AFRICA CHRISTIAN HEALTH ASSOCIATIONS'

4TH BIENNIAL CONFERENCE, 22-27TH FEBRUARY 2009

SPEKE MUNYONYO RESORT, KAMPALA, UGANDA

"Building partnerships for Health Systems Strengthening in Africa"

CONFERENCE REPORT

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Africa CHA platform

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A Platform for Christian Health Associations and Networks from Africa for advocacy, networking, capacity building and information exchange

The Hosting Team: from left; Dr Munoj Kuria – WCC, Dr Lorna Muhirwe – UPMB, Dr Sam Orach – UCMB and Dr Samuel Mwenda - CHAK

ACKNOWLEDGMENT

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Finaly we must recognize and sincerely thank some individuals who worked tirelessly for many hours before, during and after the conference to ensure that all logistics were well planned, executed and documented. These include; Mike Mugweru – ACHAP Secretariat, Dorothy Nakyanzi– UPMB, Andrew Karani – CHAK, Dr Samuel Mwenda – CHAK and Erika Pearl - IMA

May God Bless you all for your support to the Africa CHAs 4th Biennial Conference!

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ACRONYMS

AIM.....Africa Inland Mission
ART.....Anti-Retroviral Treatment
CHA's.....Christian Health Association's
CHAK.....Christian Health Association of Kenya
CORDAID.....Catholic Organisation for Relief & Development Aid
CCIH.....Christian Connections for International Health
CSSC.....Christian Social Services Commission
CHAG.....Christian Health Association of Ghana
CHAL.....Christian Health Association of Lesotho
CBCA.....Communauté Baptist au Centre de l'Afrique.
CHAM.....Christian Health Association of Malawi
CHAZ.....Church Health Association of Zambia
DIFAEM.....Germany Institute for Medical Missions
DANIDA.....Danish International Development Agency
EED.....Evangelische Entwicklungsdienst (English= Church Development Service)
DRC.....Democratic Republic of Congo
FDA.....Food and Drug Administration
FBO.....Faith Based Organization
GHWA..... Global Health Workforce Alliance
GPS.....Global Positioning System
HENNET.....Health NGO's Network
HMIS.....Health Management Information System
HRH.....Human Resource in Health
ICT.....Information and Communications Technology
ICCO..... InterChurch organisation for development cooperation
KEC.....Kenya Episcopal Conference
IMA.....InterChurch- Medical Assistance
MEDS.....Mission for Essential Drugs and Supplies
MoU.....Memorandum of Understanding

MoH.....Ministry of Health

M & E.....Monitoring and Evaluation

OVC.....Orphans and Vulnerable Children

PDA.....Personal Digitial Assistance.

PEPFAR.....Presidents Emergency Plan for AIDS Relief

PHC..... Primary Health Care

PLWHA's..... People Living With HIV/AIDS'

PMTCT..... Prevention of Mother to Child Transmission

SHU.....Save for Health Uganda

SWAP.....Sector Wide Approaches

TB.....Tuberculosis

TWG.....Technical Working Group.

UCMB.....Uganda Catholic Medical Bureau

UPMB.....Uganda Protestant Medical Bureau

USAID.....United States Aid for International Development

WCC.....World Council of Churches

WHO.....World Health Organization

WHA.....World Health Assembly

BACKGROUND

The Christian Health Associations Platform was established in order to facilitate communication and sharing of information and resources among the CHAs and other collaborating & donor partners. There are currently 26 countries that have Christian Health Associations or networks . The Africa CHAs Platform Secretariat was conceived during the meeting of CHA's in Bagamoyo in January 2007 as a '*bridge*' to help in disseminating and sharing information from various African CHA's on best practices to adopt in the areas of advocacy, capacity development, health sector partnerships and reforms, networking and communication, governance, management and policy development, monitoring & evaluation, HIV/AIDS programs amongst other issues. Every two years the platform hosts a Biennial Conference which creates a rich forum for sharing experiences and best practices in the work of CHAs and in building partnerships with governments and development partners.

INTRODUCTION AND CONFERENCE OVERVIEW

The Conference targeted Christian Health Associations from across Africa and partners from the north and south. The Conference planning and hosting was well supported by the CHAK, UPMB, UCMB, WCC, IMA World Health and CORDAID .

A planning meeting for the conference attended by representatives of CHAK, UPMB, WCC, IMA World Health, CCIH and CORDAID was held at CHAK Secretariat in Nairobi on November 12, 2008, and. The meeting discussed the conference concept paper which covered the conference theme, objectives, sessions, topics, speakers, expected output and budget.

THEME:

The Conferences theme was: ***"Building partnerships for Health Systems Strengthening in Africa"***

OBJECTIVES:

The Conference had 4 broad objectives which included:

(a) Exploring opportunities for partnerships which included Public-Private, International, and FBO-Private.

(b) Reflecting on the role of North-South medical missions in todays Africa.

(c) Discussing promising Human Resource for Health retention strategies.

(d) To facilitate a forum for networking, information sharing and building of partnerships.

These objectives were spread out over a three-day period.

- Day One covered health partnerships and medical missions
- Day Two covered health systems and human resource management
- Day Three covered health financing strategies.

(i) BIBLICAL MANDATE OF THE CHURCH HEALTH MINISTRY

The Workshop was opened by Bishop John Mamabo from Zambia who highlighted the Biblical mandate of the Church in Healthcare delivery with an emphasis on viewing the mandate as an obligation given to us by Jesus Christ. He said that it was a 'calling' to love one another and this should acknowledged as a charge from God ; 'To go out into the world to preach, teach and heal the sick'. The participants were encouraged not to shy away from showing indiscriminate love to the people suffering who come under their care.

(ii) IMPORTANCE OF PARTNERSHIPS IN HEALTH CARE

Ted Karpf from WHO gave a speech on the importance of FBO's engaging with the WHO in the area of Primary Health Care. He gave a background of the work of CHA's in moving foward Primary Health Care in the period after the independence of many countries. He presented the PHC Policy changes puzzle highlighting the importance of universal coverage to achieve equity; the importance of person-centered health services; inclusion of health in all government policies and the critical role of inclusive leadership. He urged all participants to communicate with their respective Ministries of Health to support of the draft resolution on Primary Health Care and Health Systems Strengthening which is to be tabled before the World Health Assembly in May 2009.

In brief, the 1975 World Health Assembly called for an international conference in order to discuss the challenges in depth. Then the 1977 Assembly formulated the main social target of governments and WHO as "the attainment by all citizens of the world by the year 2000 of a level of health that would enable them to live a socially and economically productive life."

He recounted how the WHO adopted a strong focus on defining the most cost-effective models for developing health personnel and health systems in low income countries and the attempt. He concluded by stating four changes in policy direction that would help in implementing Primary Health Care across countries with different levels of health status and health services. These included :

Adressing inequalities through a combination of extended health care networks, a shift from reliance on user-fees to pre-payment schemes and development of social health protection mechanisms. In addition health systems need to put people at the centre of their service delivery meaning providing a system that encompasses prevention, health promotion as well as curative and palliative care. Third is taking action action and health in all policies and lastly the call for renewal of leadership in the ministries of health of countries so as to address complexities through dialogue with multiple stakeholders in the industry.

Ted Karpf from the WHO makes a presentation on Primary Health Care at the 4th Biennial ACHA Conference in Kampala Uganda.

(iii) CHA'S ROLE IN THE HEALTH SECTOR

Manoj Kurian from the WCC drew a parrallel about CHA 's working together, so that the world would know, from John 17vs 11,Jesus where Jesus prayed that his disciples would be one so that the world would know. The people that CHA's serve would experience love from a united CHA's body. He said that in the 1970's Christian Health Institutions saw the need to work together in order to avoid wasteful duplication, streamline trainings and ensure they got discounts on purchases of pharmaceuticals and supplies etc. He said that despite the current global crisis going on, the Church should not reduce its investments or pullback on collaboration. Instead it needs to be innovative and come with ways of holding itself afloat.

(iv) PARTNERSHIPS TO PROMOTE HUMAN RESOURCE IN HEALTH DEVELOPMENT IN AFRICA

Dr Sandra Kiapi from the Global Health Workforce Alliance spoke of the importance of partnerships in addressing the HRH needs. She said that Partnerships are a vital part of the solution addressing the global challenges of strengthening health systems based on revitalization of primary health care because no single organization, sector or programme can adequately address all of the HRH challenges on its own.

She added that in the past decade partnerships had focus on more disease specific problems but its currently focused around human resources for health and health systems.

