partnered with Ipas-Africa Southern Region, an international NGO that supports government and civil society to make Malawi’s health and human rights commitments a reality for women and girls. Since 2005, Ipas-Africa Southern Region has engaged with government officials, religious leaders, and community actors to highlight the dangers of unsafe abortion and build support for abortion law reform. Ipas-Africa Southern Region works with partners to build sustainable abortion ecosystems. Ipas-Africa Southern Region selected to test the PSTA on their comprehensive ecosystems approach. They applied this approach across institutions and communities and recognized there are multiple factors that influence a person’s ability to access abortion — including individual knowledge and power, community and political support, trained and equipped health systems, and laws and policies that uphold their human rights to health and to bodily autonomy. Ipas tested the PSTA in Malawi to improve treatment for abortion-related complications at public health facilities and to build an advocacy movement that includes broad-based support for improved access to safe abortion care.

Both organizations work to improve sexual and reproductive health outcomes, but from a different angle. Ipas focuses on access to safe abortion services and post-abortion care in an enabling environment where women do not have access to safe abortion services and post-abortion care. CSA works in Nairobi County where adolescents and young people (especially young women, sexual and gender minorities, and people living with disabilities) have limited access to quality sexual and reproductive health commodities, services, and information including comprehensive sexuality education that they need in order to live healthy lives.
To help us tailor our PSTA to each local context and facilitate its implementation with our local partners, we worked with The African Health Innovation Centre (AHIC). AHIC is an organization based in Ghana focused on strengthening Africa’s burgeoning health innovation ecosystem and has strong facilitation experience and skills with a diverse range of health system stakeholders in a range of African country contexts. AHIC spun off from Impact Hub Accra in 2019 and is the first organization in Ghana dedicated to improving health outcomes through innovation and entrepreneurship. AHIC’s human design centered in-person workshop and facilitation approaches aligned with the participatory and inclusive nature of the PSTA.

Global Integrity’s role brought a new lens to systems thinking. We supported facilitation of jointly mapping root causes and stakeholders’ power and interests with multiple diverse stakeholders. We enabled knowledge exchange and the willingness to engage in rich learning conversation/discussions, and comprehensive solution ideation processes including the creation of ideas to frame and solve problems.
The PSTA comprises of four steps as shown below.

**STEP 1**
**SET-UP/PREP** Defining the overarching health system problem in the context in which it exists, including identifying stakeholders who should play a role in mapping, planning, and acting on ways to address the problem.

**STEP 2**
**MAPPING THE PROBLEM** Collaboratively working to identify the underlying causes of the health system problem, the technical and political economy factors that contribute to it, and the roles and characteristics of stakeholders that influence how the system functions.

**STEP 3**
**PLANNING** Designing actions to address the problems and stakeholder behavior changes identified in the mapping step.

**STEP 4**
**ACTIONS TO ADDRESS THE PROBLEM** Implementing the complex actions designed and prioritized to improve health system functions.
The second PSTA workshop, Blantyre with Ipas-Africa Southern Region
• 20 diverse local health system actors including: civil society & community based organizations, policy makers & administrators, health care workers, representatives of young people, gender and sexual minorities and religious leaders
The learning component of the cycle is designed to help the process of adaptation. It prepares and equips CSO partners and their local health system stakeholders to face the system complexities that were not initially identified in steps 2 and 3, including decision-maker incentives, unexpected root causes, and unintended consequences of actions.
In Malawi, the laws around abortion are restricted and only accommodate situations where the mother’s life is at risk. Ipas-Africa Southern Region advocates for policy change, specifically legislative articles and international human rights agreements. They introduced the termination of pregnancy bill to be passed in parliament in 2019. Ipas-Africa Southern Region organizes for safe abortion services and comprehensive abortion care, including guidelines that are currently in operation now.

They also work hand in hand with community members to advocate for the quality of these services. Seventy percent of post-abortion cases are taken by community members because they can’t be served by the clinics so they are being facilitated by women and girls themselves. While the Ipas team are experts on issues of safe abortion care, they have been less engaged in bringing together multiple voices and perspectives across the entire health system on the issue of safe abortion access.

Ipas shared that the workshops were very helpful because participants developed personas to help understand what issues people were actually facing. Participants were drawn from different health facilities and different stakeholders who came up with interventions that they could facilitate in their community to deliver ultimate services.

