

**AFRICA CHRISTIAN HEALTH ASSOCIATIONS
PLATFORM**



AFRICA CHA PLATFORM

**REPORT ON THE
5TH BIENNIAL AFRICA CHRISTIAN HEALTH ASSOCIATIONS
CONFERENCE**

FEBRUARY 21-24, 2001, ACCRA GHANA

**Theme: *“Improving women’s and children’s health in Africa;
FBOs response towards attainment of MDG targets”***

Compiled by ACHAP Secretariat

P.O Box 30690-00100 Nairobi, Kenya

Telephone: + 254 20 4444 1920/ 4444 1854

Email: chas@chak.or.ke

Website: www.africachap.org



Group photograph of the delegates of the 5th Biennial CHAs Conference held on February 20-24, 2011 at GIMPA Executive Conference Centre, Accra, Ghana

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**STRENGTHENING THE MANAGEMENT AND LEADERSHIP CAPACITY
OF HEALTH CARE PROVIDERS IN AFRICA: THE JOHNSON &
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BACKGROUND

The Africa CHA Platform is an information and knowledge-sharing platform that facilitates learning and joint advocacy for Christian Health Associations (CHA) and Christian Health Networks (CHN) from Sub-Saharan Africa and their development partners. ACHAP currently has 26 member organisations from 21 countries of Africa who provide a significant proportion of health services which range between 20-50% of the national health services.

In 2010, countries and the UN Agencies took stock of the progress made towards the attainment of the MDG goals at country level and globally. An MDG Summit was held at the UN in New York in September 2010 attended by Governments, UN Agencies, Donors, FBOs and civil society organisations to take stock of the progress made 10 years after the MDGs were launched. While significant progress has been achieved in some MDGs, it is of great concern that many countries especially in Sub-Saharan Africa have made little progress on MDG 4 & 5 (Maternal Health and Children’s Health).

The UN Secretary General launched a Global Strategy on women’s and children’s health with a call to action made to various stakeholders to scale up coordinated actions towards better health for women and children. The UNDP also launched an MDG campaign aimed at mobilizing and sustaining commitment on maternal and child health. Similarly, the World Council of Churches (WCC) is calling upon Religious Leaders and communities to utilize their space of influence to mobilize communities and advocate with Governments and partners towards increased investment and coordinated action to achieve better health for women and children.

In response to these calls, ACHAP members, acknowledging their unique dual role of advocacy and service delivery towards improving access to quality health care in general including maternal and child health services ACHAP dedicated the 5th Biennial Conference and General Assembly meeting, held in Accra in February 2011, to MDG 4 & 5. A planning meeting for the 5th Biennial ACHAP Conference held in Kampala in September 2010 identified the theme of **“Improving women’s and children’s health; FBOs response”** for the conference.

The conference provided an opportunity for CHAs to take stock of where different countries were with regard to CHAs contribution to the MDGs and discuss opportunities for strengthening capacity, partnerships and health systems for quality, accessible and sustainable maternal and child health service delivery through the faith based health networks in Africa.

The 5th Biennial Africa CHAs Conference was hosted in Accra, Ghana by the Christian Health Association of Ghana (CHAG) in collaboration with ACHAP Secretariat/CHAK, WCC, Cordaid, ICCO, Miserior, Difaem, CCIH and IMA World Health/Capacity Plus Project[funded by USAID] from 21-24th February 2011. 75 participants from various countries of Africa, Europe and USA attended the conference.

The conference enjoyed inspiring input of resourceful facilitators including; Dr Douglas Huber (CCIH), Jeanette Cachan (IRH), Prof Henry Mosley (Johns Hopkins School of Public Health), Dr Robert Mensah UNFPA Country Director Ghana and Dr Susan Brems & Ari Alexander of USAID both from USAID Washington

CONFERENCE OBJECTIVES AND EXPECTATIONS

1. To share information and experiences on efforts to improve maternal and child health services by member CHAs and CHNs in Africa.
2. To identify issues for joint advocacy with and for the CHAs and CHNs in Africa that will lead to improvements in maternal and child health services in Africa.
3. To identify the capacity development needs of CHAs and CHNs that will enable them improve upon their service delivery and in particular to improve upon maternal and child health services they deliver.
4. To review, identify and initiate continental and international partnerships that will enable ACHAP and its members increase commitment of African and international duty bearers to improve maternal and child health in Africa.
5. To create opportunity for capacity building, knowledge exchange and sharing of tools in maternal and child health services and leadership