She cited a meeting in March 2008 where GHWA held a forum in Kampala, which attracted some 1,500 persons from a wide range of constituencies such as academia, politicians, policy makers and health planners which identified public-private partnerships as an important element, alongside cooperation between the various levels of government (central, regional and district) within countries in determining management and capacity building needs.

(v) PARTNERING WITH GOVERNMENTS THROUGH MOUS

(a) CSSC

Euniace Bandio from Tanzania reported on the partnership between CSSC and the Government of Tanzania. He presented the model of Church Hospitals becoming Designated District Hospitals. MoU between Government and Churches on CSSC Grant in Aid (GA) Service Agreement DDH/CDH Agreements

(b) CHAG'S MOU

Philibert Kankye of CHAG presented the history of the development of a Memorandum of Understanding between CHAG and Government. The MoU currently governs Human Resources in Health, Finance, Health Insurance, Reporting and Information sharing.

He shared how commitment and external Technical Assistance were vital in seeing the process through. In this model, the church health services produce comprehensive annual budgets and plans which feed into the national health plan and budget. The Government contributes to bridging the identified funding gap and funds salaries for health workers, recurrent expenditures etc . The MoU clearly states that ownership of the institutions remains under the church and autonomy of the institutions is maintained.

The implementation of the MoU is overseen by a partnership Steering Committee. CHAG agreed to adopt the policies of the Ministry of Health while periodically submitting its HR needs to the Ministry for support. On its part, the Ministry of Health agreed to facilitate equitable distribution of health professionals among its agencies including CHAG. Due to this MoU, CHAG's relationship with the government has reached a level where they do joint planning and hold a combined health budget.

As a result of the MoU, CHAG has experienced lower staff turnover, increased staff productivity, increased motivation as a result of increased salaries and increased professional and technical skills for service delivery. Others include increased infrastructural investment in nurses training school, an increased number of nurses to fill in vacancies at nursing schools and an increase in ratio of professional to nonprofessional staff in hospitals among many others.

Querries were asked concerning the capacity to do accreditation by facilities affiliated to CHAG (ie developing standards of awarding insurance schemes in conformity with the Ministry of

Healths Standards). It was said that when CHAG started implementation of insurance scheme it was an issue, because the capacity to do so at council level was not there. At stakeholders meeting CHAG facilities were to come up with preliminary accreditation requirements in order to be considered.

From this year however, facilities would go by the law, which says that the facilities that wants to be part of the insurance scheme would have to apply for accreditation from the health insurance council. Monitoring on compliance is done by a team located in the health insurance council at district and regional level.

(c) CHAL'S MOU with Government

Baptista Ramashamole from the Christian Health Association of Lesotho (CHAL) shared on the signing of the MoU between the Association and government. Under the MoU, The board of CHAL would incorporate three representatives from the government as members, at district level, CHAL hospitals' boards would include a Government representative as a member, all CHAL institutions would be governed by the National Health and Social Welfare policies, guidelines and protocols. CHAL would submit audited financial reports, done by external auditor (the end of June) for budgeting and performance analysis. CHAL member units would give proper and timely reports of their activities; Funds received from government would be banked in local registered financial institutions. As a result of the MoU, more HIV & AIDS patients have been enrolled into ART programmes, Infants have been treated in large numbers, general access to quality health services has increased, and there has been a significant shift in service expedition from hospitals to health centers

(d) CHAK; The journey to an MOU for Kenya

Dr Samuel Mwenda from the Christian Health Association of Kenya (CHAK) shared on the steps taken in Kenya to reach a MoU between the GoK and Faith-based Health Services. He spoke of the Technical Working Group established to guide the process. This group had three primary objectives: (i) Provide a structured forum for engagement, (ii) Conduct a situation analysis, and (iii) To develop a partnership policy framework to be guided by a SWAp. He highlighted the importance of joint study tours of 5 countries to study examples of government and church relationships. Concerning steps taken to reach the MoU he shared on how CHAK,

the Kenya Episcopal Conference (KEC) and the Mission for Essential drugs (MEDS) presented an advocacy document seeking increased collaboration and support to the Minister for Health in July 2004 . Because of this, the CHAK-KEC-MEDS team on one hand and the Ministry of Health on the other hand formed a technical working group to deliberate more on the fine points of the discussions. Deliberations were held with the Minister for Health and subsequently, the head of state agreed on the need for a Memorandum of Understanding to guide the partnership between Faith Based Health Services and the Ministry of Health. He shared on how a team of CHAK-KEC-MEDS & HENNET toured visited 5 African countries which had MoUs between their CHAs and Governments, this was to provide lessons in how to go about structuring these as well as draw inspiration from the contexts in which they worked. During the tour they found out that Church health services are highly regarded by the Government and are included in policy development, governance and coordination in health sector and in resource allocation. He wrapped up his presentation by noting that negotiations on Memorandums of Understanding between Faith Based Health Facilities require patience, dedication, commitment and involvement of various key stakeholders.

(a) DISCUSSION

Discussion: Discussions from the presentation focused on dialogue with technocrats in making MoU,'s which should be accompanied by parallel lobbying and advocacy especially targeting political actors. Concerns about transparency and accountability needed to be addressed on both sides and should be included in the MoU. MoUs played an important role as tools for formalizing relationships with government, ensuring recognition of the faith based contribution and ensuring continuity after political change has taken place. An important comment raised the challenge of maintaining the Christian identity and mission while negotiating support from government and donors via MoUs and contracts (e.g. secondment of staff, hiring and disciplinary procedures, conditionalities). It was noted that CHAs need to take responsibility for maintaining the relationship envisaged in the MoU. This required a willingness to be accountable and transparent with finances and reporting.

Participants wanted to know about the identity and ownership of facilities owned by Christian Health Associations in the face of governments intervention in the area of financing of these facilities. Would they lose identity ? Would ownership get transfered to government in the long

run ? The Christian Health of Lesotho said that from its MoU, it retained the prerogative of hiring of staff working . CHAG said that it made it clear that under the MoU, it would retain its institutional management systems. Staff from government were required to meet certain perfomance criteria too.

CONCLUSION

In conclusion, it was noted that MoUs are an important tool for formalizing relationships with government, ensuring recognition of the faith based contribution and ensuring continuity after political change has taken place.

Ownership of the Church Health Institutions would be threatened when Government increasingly supports them but the general consensus was that this needs to be clarified in the MOU at the start so that the identity and autonomy of the institutions is protected.

(vi) DONOR/GOVERNMENT PARTNERSHIPS

Mike strong from USAID/PEPFAR said there was political support for re-authorization of PEPFAR-2 by the US Congress.

He said that, of the 22% funding that PEPFAR allocates to FBOS:

- 30 -70% is targeted at health services
- 90% is targeted to care for orphans
- Critical agents for behavior change

He spoke of the importance of good governance and accountability, quality of care, and public relations and fundraising as key components of a successful PEPFAR project. He said it is very likely that funding for PEPFAR will continue. He encouraged participants to evaluate their strengths, to document and present the evidence, and communicate and network.

Francis Runumi from the Ministry of Health in Uganda spoke of the need for leadership with strategic vision, appropriate systems designs, and technology and resources. He also commented on the high migration rates of trained health workers to places where salaries and benefits are more attractive. He stressed that leadership and management skills are the core of an efficient

and effective health system. He said that the biggest crisis was the Human Resource in Health problem in Uganda where :

- 31% of health services are provided by the Private not for profit sub sector and 46% by Government. Hence there was need to tackle the issue of coordination in order to improve efficiency.

DISCUSSION

Participants lauded the political will of the US Government to empower the fight against HIV/AIDS through PEPFAR funds. It was discussed that leadership in partnerships was critical. There was a suggestion about counterfeit drugs funded by PEPFAR finding their way into the market. The meeting was told that only FDA approved drugs, both branded and generic were used by PEPFAR and the National Drug Authority regularly intercepts countefeits. It was noted that the Ministry of Finance Planning and Economic Development was the only one that received PEPFAR funds as Principle Recipients however FBO's in Uganda could advocate to be sub-recipients of these funds. It was noted that there needs to be a legal framework before salaries between the Private & Not-for Profit Sector and the Ministry of Health were harmonized. Presently the disparities in salaries was causing the attrition of workers to move to the Government side.