As Ipas workshop participants mapped the challenges, they felt that one of the biggest barriers was policy and legal restrictions. Restrictive laws favor rich people; the legal framework is not conducive for some SRHR services. Discrimination laws, policy amendment, and political influence from ruling and opposition parties on laws and policies all contribute to making SRHR difficult to access. As Global Integrity worked with
AHIC to develop the PSTA for the second workshop, Ipas addressed the opportunities where stakeholders, such as the Ministry of Health and community health workers, could make a difference to these challenges.

Identifying key actors through power, influence, and interest, and then mapping key milestones in the journey of identified personas helped workshop participants arrive at effective action plans. Ipas prioritized a series of actions across these challenges, with different impact and different resource needs. Five months later Ipas reconvened to review the 36 total activities which had been underway in Malawi or were already planned for implementation in three primary topic areas (Legal/Policy Environment, Community Attitudes & Limited Collaboration, and Inadequate Resources). The team reviewed these in regards to scalability, success factors, challenges and proposed changes.

“Service delivery can be limited when providers don’t have a full understanding of complicated abortion law. During the session, clinical providers shared that they do not receive legal training during their initial medical education or continuing professional development courses. This can place providers in a tricky situation when treating a patient, as they may be unaware what services they are able to provide to whom under the law. This can cause provider hesitation, and in turn, limit the options available for patients. This key learning was followed through the workshop to the solution stage.”

— from the World Cafe Challenge Mapping section of the workshop (AHIC report)

CSA Kenya

In Kenya there has been a significant reduction of HIV cases amongst adults, but the rates are still surprisingly high amongst adolescents and youth. Kenya’s Center for the Study of Adolescence works on a number of SRHR issues, with a focus on unintended pregnancies and high rates of sexually transmitted infections such as HIV.

The root causes for this problem lay mainly with lack of information and access to accurate information, often due to religious and cultural barriers that exist in the country. Many think information encourages youth to be sexually active when in reality it’s the opposite.

The program that CSA chose to work on, Right Here Right Now, brings in seven different partners working in various aspects of SRHR. CSA is a host and partner with their area of strength in sexuality information and education. Other partners include Nairobits, a digital organization teaching young people about how they can utilize digital spaces, the Network of Adolescents and Youth of Africa (NAYA), and Sexual Reproductive Health and Rights (SRHR) Alliance, which focused on budget advocacy at the sub-national level, DREAM Achievers Youth Organization (DAYO) dealing with PWDS, the National Gay and Lesbian Human Rights Commission (NGLHRC) group that deals with gender minorities, and Love Matters Kenya (currently Africa Media Trust) that work in online communication.

Youth and adolescents are not involved in SRH policy development and SRHR issues are not prioritized by state actors. “We identified it as a problem because during the baselines and implementation being conducted, state actors were not responsive to the stakeholders, so we brought in stakeholders during workshop engagement and then we mapped with the beneficiaries — adolescents and young people. Just from hearing their inputs we could see that disconnect in what was being implemented,” Dollarman Fatinato, CSA Kenya, described.
“We deliberately want to have young people involved at the policy level,” Fatinato affirmed. They were also able to host a series of conferences related to sexual and gender minorities to share the success and challenges of their work and get buy-on some of these approaches.

Through the workshop, CSA nuanced and changed their action plans to emphasize youth involvement. They had young people being trained on digital content and how to use those tools to build public support and target policy leaders with online engagements.

The biggest difference that CSA experienced as part of the PSTA process is how CSA looks at programs from conceptualization, the design, the implementation, the M&E — the imagination. CSA now factors in a broad participatory approach from the start to finish. They frequently brainstorm with young people how they can share info with their peers, and were able to come up with approaches used in the community set-up, such as games, which have already begun development. “These games will be used in the community for better intervention. They are fun! They have young people receiving accurate SRHR information,” Fatinato added.