(vii) MEDICAL MISSIONS MODEL OF PARTNERSHIP IN AFRICA – ROLE AND POTENTIAL

Justus Marete from Kijabe Hospital reported on the ways in which missionaries have historically assisted the hospital. He said that they supplemented the work of local staff. He pointed out to the difficulties they undergo due to lack of proper orientation or adjustment to the local environment. Their advantage is that they can work from a politically neutral standpoint and might serve to stabilize the work situation. In addition, they helped subsidize good quality medical care available to poor people, they have endowed referral hospitals in which they work with research capabilities and education programs, in addition missionaries attract good and quality equipment from their sending organizations. Lastly, their presence validates the diversity of the body of Christ and various gifts working together to create value.

The future of partnerships he said lay in sustainability, driven by marketing facilities both locally and internationally and gettning more partners on board such as the Ministries of Health, Constituency Development Fund office, youth and women groups. He wrapped up by saying the hospital was in the process of installing a Health Management Information System to track costs.

Pam Howorth from AIM International presented the Biblical basis of partnership. She presented some of the historic roles and importance of missionaries and discussed the paradigm shift in missions from long-term, institutional linked positions to shorter-term, specialist roles. In the past these roles were created by the sending organization, but now they need be more defined according to the needs of the host partner and should complement (not compete with or replace) existing staff positions.

She pointed out that in the past, organizations were few with broad visions and along denominational lines. Today, they are many, with narrow visions and are non-interdenominational. In the past, organizations used to come for 30-40 years. Today they are looking for strategic significance and want to work through relationships.

Bruce Dahlman from the Institute of Family Medicine said that in America, there is a growing interest in global health, partners in the North are asking how they can be of service. It is an untapped potential between the organizers and the church that is willing to offer services. However the sending institutions and the receiver institution need to be aware of each others needs.

IMPLICATIONS FOR PARTNERSHIPS

Faith Based Health Centres need to identify ways to utilize short term workers, establish external linkages and long term relationships, establish relationships with donors and mission agencies.

DISCUSSIONS

The distinction between donors, partners and missionaries. In addition, what value do mission personnel gain from the local staff and culture that enhances their abilities? The value of cultural diversity, different training backgrounds and styles and what these portend to the nature of work. It was observed that missionaries needed to be patient and also politically and culturally

aware of the host environment. The experience of some participants highlighted the importance of proper orientation of missionaries to the work and culture of the host institution. It was reported that there is a growing interest in International Missions in parts of North America and Europe. The important need is to dialogue on ways in which the interest and availability and skills of those interested can be matched to critical capacity needs.

(iii) HUMAN RESOURCES FOR HEALTH

(a)Dr. Juliet Bataringanya from WHO Uganda made a presentation on The role of Health Systems Strengthening in enhancing quality and sustainability. She stressed the importance of community-based programs and lessons to be learned from the Christian Health Associations. She reported that a common framework for measuring Health Systems Strengthening was under development and would be composed of the following:

- Human resources (number of staff, retention and continuity which must change with changing needs.
- Leadership and governance (what policies and structures are in place? Are they functional?
- Finance (how much funding for each partner, rate over time)

(b) Dr. Olivier Musongya, the Medical Director of CBCA, Goma, DRC spoke on support from the government. in DRC, opportunities and challenges. He presented the structure of Health Services in DRC from the National Ministry of Health to Provinces, to Health Zones with Referral Hospitals and Health Centres. He mentioned the Public Service Statutes which govern committed leadership, policy development and effective management.

(c) Dr. Samuel Mwenda from CHAK spoke about **Health systems and policy strengthening initiative for the CHAK network**. He gave the membership profile of CHAK, its mission and core functions. The challenges he reported from a 2004 HR study revealed increased workloads, financial shortfalls, lack of essential medical equipment, and inadequate HR policies. He then pointed to some of the recent successes which have come as a result of faith, prayer, vision committed leadership, policy development and effective management.

(c) **Isaac Mpoza Kagimu,** the Human resources advisor for UCMB presented the Cordaid – Human Resource inHealth Best Practices Publication. The publication is based on task shifting to increase the quality of pharmaceutical services in Ugandan catholic Hospitals. Following the identification of shortages in pharmaceutical staff in the '90's, pharmacy assistants were trained and quality of services improved.

(d) **Everd Maniple**, from Uganda Martyrs University, spoke of the need for increased training in health care management. The program at UMU is need-driven with partnership between public and private sectors and academia.

(e) **José Utréra** of Cordaid, introduced the publication "Quest for Quality". The document includes evidence-based recommendations for addressing HRH issues in Africa. It will be published in March 2009.

(f) Dr. Sandra Kiapi from the Global Health workforce Alliance presented some of the challenges of the HRH brain drain in Africa. She gave some overview of statistics of international migration of health workers, pointing out that 1 in 4 doctors and 1 nurse in 20 trained in Africa is working in developed countries, this is against the background of the fact that Africa carries 25% of the global burden disease, but only contributes 3% of the world's health workers.

To combat migration of the much needed health workforce, she called for agreements between the countries importing health workers and those exporting them. She referred to the Kampala declaration which calls for Governments in nations that are affected by brain drain to monitor their workforce flow and make this information available and use it to inform policy and management decisions.

(g) Doris Mwarey, HRH Manager with Intra Health and Capacity Project, spoke of job dissatisfaction among faith-based organisations. She pointed out to factors that cause high turn-overs, these include Poor financial compensation, weak performance, management,

leadership and supervision structures, Deteriorating living and working conditions,Inadequate equipment and supplies, Lack of recognition for good work.
Stress/burnout due to heavy workload, Gender related issues (sexual harassment and discrimination) Limited opportunities for career development, Safety and security concerns. She shared on country level experiences carried out by the capacity project in 7 African countries on practices of retention and concluded that there was a need for more accurate data to establish the real magnitude of turn over prior to selection of a retention scheme. Talent management, succession planning, supportive supervision and management and flexible incentive packages were among a raft of policies identified that would enhance retention and HRH well-being.

(iv) GOVERNANCE OF HEALTH FACILITIES

(h) Jimmy Opiyo from Joint Medical Stores (JMS) Uganda, made a presentation on Corporate governance: the role and responsibilities of Board of Directors in enhancing corporate growth and sustainability. In his presentation he said one of the major roles of the Board is to nominate new trustees, but also to appoint members, appoint delegates to the AGM, and to advocate for strategies that benefit the organisation. He explained that JMS is owned by the Board of Trustees who have their own evaluation metrics in place. They keep their boards small and delegate responsibilities to Board Committees while ensuring the boards are kept trained on basic skills and risk management skills. They face challenges of keeping their various governance organs up-to-date with skills, competence and knowledge to manage business as well as put in place systems to check the quality of drugs they receive.

(i) Francis Gondwe, the Executive Director of CHAM's Executive Director, gave a presentation on Governance of Church Health Facilities: He enumerated the challenges faced by CHAM and the capacity-building strategies it was working on. Some of the challenges they faced included unclear roles and responsibilities of Board members, a lack of a code of conduct for staff at the secretariat, and an inadequate skills mix among Board members, this last one leading to slow decision making, inadequate discipline within board members leading to a dysfunctional board. He added that good corporate governance was a huge challenge for CHAM. He gave a presentation on the areas that the board is working on to improve the gaps in skill mix, which include short course trainings in corporate governance, coming up with a code of conduct for

the board, an introduction of Terms of References for selecting and appointing board members plus composition of the board and the qualifications of members Board members.

(j) Sam Orach of UCMB who was scheduled to present did not, due to time constraints, however his presentation on good governance and management for sustainability of health care of UCMB health facilities highlighted what UCMB had done to strengthen governance and management in its member health units. His presentation pointed out that good governance and management opened the doors for opportunities for partnerships, provided a framework for accountability by partners, but also put stress on the everyday systems, especially accountability systems in the domain of HIV/AIDS.

He said the challenges UCMB faces in its implementation of these systems include embedding them in lower level facilities, a high attrition of HR people who help in its implementation, an unwillingness of many partners to supports these particular aspects of strengthening, people who do not see the benefits of changing the status-quo of management, and lack of sustain support in order to fully implement these. He concluded by saying that it was important to support the strengthening of good governance among CHA's because they are the ones that support the government in its implementation of health services.

(k) **Potiphar Kumzinda from CHAM** who was scheduled to present did not do so due to time constraints. His presentation on Scaling up training of nurses in Malawi through partnership with Government highligthed how CHAM facilities had been affected by brain drain and led to subsequent deterioration of health services. It highlighted the MoU as the basis of the partnership understanding and how they went about strengthening HR in their health facilities namely through infrastructure expansion, staff motivation and retention schemes, full student scholarships, provision of teaching and learning materials, as well as an improving quality of nursing education. As a result of this partnership, CHAM health facilities have constructed new infrastructure such as classes for students, accomodation facilities as well as improving on the quality of teaching programmes. They have managed to put structures in some of their health. facilities such as libraries, laboratoeis and dining rooms which help in improving the quality of training. Student enrolment had doubled as seen in the graph below.;

In addition teaching staff for the nursing programs had increased by 26% . This has been attributed to the availability of improved accommodation in addition to the monetary incentives given to nurses among many others.

He concluded by saying that the programs success was attributable to the strong partnership that the Government of Malawi had had with funding partners. He said that CHAM health facilities needed to retain the tutors whom they had attracted and this called for extra incentives which was proving to be a challenge. In addition there was a minimum level of staffing necessary to carry out quality provision of services.

(v) FIELD VISIT

Participants took two field exercusions:

One group went to **KISUBI HOSPITAL**, to learn from its governance system. The other went to **KIWOKO HOSPITAL** to learn from its community-based financing system.

REPORT FROM KISUBI HOSPITAL FIELD VISIT :

Kisubi is one of the 27 UCMB Hospital. It is a 100 bed rural Hospital. The group was met by the Medical Superintendent, the Chair of the Hospital Board, and other senior nursing and administrative staff.

The initial presentation explained the Hospital governance structures and how they are functioning in practice. Issues raised by the group included:

- How staff motivation was addressed.
- The role of UCMB Secretariat in strengthening governance .

- Whether there were opportunities for Board members to meet Board members from other facilities .
- The changing role of the Hospital as it now has supervisory responsibility for Government facilities in the sub-district.

Key observation points from the Kisubi experience:

- Management Tools developed by UCMB Secretariat have greatly helped Hospitals strengthen their governance
- Performance Monitoring & Feedback using routine data, and making comparisons over time and with other Hospitals, has been a powerful performance improvement tool.

REPORT FROM KIWOKO HOSPITAL FIELD VISIT:

The Community-Based Insurance System is implemented by an organization called 'Save for Health Uganda' (SHU)

It is based in the in Luwero, Nakasongola and Nakaseke districts. Kiwoko hospital is the main provider for SHU and is owned by the Anglican Diocese of Luwero. The credit scheme offers an arrangement where members contribute money in advance and if one is sick then she/he can borrow from the fund. SHU found that within the surrounding communities there is a very poor perception of health care providers and people were not accessing health care for a variety of reasons: 1) People were ill and had no finances to access health care, 2) Some could afford health care, but the services needed for treatment were not available and 3) People had the option of accessing traditional healers. There are two schemes from which the locals choose from. The first is a credit scheme where people pay a onetime fee and they can withdraw funds as necessary for their health care and repay within one to three months. The second, and more popular, is the insurance scheme. Members pay a yearly membership and are then eligible to receive up to 100,000 Uganda Shillings worth of care paid for by the scheme per illness. (The scheme sees a lot of usage due to Malaria.) If the expense of the illness is more than 100,000 Uganda Shillings (Ugs) the individual is responsible for the difference. Upon seeking treatment within the in/out patient wards an individual shows their membership card and pays the 2,000 UgS admission fee. After that admission fee the scheme pays up to 100,000 UgS. If an emergency occurs and the patient is in good standing, a loan may be extended.

Kiwoko Hospital has an agreement with local Hospitals so that if a patient visits them, they will presented the patients bill to Kiwoko Hospital for clearance.

Education is done within the communities to raise awareness in the program and people are encouraged to buy into the insurance scheme by household. Participants arrange themselves into groups, identifying a representative based on their trustworthiness and respect within the community. Funds are not released to a group or depositedwithout three representative signatures.

For 1-4 people it costs 14,400 UgS (3,600 UgS/person); so it is more economical to join as a group living under one roof rather than as an individual. There are different premiums to choose from and the groups choose what works best for them. Each group has a manager who is responsible for the money. However, the money cannot be deposited/received from the account without three signatures.

SHU provides technical support to participating communities in the form of capacity building for communities, scheme members, fund managers, and participating Hospitals. SHU also monitors and evaluates the relationship between the Hospital and patient. All administrative costs and salaries are supported by EED. This, the participants observed is not necessarily sustainable in the long term.

(viii) HEALTH CARE FINANCING AND SUSTAINABILITY

Dr. Christine Kirunga from DANIDA gave an overview of the Health Financing Options open for Developing countries, the status of health financing in the least developed countries and the responsibilities of the different stakeholders in the entire framework. In line with the objectives of providing quality health care, she talked of health systems being efficient, having equity and feasibility as well as political acceptability.

For the stakeholders, she said that at International level, the multilateral agencies and charity organizations needed to provide long term support to the national health systems of the target country, national governments and ministries of health needed to provide stewardship in order to achieve systems objectives, they also needed to come up, in consultation with stakeholders, a health financing strategy for the country.

She concluded by saying that CHA's on their part needed to participate in sector policy formulation and implementation and build the capacity of their member health units towards innovative health services management.

(a) NATIONAL SOCIAL HEALTH INSURANCE IN GHANA

Philibert Kankye, the Executive Director of the Christian Health Association of Ghana (CHAG) gave a presentation on the Ghana National Health Insurance Scheme. He said the scheme was established to cater for the poor and vulnerable in the society in line with the Ghana Poverty Reduction Strategy. This was after evidence pointed to the fact that 80% of Ghanaians could not afford 'out of pocket' payment for health services. The policy is based on the principles of equity, risk equalization, cross subsidization, solidarity, quality care, efficiency of premium collection, community of subscriber ownership, partnership, re-insurance, and sustainability. He highlighted the benefits of the scheme which include 80% coverage of the disease burden. The policy implementation has encountered challenges, such as a lack of proper definition of who the poor are, children whose parents are not registered are denied access and there is un-due delay of payments. He also shared on how the programme is evolving to include changes such as children being de-coupled from their parents to ensure wider coverage of children, including Anti-Retrovirals in the policy package and re-defining in scientific terms what being poor means.

(ix) OPPORTUNITIES IN MOBILIZING INTERNATIONAL FUNDING: THE CHAZ EXPERIENCE

The Executive Director of the Churches Health Association of Zambia Mrs Karen Sichinga presented on opportunities in mobilizing international funding from CHAZ's perspective. She outlined the process involved raising funds which includes, proposal developments, meetings with donors, the use of existing grants agreements and networking plus publicity and working with the media. She presented conditions necessary to mobilizing international funding which include having a national presence, having documentation as well as monitoring and evaluation systems and having transparency and accountability among others. Among the challenges in mobilizing funding include donor dependency, unhealthy competition between local and

international NGO's and delayed disbursement after approval. Among the lessons she shared in this field was the need to levarage an organizations comparative advantage and justify one's existence. Transparency and accountability are crucial, investment in strategic relationships such as with the media who must be trained on how to report and of course prayer.

(a) DONOR DEMANDS, COMPLIANCE AND HARMONIZATION

Dr Jérome Wolo from Niger gave a presentation on donor demands, compliance, harmonization and challenges. His presentation gave a contrast on on the difference in lifestyle between donor countries and recepient countries. He said that the west was steeped in a culture of speed and an emphasis on material wealth and the subsequent downside of solitude, depression and divorce. He compared this with the life that most Africans lived, which was modest in material terms, and a mindset caught between two worlds. As a result of donor imposed programs, and cultural imposition that came with donor programs, he said receivers of donor monies did not won the projects and there existed some form of friction between the donor agency and the receiving agency.

To redress this situation, his presentation called for a mindset change among both donors and receivers.

For donors to view their relationship not just as a donor-receipient relationship but as a continual puzzle where pieces fall into place to form the whole. He urged participants to look at studies on teleperception, telekinethesis at University of Niger.

(b) QUESTIONS ON HEALTH CARE FINANCING

Questions were asked about how possible it was for individuals in the least developed countries to finance their own health care,

It was said that in Ghana, and Niger, governments worked through national health systems to pool resources to enable individuals offset the weight of financing their own health care. In Ghana for example, the government used budget funds, premiums and taxes to help offset the high cost of providing health services.

In coming up with service level agreements between different CHA's and their governments, CHA's were encouraged to learn from each other. Partners were urged to contextualize their

models of financing to each countrys' need so as to guarantee better stewardship of their resources.

STRATEGIES FOR M&E BY A GLOBAL FUND PR: CHAZ EXPERIENCE

Catherine Mulikita, from CHAZ shared on the strategies for Monitoring and Evaluation by a Global Fund Principle Recipient, drawing her examples from CHAZ which is a Principle Recipient from Global Fund.