## Similarities & Differences in Partner Strategy, Context and Issues

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<tr>
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<th>IPAS</th>
<th>CSA</th>
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<tr>
<td><strong>Problem Statement</strong></td>
<td>Many women in Malawi who want/need access to safe abortion services and post-abortion care do not have access to them.</td>
<td>Adolescent and young people in Nairobi County have limited and/or insufficient access to quality sexual and reproductive health commodities, services and information.</td>
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| **Contextual Elements** | > Proposed bill aiming to expand legal abortion tabled in parliament  
> Negative community attitudes toward abortion services, post-abortion care (PAC) and SRH services  
> Health systems are incapable of sufficiently providing these services to young women living in poor/low-income communities. | > Nairobi County has a high prevalence of HIV/AIDS, teenage pregnancy and unsafe abortions.  
> Further, the 0.9 million Kenyans living with some forms of disability are often ignored in provision of sex education and services.  
> Negative community attitudes toward SRH services, especially for gender minorities |
| **Strategy** | > Developing strong collaborative relationships between diverse stakeholders/sectors in the abortion space  
> Building a more diverse base of policy supporters  
> Training Health Care Workers (HCWs) to provide adequate PAC services and SRH youth champions to inform and raise awareness about their rights | > Generating public support & reinforce positive norms & values regarding young people, people with disabilities (PWD) & LGBTQ SRHR rights to access services  
> Identifying policy gaps and issues in the health system  
> Capacity building of HCWs, teachers, and communities to understand unique needs of sexual and gender minorities  
> Raising awareness among young people, PWDs and gender minorities |
| **Structure** | > Global CSO with local office in Lilongwe collaborating with diverse stakeholders at the district level nationwide | > Local CSO implementing at the district level across multiple counties nationwide |
HOW WE LEARNED

As Global Integrity, we wanted to understand how systems thinking can be applied in local contexts. We studied the implementation of the PSTA and associated cycles of learning to generate evidence to inform adaptations. We also observed contextual factors that acted as enablers and barriers in running the PSTA. Given the innovative and developmental nature of our questions, we decided on a Developmental Evaluation (DE) approach. The following table summarizes how the mixed methods implemented helped us answer each Key Learning Question (KLQ). Our learning report shares more of our outcomes and process in detail.

<table>
<thead>
<tr>
<th>KLQ#1: To what extent is actors’ capacity to operate in more adaptive-learning centered ways changing? What other expected and unexpected outcomes are appearing?</th>
<th>ONGOING SYSTEMATIZATION OF PSTA ADAPTATIONS</th>
<th>IN-THE-MOMENT EVALUATION METHODS</th>
<th>DEBRIEFING SESSIONS</th>
<th>END OF THE PROJECT EVALUATION ACTIVITIES</th>
<th>PEER LEARNING EXCHANGE</th>
<th>POST-LEARNING CYCLE TEAM REFLECTION CHECKPOINTS</th>
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<th>KLQ#2: What are the enabling factors and barriers associated with the implementation of the PSTA?</th>
<th>ONGOING SYSTEMATIZATION OF PSTA ADAPTATIONS</th>
<th>IN-THE-MOMENT EVALUATION METHODS</th>
<th>DEBRIEFING SESSIONS</th>
<th>END OF THE PROJECT EVALUATION ACTIVITIES</th>
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<th>KLQ#3: What program components are playing a more meaningful role in achieving the expected outcomes?</th>
<th>ONGOING SYSTEMATIZATION OF PSTA ADAPTATIONS</th>
<th>IN-THE-MOMENT EVALUATION METHODS</th>
<th>DEBRIEFING SESSIONS</th>
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WHAT WE LEARNED

People do systems thinking even if they don't call it by that name. CSOs may not actively use the term actor mapping but they understand people’s positions and the relationships they hold. Global Integrity helps them systematize this process, specifically making it more participatory, and gives credit to this important knowledge.

We found by the end of our workshops that both Ipas and CSA felt more comfortable taking the time to apply adaptations, mapping accountability in their system and understanding those implications, adjusting their action plans to take into account power dynamics and relationships amongst actors, and understanding systemic root causes.

> POWER DYNAMICS AMONGST STAKEHOLDERS

A health system consists of multiple actors and the behavior (decisions and actions) of those actors is influenced by their values, beliefs, as well as the things that interest and incentivize them. Both CSA Kenya and Ipas-Africa Southern Region had clear, well-thought-out action plans on how to improve SRHR education and post-abortion care respectively through policy changes and increased engagement with partners. What they were not doing was bringing in their beneficiaries — youth, sexual minorities — early on in the decision making process. By working to think through the lens of their beneficiaries, they understood how their actions could be much more participatory. They learned to involve the people they were trying to help in the decision making process. By the end of the workshops, they started bringing youth into high-level government meetings that they had never been in before. By bringing people into those meetings we believe the policies and end results will now be better.

During the PSTA workshop, there was always a risk that religious and cultural beliefs held by some of the workshop participants intersected with how the nature of the problem was mapped, discussed and prioritized. This combined with the unequal power dynamics among the different stakeholders meant that the values and beliefs of the more vocal and influential workshop participants had the risk of dominating the mapping and planning discussions.