She said that CHAZ had its own Monitoring and Evaluation System that fed into the national system and that it implemented Global Fund programs withinthis national framework of M& E. CHAZ does M& E for Malaria, Tuberculosis and HIV/AIDS. She said that M&E at grassroot level is aided by Community Health Volunteers who are chosen either because they have been cured from Tuberculosis, are People living with HIV/AIDS (PLWHA's) or ordinary folk.

In order to strengthen the M& E system at grassroot level the volunteers are trained in ART adherence support, how to conduct awareness campaigns and Directly Observable Treatment Short Courses. She gave a flow of what is monitored in each of the disease components:

For HIV/AIDS : the indicators were

- ART clients
- HIV + people on nutritional support
- PMTCT cases reported
- OVC's supported

For Malaria, the indicators were :

- Insecticide Treated Nets distributed
- Children under 5 causes of mortality

For Tuberculosis : The indicators were :

- TB cases treated
- HIV and TB co-infection cases
- New smears with TB cases detected

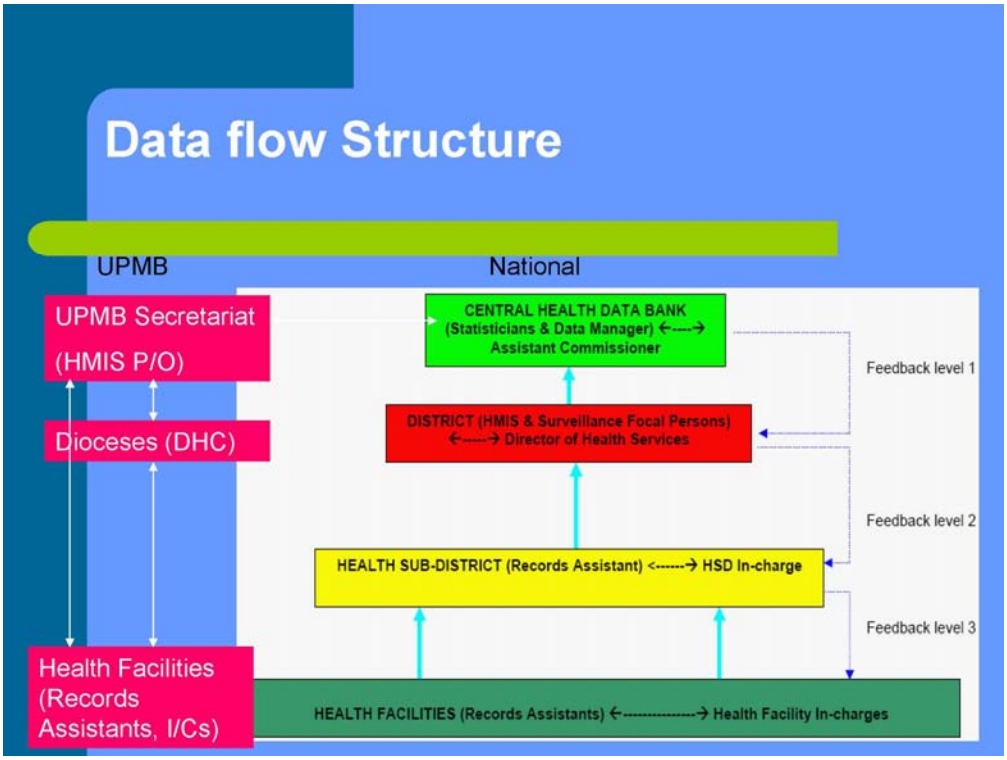
She wrapped up her presentation with the challenges to M & E which include poor record keeping, incomplete and late reports, weak health systems and high demands from the Global Fund, other include high staff turn-over. Some of the solutions being implemented include biannual review meetings with member Christian Health Institutions, Technical support visits and data quality audits.

Questions were asked on how CHAZ does evaluation of its assets as Principle Recipients together with other 4 Principle-recipients in the country. It was said that implementation of programmes was similar, and they share a similar database. For reporting tools, depending on the disease components that different PR's deal with, those working with need to have the same wording as that of they ministry they report through.

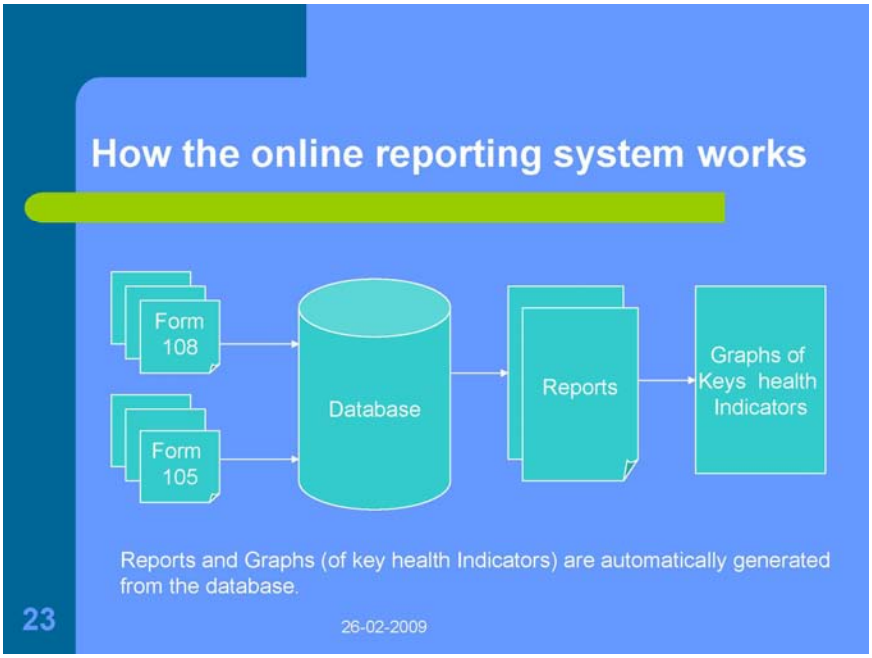
(x) USE OF ICT TO STRENGTHEN HMIS

Ambrose Muhumuza fromUganda Protestant Medical Bureau (UPMB) shared on using Information Communications Technology (ICT) to enhance Health Information Management Sytems.

The HMISystem in Uganda was first designed in 1985 with the objective of collecting data for selected communicable and non- communicable diseases. He said that the HMIS system in Uganda was made solely for the purpose of Monitoring and Evaluation. In 2005 the HMIS was revised through a participatory process involving stakeholders in order to integrate HIV/AIDS indicators in detail.



He said that Information Technology in the health sector dealt with the use of electronic equipment and software to convert, store, protect, process, transmit and securely retrieve health information. This covered mobile phones,computers,PDAs, GPS devices. He said that in order for HMIS to be functional data needed to be captured, processed into information, utilized at various levels and then disseminated. See diagram below:



He enumerated the challenges faced by the system which include a lack of embracing technological innovation and prioritizing information management culture, high staff turn-over leading to loss in staff investments, and lagging behind of health centers due to their remoteness and lack of technology. Data capturing tools are not easily available in sufficient quantities while various district and national level databases need to be strengthened.

(b) USE OF INFORMATION COMMUNICATION TECHNOLOGY & HMIS TO STRENGTHEN MANAGEMENT SYSTEMS AND FOR ADVOCACY

Charles Kirumira from UCMB shared on the use of Information Communication Technology to strengthen Management systems for advocacy. His presentation highlighted the fact that the Record Offices in Member Health Units, Diocesan Health Coordinators Office and Hospital Managers were targeted for training in Microsoft Office applications, basic ICT skills and use of ICT equipment. He presented a benchmark of the ICT progress. As a result of strengthening the ICT system, member hospitals have been able to use information obtained from data to make strategic and management decisions. In addition, the hospitals are now making use of the cost based accounting systems, as they produce timely accounting reports. In addition health centers have been able to compare performance over similar periods of time, monitor staff attrition and

retention regularly, and use this information to plan for recruitment, planning capacity building sessons and investigate reasons for high staff turn-over.

(b) Using the HMIS as a tool for Monitoring & Evaluating

He further shared on how UCMB hospitals use data from the Ministry of health to monitor the implementation of the National Health Sector Strategic plan as well as indicators of perfomance for health facilities. Managers can monitor health units performances by logging onto the UCMB data server and running querries. The trends in performance are used for management decisions and informing governance decisions. As a tool of accountability, managers use results obtained to report to their boards. The system is also used for accountability to external stakeholders such as the Ministry of Health, Development Partners and Donors. It is also used for appraisal and perfomance analysis of staff and hospital and diocesan health departments.

(c) Using the HMIS information for Advocacy

Charles further shared on how information generated from the HMIS is used to lobby with member hospitals for equitable charges, on behalf of the poor, in addition, it helps the hospitals come up with efficiency measures in the cases of monitoring usage and to guide in recruitment and management of Human Resource . Together with UPMB, they shared the figures with Members of Parliament, Ministry of Health Officials and Development partners. They have also used it to lobby for equitable salaries between government employees and those working in the 'not-for-profit' organizations in health. He concluded by saying HMIS can be used to gather data internally, nationally and internationally.

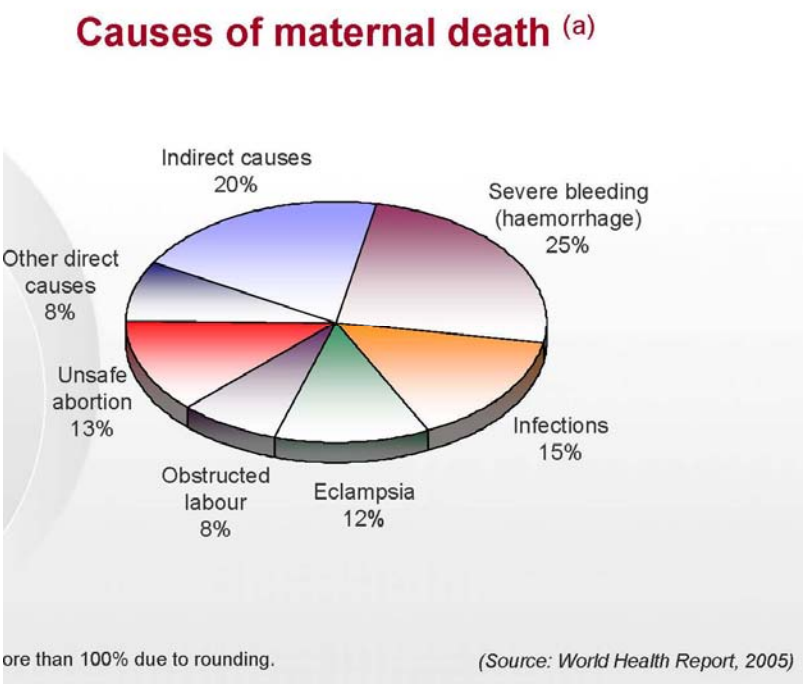
MAPPING HEALTH FACILITIES TANZANIA

Petro Pamba presented on mapping health facilities in Tanzania. His presentation covered that Health Facilities Survey, Basic Health Facility Information, and the Challenges Encountered among other factors. He gave a data collection status of Hospitals and Facilities which carried data on their community and infrastructure programs. He also gave a breakdown of the National Database Development Process. On the challenges met in the implementation of the Database

Development Process, he enumerated among others; Poor data recording on facilities, a lack of vision and mission statements from hospitals, no valuation of assets and lack of internal communication between departments. To overcome these, he suggested a training on data recording, and a review of hospital administration sstructures.

(x) CONTRIBUTION OF FAITH BASED ORGANIZATIONS TO MATERNAL AND NEWBORN HEALTH CARE IN DEVELOPING COUNTRIES

Marianner Widmer gave a presentation on Improving Maternal and Newborn Health. She gave causes of maternal deaths: As shown below:



She said FBO's continue making a significant impact with their services and policy makers have acknowledged this. She presented a questionnaire that WHO had come up with to map the evidence of the impact of FBO's in health. The outcomes of the questionnaire would be used to write a document on now FBO's contribute to maternal and neo-natal health care and to disseminate this evidence widely for action through publications in scientific journals to other audiences. She said they would identify Faith Based Organizations that would be willing to participate in the mapping exercise before starting the exercise.

Donors shared the objectives of their organizations and potential areas of collaboration.

REPORT OF THE 4TH BIENNIAL CHAS MEETING

During the last day of the Africa CHAs 4TH Biennial Conference held in Kampala on 23-26th February 2009, discussions were held to provide feedback on the value of the Platform to the work of CHAs and to build consensus on the priority focus areas for the next two year period. Generally the Platform and it's Secretariat were highly appreciated as a vehicle for facilitating communication, networking and information sharing. The Quarterly CHAs Bulletin were appreciated and the information and experiences exchange through documents and meetings were well regarded. The members present emphasized the need for strengthening the Platform and the Secretariat in order to cope effectively with increasing demands in advocacy, networking, communication and the building of a well resourced information Hub for the Christian Health Associations. The meeting endorsed that CHAK continue to host the Platform Secretariat for another two-year period at it's secretariat in Nairobi, Kenya.

The meeting identified the following as the priority focus areas for the Platform and it's Secretariat for the next two-year period 2009 – 2011;

1. Facilitate communication among the CHAs and Partners
    a. Africa CHA Platform Quarterly Bulletin in English & French – to include HRH issues formerly handled by IMA World Health through the HRH Hotline
    b. Register & host an Africa CHA Platform website – The website www.africachap.org - has already been registered and accessible on the internet
2. Build an information Hub for CHAs – transfer CHAs Policy documents and reports hosted by IMA to ACHAP website
3. Maintain an updated CHAs Database
4. A Governance structure that will enhance CHAs participation and ownership (Editorial & Planning Committee, CHAs Advisory Committee and Africa CHAs Biennial General Meeting)
5. Facilitate networking through referrals & linkages and supporting south-south exchange visits
6. Support north-south linkages and partnerships
7. ACHA Platform members to pay an Annual Subscription fees of US$200 to enhance ownership and sustainability

8. Facilitate planning & hosting of capacity building and experience sharing activities in collaboration with CHA Partners
9. Coordinate advocacy for the CHAs on matters of mutual interest
10. Support documentation and dissemination of case studies of best practices from CHAs
11. Host and support the CHAs HRH-Technical Working Group activities which should be expanded to include the broader Health Systems Strengthening
12. Facilitate the planning and hosting of the Africa CHAs 5th Biennial Conference to be held in Accra Ghana in 2011
13. Report on the progress made at the Biennial General Meetings.

APPENDICES

1. CONCEPT PAPER FOR THE AFRICA CHRISTIAN HEALTH ASSOCIATIONS 4TH BIENNIAL CONFERENCE

Preamble

The Bagamoyo Commitment made by Christian Health Associations (CHAs) during the Conference held in Bagamoyo, Tanzania in January 2007 recommended the strengthening of a support Platform for all CHA's in Africa. This was to include a small rotating secretariat that would improve networking and communication between CHA's and associated organizations in Africa and elsewhere. CHAK was mandated to host this secretariat for the initial 2-3 year time period. The platform was mandated to facilitate discussion on specific issues concerning CHA's and also to facilitate the preparation of the next CHAs Conference in 2009. CHAK has taken this mandate forward by taking the initiative to coordinate the preparations for the next CHAs Biennial Conference which will be held in February 2009. CHAK will collaborate with Uganda Protestant Medical Bureau (UPMB), Uganda Catholic Medical Bureau (UCMB) and World Council of Churches (WCC) to host the next CHAs Conference in Kampala, Uganda. The Conference will target Christian Health Associations from across Africa, partners from the north and south and CHAs from India. For this to succeed we shall need the partnership and support

of various partners. We are grateful to note that WCC, IMA WorldHealth and CORDAID have already confirmed their support. We however need more partners to join and support to ensure adequate resources to support all CHAs to participate.

A Planning meeting for the CHAs 2009 Conference was held at CHAK Secretariat in Nairobi on 12th November 2008 and was attended by CHAK, UPMB, WCC, IMAWorldHealth, CCIH and CORDAID. The meeting discussed the Conference Concept Paper which covered the conference theme, objectives, sessions, topics, speakers, expected output and Budget. This Concept Paper summarizes the consensus attained on the 2009 CHAs Conference.