As such, there were barriers to engaging in root cause analysis and joint mapping of challenges because of convening different stakeholders who have different value propositions, beliefs, and ideologies. During the Malawi workshop, dominant workshop stakeholders influenced what root cause challenges were mapped, how they were mapped and discussed, as well as which root cause challenges were prioritized. Some of the workshop participants from the Malawi mapping and planning workshop who wanted to map and discuss challenges associated with vulnerable groups such as LGBTQ youth and sex workers were shut down by religious leaders and other more conservative workshop participants. In the case of Kenya, project partner CSA made the strategic

“What I learned today, changed my perception about the youth. In the facility where I am working (as a care provider) we have a youth-friendly center, so how we deal with them (youth) in that center will be different.”

— 1st workshop participant Kenya
choice to deliberately exclude religious leaders from participating in the mapping and planning workshop because they were aware that their beliefs would interfere with other workshop participants who could freely discuss SRH service challenges being faced by the LGBTQ youth community.

Having diverse stakeholders particularly at the first PISTA workshops made it challenging to discuss and explore issues — not all participants were comfortable with discussing and mapping sensitive SRH issues. After observing the impact of these power dynamics, we adapted the design of the second workshop to ensure that power dynamics supported mapping and planning of actions rather than hindering this process.

It also underscored that just as it was important to invite as many diverse stakeholders as possible to map the problem thoroughly by drawing on the many different, voices, experiences, and perspectives of those in room, it was equally important to convene workshop participants who have a certain level of openness and willingness to explore the issue fully, listen, and engage with other actors in the system that they do not necessarily agree with.

“When we separate stakeholders in our workshops and meetings it does not help us to fully understand why certain stakeholders act the way they do or why they took that particular position but through this participatory way it helps us to understand why a particular person has taken that position and to understand from their perspective their decisions and appreciate the role they play. Once we understand each other it paves the way for a common solution to be found. That is why for us engaging faith leaders is becoming easier because we simply ask them to explain their positions and decisions to us. So we are starting to see some milestones because of the multistakeholder participation.”

— Ipas

“When asked about the main takeaway from their engagement in the workshop, 38% in Kenya and 35% in Malawi cited knowing the actors and the importance of generating relationships, collaboration, and coordination amongst different actors in the system to create change.

— CSA, 3rd workshop, project reflection

Creating an enabling environment

We brought an intentional approach to acknowledging and leveling power inside and outside the workshops. Simple icebreakers and games can absolutely change the way people relate to each other. On our first day of our workshops in Malawi, people entered formally, quietly, and kept their distance, aware of entrenched power dynamics. By day three, it was hard to tell people’s level of power from their appearance and actions. The environment we generated allowed them to engage in an open and dynamic space, where everyone felt comfortable sharing and disagreeing if needed. This contributed to building relationships based on trust amongst them.
One of the key ways we supported the organizations was through adapting the PSTA to their context, priorities, and needs. The check-ins with them before, during, and after the workshops allowed us to tailor the methodology, and ensured that all partners owned the process. We were open about our thinking, the why and the how behind every step, and adapted it to each context with a high level of flexibility for change as well as being very transparent with our partners throughout the process.

The workshops were designed to provide space for participants to propose new solutions which were adopted or adapted into current work based on peer feedback. Stakeholders gave their feedback on proposed actions and even came up with new ideas about how they could work together on activities, such as how to improve law reform and community engagement with SRH issues. As a result, these collaboratively-developed solutions were designed into tangible actions that partners took forward after the workshops.

Partners had the opportunity to reflect on two completed action learning cycles, which provided new evidence regarding whether partners adapted their actions in response to learning that occurred throughout the project life cycle.

Ipas and CSA shared myriad concrete examples of this outcome being achieved, including:

- Adapting outreach materials for comprehensive sexual education (CSE) to provide offline screening options to ensure that marginalized communities have access (CSA)
- Working with their own partners to undertake root cause analysis and stakeholder mapping to adapt project work plans (CSA)
- Diversifying SRHR services in Ministry of Health facilities and increasing thematic areas of work based on learnings from PSTA (Ipas)
- Adapting engagement strategies with youth-focused community based organizations to improve work with these beneficiaries (Ipas).