Theme: *"Building partnerships for Health Systems Strengthening in Africa"*

- Venue: The Speke Resort & Conference Centre, Munyonyo, Kampala, Uganda
- Hosts: UPMB & UCMB supported by CHAK / Africa CHAs Platform Secretariat and WCC. And also with funding support from various Partners
- Conference moderators: Manoj Kurian (WCC, Geneva) and Frank Dimmock (PCUSA, Lesotho)
- Dates**: 23rd – 26th February 2009**

Conference objectives

The conference objectives include;

1. To explore opportunities for partnerships with Christian Health Associations in Africa towards strengthening health systems and sustainability. These shall include;
    - International health partnerships
    - Public-private-partnerships
    - FBO-private for profit partnerships
2. To reflect on the role and potential of North-South Medical Missions in Africa in today's context
3. To discuss promising retention strategies for Human Resources for Health

4. To share some innovations and best practices in health care financing
5. To facilitate networking for sharing information, learning and building of partnerships

Expected outputs

The expected outputs include the following;

1. Improved understanding of the various forms of partnerships in health that enhance capacity and performance of CHAs health services
2. Shared understanding on the potential and role of north-to-south medical missions
3. Shared experiences in health systems strengthening programmes and strategies
4. Identification of critical retention strategies for HRH in CHA health facilities
5. Shared knowledge and experiences of innovative health financing strategies that promote access and sustainability
6. Enhanced networking for sharing information, experiences and resources

Structure of the programme

The programme has been divided in 3 main sessions, two side sessions and one outdoor activity

i. Day one covers – Health partnerships and medical missions
ii. Day two covers – Health systems and Human resource management
iii. Day three covers – Health financing strategies

There will be a pre-conference session for the CHAs HRH Technical Working Group facilitated by the Capacity Project through IMA WorldHealth. And there will be another optional session after the conference discussing issues of access to the Global Fund facilitated by Milton Amayun from CCIH and International Aid.

The detailed draft program is available on the website. Any feedback is welcome. CHAs and partners are encouraged to share in the presentations, panel discussions, plenary sessions and Exhibition

Conference Registration

Conference participation is limited to registered participants only. The Registration fee is $300. A Copy of the Registration Form can be obtained from the Secretariat or CHAK website: www.chak.or.ke All completed Registration Forms should be submitted to the Africa Christian Health Associations Platform Secretariat using the contacts below;

Mike Mugweru

Africa CHAs Platform Secretariat Officer
Christian Health Association of Kenya
P.O Box 30690,
00100, Nairobi, KENYA
Tel : 254-20-4441920/4441854, 254-733-334419, 254-722-203617
Fax : 254-20-4440306
E-mail: chas@chak.or.ke ; secretariat@chak.or.ke

2. *AFRICA CHAS 4TH BIENNIAL CONFERENCE PROGRAMME*

Theme: "Building partnerships for Health Systems Strengthening in Africa"

DAY ONE: 23RD FEBRUARY 2009 – Arrival and registration of the conference participants

9:00 – 5:00pm CHAs Human Resource Technical Working Group meeting - pre-conference meeting by IMA WorldHealth/Capacity

6:00 – 7:30pm - EPN Cocktail Reception for CHAs

DAY TWO: 24TH FEBRUARY 2009: Exploring partnerships

TIME	*SESSION*	*FACILITATOR*	*MODERATOR*
8:30 – 10:30 am	***Opening session**:* • *Biblical mandate on Church involvement in health Service delivery* • *CHAs role in the Health Sector; tracing the historical perspective*	*Bishop John Mambo, Zambia* *Manoj Kurian, WCC* *Ted Karpf, WHO (supported by WHO*	*Samuel Mwenda*

	• *Importance of Partnerships in Health care* • *Partnerships to promote HRH development, motivation and retention in Africa*	*Africa Region) GHWA-WHO*	
10:30 – 11:00am	***TEA/COFFEE BREAK***		
11:00 – 1:00pm	***Panel one – CHAs Partnering with governments through MoUs*** • *Ghana – CHAG MoU with Government* • *Lesotho – CHALe MoU with Government* • *Tanzania – The District Designated Hospitals model of partnership between CSSC and Government* • *Kenya – The journey towards achieving an MoU between FBOs and Government; building on lessons from other CHAs in Africa*	*Philibert Kankye* *Baptista B.B.P. RAMASHAMOLE* *Euniace Bandio* *Samuel Mwenda*	*Lorna Muhirwe*
1:00 – 2:00pm	*LUNCH BREAK*		
2:00 – 4:00pm	***Panel two: FBO – Donor partnerships*** • *USAID/PEPFAR partnership opportunities – Mike Strong* • *Opportunities presented by the International Health*	*Mike Strong, PEPFAR Coordinator, Uganda* *Rob Alistair, DFID*	*Milton Amayun* *Bruce Dahlman*

	Partnerships (IHP) ***Panel three : Medical Missions model of partnership in Africa – role and potential*** • *Mission Hospital perspective; AIC Kijabe Hospital* • *Missionary expartriates sending agency perspective; AIM*	*Uganda (to be confirmed)* *Justus Marete* *Pam Horworth*	
4:00 – 4:30pm	*TEA/COFFEE BREAK*		
4:30 – 5:00pm	*Reflection session*	*Frank Dimmock*	*Munoj Kurian*
6:00 – 7:00	*COCKTAIL RECEPTION*	*Lorna Muhirwe/ Sam Orach*	

DAY THREE: 25TH FEBRUARY 2009: Health Systems Strengthening

TIME	*SESSION*	*FACILITATOR*	*MODERATOR*
8:30 – 10:30 am	• *The role of Health Systems Strengthening in enhancing quality and sustainability* • *HRH support from Government in DRC; opportunities & challenges* • *Health systems and policy strengthening initiative for CHAK network* • *CORDAID HRH promising practices publication - CORDAID*	*Dr Juliet Bataringanya, WHO Uganda* *Olivier Musongya, DRC* *Samuel Mwenda* *Isaac Mpoza, UCMB Everd Maniple, UMU*	*Vyumila Chitimbire* *Philibert Kankye*

	Panel 4 : HRH session • *The challenge of HRH brain-drain in Africa – GHWA* • *HR retention and motivation strategies* • *Scaling up training of Nurses in Malawi through CHAM partnership with Government* • *Opportunities for Family Doctors/Physicians training in Africa*	*GHWA* *Doris Mwarey, Capacity project* *Pontiphar Kumzida, CHAM* *Bruce Dahlman, INFAMED*	
10:30 – 11:00am	***TEA/COFFEE BREAK***		
11:00 – 1:00pm	***Panel 5: Governance of Health facilities*** • *Corporate governance; role and responsibilities of Board of Directors in enhancing corporate growth and sustainability* • *Governance of Church health facilities; challenges and capacity building strategies by CHAM –* • *Governance and management capacity building of UCMB health facilities* • *Working with professional*	*GM, JMS Uganda* *Francis Gondwe, CHAM* *Dr Sam Orach, UCMB* *TBD*	*Gerome Wolo*

	associations and regulatory authorities		
1:00 – 2:00pm	*LUNCH BREAK*		
2:00 – 2:30pm	*Reflection session*	*Frank Dimmock*	*Manoj Kurian*
2:30 – 6:30pm	***Excursion & networking**: Visit to some selected Best Practice Sites in Uganda;* • *Kisubi Hospital (UCMB - for Governance best practice)* • *Kiwoko Hospital (UPMB- for financing best practice)*	*Lorna Muhirwe/Sam Orach*	