Most important, working with partners and change agents to analyze, plan, implement, and then evaluate their actions doesn’t happen in a linear way. We are constantly revising action plans, the actions we need to test are not always rapid so we can’t always implement quickly, and evaluating impact is not something we can do right away.

Adapting to Cultural Contexts

People have different ways of relating to concepts. For example, power dynamics. So we had to adapt terminology, prompts, and conversation topics. A prompt like “Tell us a moment you disagree with your doctor and health provider” that resonated in one area, absolutely didn’t apply or work in another, where doctors hold such power and respect that people will not naturally feel comfortable questioning them. We adapted for cultural contexts.
ACCOUNTABILITY

Discussions about accountability emerged subtly. During the first workshop, participants focused on discussing and mapping root causes to SRH challenges and touched briefly on some of the accountability gaps and concerns in the health system, but accountability discussions did not organically emerge during the first workshop. As such, the agenda of the second PSTA workshop was adapted to incorporate more deliberate activities for exploring accountability.

Workshops facilitated peer learning and knowledge exchange about the local health system context, SRHR challenges, and health accountability with the use of interactive games. These games helped participants root concepts into actual real life scenarios, which allowed them to reflect on their lived experiences. Workshop participants especially appreciated the accountability discussions because they were based on a reality they experienced, understood, and could easily relate to. They also highlighted the service delivery implementation gaps including opportunities for interventions. As a result, participants were better able to interlink activities to gaps which helped them see how multiple political economy and technical factors impact the system.

We hypothesize that our model of not providing additional resources for actions may have led partners to test actions that were less ambitious and potentially impactful because these were the ones that fit within their scopes and existing resource pools. We did however observe discussions during the workshop in which stakeholders brainstormed bigger, longer-term, and more resource-intensive actions that were then not undertaken.

As Global Integrity, and of importance to other INGOs, we have to carefully balance the tensions between the views we bring and what local actors want. This becomes tricky with regard to how we define accountability. If we define it as holding citizens and governments to uphold the law, then what do we do in a country where there are no rights to safe abortions? How do we press for human rights progress while also respecting existing practices?

Workshop Innovation: The Accountability Wall

After recognizing that the prompts used to discuss accountability in the first workshop did not lead to deep discussion, AHIC developed the idea of using an Accountability Wall for the second workshop. The wall was introduced on the first day and included three scenarios with accountability implications and corresponding questions about responsibility, accountability, and action. By anchoring the accountability discussion on real scenarios and asking questions that did not always use the sometimes-sensitive term “accountability,” AHIC facilitators were able to draw out more nuanced and deep reflection on issues of accountability. The facilitators also included activities that came back to the wall every day of the workshop, allowing the discussion about these issues to continue to mature as participants became more comfortable with the topic and with each other.
> SYSTEMIC ROOT CAUSES

The impact of the soft elements of the health system — power dynamics, values, incentives — have an impact on hard elements in the system — infrastructure, medicine, human resources.

It’s easier to talk about the things we can see and actually measure, but the goal of the PSTA is to have partners identify and map out soft elements. That didn’t come easy. We adapted to come up with the right tools to measure and discuss these soft elements.

Participants reported that because of their participation in the workshop they now could identify new underlying causes behind the limited access to quality sexual and reproductive health services to young women, sexual and gender minorities, and people living with disabilities.

Both partners highlighted how the PSTA allowed them to better understand root causes underlying the health system problems on which they were working. In the case of Kenya for example, CSA noted that the root cause mapping helped them to identify the SRH information needs for adolescents and young people which the organization and partners then used to redesign community sexuality information outreach activities. Finally, partners cited that this increased understanding is something that they have not only used during the PSTA project, but that they have also increased their capacity for taking a system lens in identifying problems and solutions.

“In projects, we fail because we don’t take much time to systematically analyze who are the stakeholders, what is their conflict, their interests. This methodology has brought that new thinking to me.”

— 1st workshop participant Malawi
SMALL TWEAKS, BIG IMPACT:
BEYOND THE PROJECT

During the final reflection workshop, both CSA and Ipas confirmed that they are continuing to use PSTA tools in their work. They also expressed how the PSTA led to a shift in how their organizations collaborated with partners and beneficiaries — specifically adapting their practices to ensure that the people they were seeking to benefit and influence have more say in the work. As one of the most significant changes that they experienced, CSA highlighted that PSTA tools ensured that they have more focus on participant responses and feelings.

Based on their mapping of stakeholders, CSA adapted their actions to directly include young people, parents and faith leaders in meetings that they held with the Ministry of Health and Ministry of Education. While CSA continued to build sustainable partnerships with the Ministry of Education and others, after the first workshop they used some of those approaches in initiating new relationships. In Kisuma, they were able to hold inception meetings with young people at the center of the process. After hearing directly from these constituents, the government stakeholders themselves decided to continue to engage directly with these representatives and invite them to future meetings for feedback, an action they had not previously undertaken.

Since experiencing participatory workshops, both CSA and Ipas have reported increasing how regularly they convene stakeholders to co-create or iterate project strategies and activities. Both CSA and Ipas say instead of designing and planning activities on their own, they have adapted their community engagement approach to be more inclusive, increasing how frequently they are jointly ideating solutions with multiple stakeholders and especially their youth partners. CSA stated they are now more comfortable and open to receiving feedback and ideas and inviting feedback and suggestions from their youth partners and stakeholders so that they make further changes and improvements to their work. This has especially improved and helped to clear any misconceptions and stereotypes they have about young people’s ability to make strong contributions and partnerships.

“The members of Parliament were shocked to see youth champions who attended the workshops presenting so well and so confidently, who were not afraid to demand things and say take this issue forward on behalf of us as youth champions and present them at the August House of Parliament.”

— Ipas, 3rd workshop, growth reflection

“We have seen that multistakeholder participation and collaboration towards the same goal has increased ... I will give you an example of Ipas’ digital application platform. We have doctors, youth champions lawyers, nurses, police officers, people with disabilities — all these different stakeholders are working together to achieve the same goal.”

— Ipas, 3rd workshop, growth reflection
One example from Ipas-Africa Southern Region showcases how the PSTA directly supported the adaptation of one set of actions related to their advocacy in response to religious leaders’ work on the Termination of Pregnancy (ToP) Bill:

“When the Bishops’ statement came out, we decided not to just be counter reactive but rather to apply a new stakeholder analysis strategy and try to uncover why the religious leaders felt the way they did and try to engage them on those issues instead by getting them to clarify their stance and the reasons for the position that they had taken, and try and arrive at a place of common understanding.”

— Ipas

Ipas cited that the government changed position on a SRH bill and Ipas was able to reevaluate intervention and decide what they could do in response to this powerful shift within the local health system.

“Having multiple stakeholders enriches conversations and solution ideation processes massively … when you are looking for solutions, sometimes when you have the same group of people trying to solve the same problems what happens is that over time you more or less end up with the same solutions. It’s tougher to try and come up with something new and innovative. When you have people who are extraneous to the problem, sometimes you can have fresh thinking.”

— CSA, 3rd workshop, project life cycle reflection
CONCLUSION

This project started with curiosity. We knew that systems thinking approaches have great potential to address deeply embedded service delivery challenges and the technical, political, economic, and social causes that underlie them. However, systems thinking has traditionally been designed and tested with academic partners and with significant resources, without adaptation to engage with civil society and grassroots organizations. It’s seen as “too complicated, too complex” to bring into local organizations. While we did not do a comprehensive impact evaluation of this project, this was a test for us on if and how the PSTA approach could help local civil society organizations and their contributions to achieve better health outcomes.

For Ipas-Africa Southern Region and Kenya CSA, this was the first time they were trying this approach. It was new information, a new methodology to identify diverse stakeholders. By the last set of workshops people were more engaged in root causes — which meant they weren’t addressing them like before. Now, they are actually using this approach to move forward and they believe their work is stronger because of that. They are doing things in a smarter and more participatory way.

In addition to the lessons learned and shared, the pilot of this approach in Malawi and Kenya revealed several questions that are worth further exploration to continue to make the PSTA work better for partners worldwide. Are the organizational changes that were observed (such as increased collaboration and participation) pre-conditions to systems changes? Can the PSTA better address power imbalances for the most powerful and most vulnerable stakeholders?

As Global Integrity, we learned how to do this better. We learned that we have to make all of this — for example, power mapping, identifying root causes, accountability discussions — more interactive. We learned that applying accountability to sensitive and controversial health issues like the ones these CSOs were dealing with was quite tricky. How can you be accountable for applying a law on abortion rights when it doesn’t exist? How do you address things that don’t fit into a legal framework?

Using the PSTA approach, our partners were able to find allies and champions outside of the policy realm, and find small windows of opportunity to improve access for their beneficiaries since a lot of the traditional avenues we would look into weren’t available. We learned quickly how to adapt for context.