DAY TWO: 26TH FEBRUARY 2009: Health care financing and sustainability

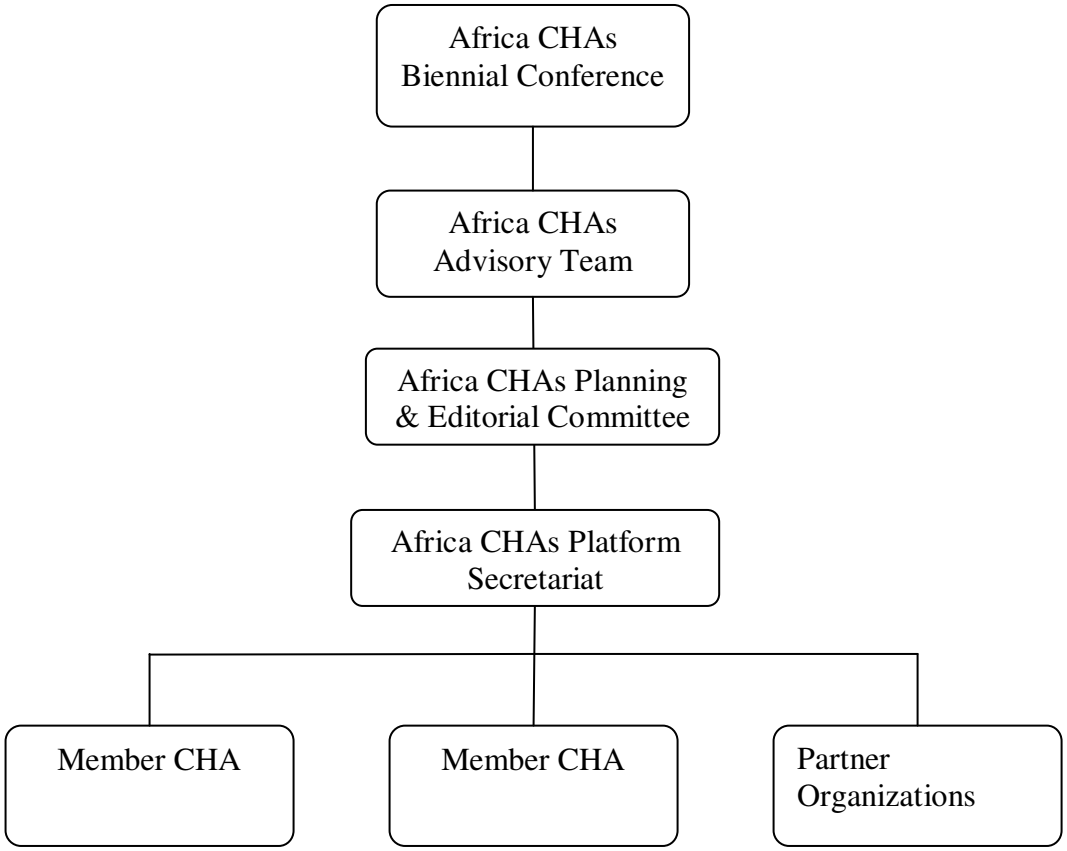
TIME	*SESSION*	*FACILITATOR*	*MODERATOR*
8:30 – 10:30 am	• ***Key note address**: strategies for health care financing towards sustainability* ***Panel 6: Health Financing*** • *Output based financing; Service Level Agreements (SLA) in Malawi* • *National Social Health Insurance in Ghana* • *Community based health financing initiatives* • *Diversifying health care funding sources; the case of Kenya*	*Dr Christine Kirunga, DANIDA, Uganda* *Francis Gondwe, CHAM* *Philbert Kankye, CHAG* *Joseph Kigundu, CHeFA-EA* *Justus Marete/Samuel Mwenda* *Karen Sichinga,*	*Sam Orach*

	• *Mobilizing international funding opportunities; the experience of CHAZ.* • *, Harmonization of donor funding: values based relationships*	*CHAZ* *Dr. Jerome Wolo, Niger*	
10:30 – 11:00am	***TEA/COFFEE BREAK***		
11:00 – 1:00pm	***Panel 7 : Strategic information management (HMIS and M&E)*** • *Strategies for M&E by a Global Fund PR; CHAZ experience* • *Use of IT to strengthen HMIS* • *Using HMIS information for advocacy* • *Mapping of Health facilities in Tanzania* • *The ARHAP Study* • *Study on the involvement of the FBOs in providing maternal & neonatal health care*	*Christine Mulikita, CHAZ* *UPMB* *Sam Orach, UCMB* *Petros Pamba, CSSC* *Frank Dimmock/Mike Mugweru* *Mariana Widmer, WHO*	*John Essobe*
1:00 – 2:00pm	*LUNCH BREAK*		
2:00 – 4:00pm	***Panel 8: Getting to know the partners; facilitating partnerships*** *WCC, MISERIOR, CORDAID, ICCO, IMA World Health, MMI, EED, EPN, GHWA, WHO, DIFEAM, CCIH, International AID, CIAGP …..etc*	*Each partner organization will present a brief overview of the organization (10 min)*	

4:00 – 4:30pm	*TEA/COFFEE BREAK*		
4:30 –6:00pm	***Africa CHA Platform Annual General Meeting (AGM) & Closing Ceremony***	*Frank Dimmock, Samuel Mwenda*	*Munoj Kurian*

3. AFRICA CHRISTIAN HEALTH ASSOCIATIONS PLATFORM GOVERNANCE STRUCTURE

The CHAs 3rd Biennial Conference held in Bagamoyo, Tanzania in January 2007 established the Africa CHAs Platform Secretariat through the "Declaration of Commitment". CHAK was requested to develop a Concept Paper to set up the Platform Secretariat which was to be hosted at CHAK Secretariat in Nairobi. CHAK established Africa CHAs Platform Secretariat in May 2007 with financial support from WCC and DIFEAM. In order to ensure sustained ownership, participation, transparency and accountability that would enrich the work of the Secretariat in serving the Platform objectives and aspirations, the following governance structure was adopted by the 4th CHAs Biennial Conference that met in Kampala, Uganda on 23-26th February 2009;



1. Biennial CHAs Conference

This shall constitute the top authority/organ of the CHAs Platform. All CHAs and Partner organizations shall be eligible to attend and vote on major policy issues and programmatic plans.

TOR

i. To receive and review financial and activity reports from the Platform Secretariat.
ii. To be responsible for approving a two-yearly work plan & budget for the Secretariat
iii. To decide on the country location of the Platform Secretariat and the Host CHA
iv. To determine the host country and CHA for the next Biennial Conference
v. It shall create a forum for sharing experiences, case studies, best practices and study findings on issues of common interest among the CHAs
vi. The CHAs Conference shall be organized by the Secretariat in collaboration with the host CHA and with the support of Africa CHAs Platform Advisory Team
vii. The Conference shall be moderated by WCC Programme Executive for Health and Healing
viii. The report of the Conference and records of any resolutions shall be maintained by the CHA's Platform Secretariat Officer and shall be disseminated to all members

2. Africa CHAs Platform Advisory Team

Membership – This shall be a team drawn from Member CHAs and Partner organizations who will provide advice to the Platform Secretariat Officer and the Platform Planning and Editorial Committee on the activities and publications of the Platform. The membership shall be as follows;

- Host CHA – CHAK - Kenya
- Southern Africa – Zambia –CHAZ and Malawi - CHAM
- Central Africa - DRC & Cameroun
- Eastern Africa – Uganda – UCMB/UPMB and Tanzania – CSSC
- Western Africa – CHAG (Ghana)
- Partner organizations – WCC, DIFEAM, IMA, CORDAID and EPN

Mode of operation – electronic communication through e-mail and conference calls

TOR

i. To provide advise and input on the final content of Africa CHAs Bulletin and one Contact Magazine issue on CHAs annually
ii. To provide advise in the planning of the various platform events
iii. To represent the interest of their respective regions and partner organizations in the CHAs Platform activities.
iv. To promote the image and interest of the CHAs Platform in their organizations, countries and regions.
v. To support resource mobilization for the CHAs Platform activities and events
vi. The moderator shall be Frank Dimmock from PCUSA who is based in Lesotho and who has supported various CHAs in Africa for several years

vii. Secretariat services shall be provided by the Platform Secretariat Officer
viii. Participation shall be on voluntary basis as a contribution to the vision of the CHAs Platform

3. Africa CHAs Platform Planning and Editorial Committee

This Committee shall have majority of it's members drawn from within the host country. It shall have atleast quarterly meetings to support the Secretariat officer and the Host CHA in the planning of key events of the Platform and to plan for and assist in, the editing of the Platform publications. Members from other countries will be sent the report of the meeting deliberations and/or the draft publications for their review and input before they are finalized for dissemination.

Membership

- Dr Samuel Mwenda – General Secretary CHAK – Chair
- Anne Kanyi – Communications Officer – CHAK
- Peter Ngure – HIV/AIDS Programme Manager – CHAK
- Michael Mugweru – CHAs Platform Secretariat Officer – Secretary (bi-lingual)
- Stella Etemesi – Network & Communications Manager – HAI (bi-lingual)
- Anjela Nyagah – Communications Officer – EPN
- Dr James Mwenda – Customer Services Manager, MEDS
- AACC- representative
- Dr Robert Ayisi – Executive Secretary, KEC-Catholic Health Commission
- John Ebesi Essobe – Cameroun (Francophone)
- Dr Munoj Kurian – WCC

TOR

i. Planning for the production and publication of four issues of the Africa CHAs Bulletin and one issue of Contact Magazine on CHAs annually
ii. To review the previous issue of the publications and address any feedback received from the readers
iii. Support the editorial work of the articles to ensure quality and diversity of both sources and content
iv. To support planning for platform events such as conferences, workshops and meetings. Additional members may be co-opted to support planning of specific events.
v. The meetings shall be chaired by the Host CHA
vi. Secretariat services shall be provided by the Platform Secretariat Officer
vii. Correspondences shall be directed through the Secretariat Officer

Participation shall be voluntary as a contribution to the CHAs Platform vision. However road travel costs to attend the meetings shall be refunded at the existing Host CHA's transport rates.

4. AFRICA CHA'S 4TH BIENNIAL CONFERENCE, KAMPALA
22 -27 FEBRUARY 2009
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