Expected Outcome of the Conference

1. Increased knowledge and skills in Reproductive Health services from workshops and networking
2. Improved understanding of the status of maternal and child health MDGs and the challenges
3. Recommendations on strategies for enhancing FBOs contribution to MDGs and commitment to action
4. Enhanced partnerships for health related MDGs
5. Consensus on enhanced Governance structure for ACHAP and endorsement of ACHAP Constitution
6. Consensus on a commitment statement for scaling up maternal & child health services by CHAs and an Action Plan for joint advocacy through ACHAP

Expected outputs

1. Recommendations on strategies for enhancing FBOs contribution to MDGs and commitment to action
2. Enhanced partnerships for health related MDGs

3. Consensus on enhanced Governance structure for ACHAP and endorsement of ACHAP Constitution
4. Consensus on a commitment statement for scaling up maternal & child health services by CHAs and an Action Plan for joint advocacy through ACHAP

DAY 1 FEBRUARY 21, 2011: PRE-CONFERENCE WORKSHOPS

WORKSHOP 1: STRATEGIC LEADERSHIP FOR HEALTH SYSTEM TRANSFORMATION

By Professor Henry Mosley, John Hopkins School of Public Health & CCIH, USA



Professor Henry Mosley(middle) takes participants through a session in leadership

INTRODUCTION

Professor Henry Mosley from CCIH & John Hopkins School of Public health facilitated a workshop on leadership for health systems transformation. This was an exciting and interactive leadership learning session which took a full day and provided concise and comprehensive highlights on a transformational leadership course that he delivers in 5 days. Participants were also provided with copies of the materials in print and electronic form (CD) to take to their countries for further study, reference and dissemination.

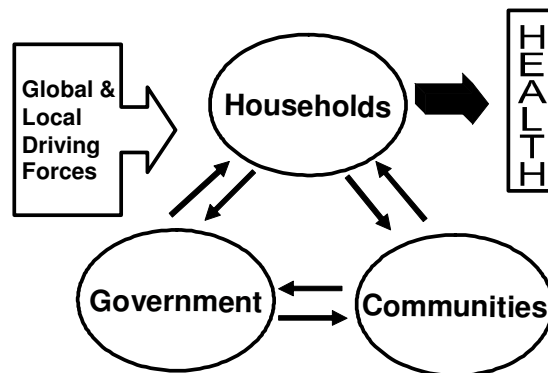
Mothers as producers of health

It was said that households, particularly mothers, are the primary *producers* of (reproductive) health.

He reiterated that transformational change at every level in the health system play two key roles -

- Catalytic - Generating a shared vision of a healthier future that people want to create
- Action learning - Encouraging the development of learning organisations that leverage the vast resources of ordinary people to transform their own societies to improve health.

A new paradigm for health systems transformation was presented as follows:



The paradigm above recognised that doctors, nurses, hospitals, health centres, etc, do not *produce* health:

It places households at the centre of health production and more so mothers in the case of maternal and child health.

He said that household health productivity, like the productivity of every institution in society, depends upon three basic capabilities – *values, practices* and *resources*. The interactions of values, practices and resources can be considered as the household's/community's "culture".

From this perspective, the household health system can be said to have a self-sustaining "culture" of production. Consequently, to improve health productivity in a society, every household needs to have an understanding of the changes needed in values, practices as well as resources required for better health outcomes and the motivation to make these changes. It requires the cultivation of a learning culture.

Learning would help in order to:

- (a) Understand deeply how health is produced at the household level;
- (b) Develop practical indicators of all aspects of household health productivity;
- (c) Restructure agencies and organisations to be able to measure and monitor household health productivity and facilitate the changes needed to improve the performance of the health production system.

THE ROLE OF LEADERSHIP

It was said that the 21st century will be a century of change driven by political, social, economic, technological and environmental forces. These will profoundly affect the capabilities of households and communities to produce and maintain health and general well being.

To assist households in efficiently producing health in the presence of these forces, governments will need to change, and new institutions will need to be created.

The action learning process for health system development

The action- learning model depicts three areas for action-learning:

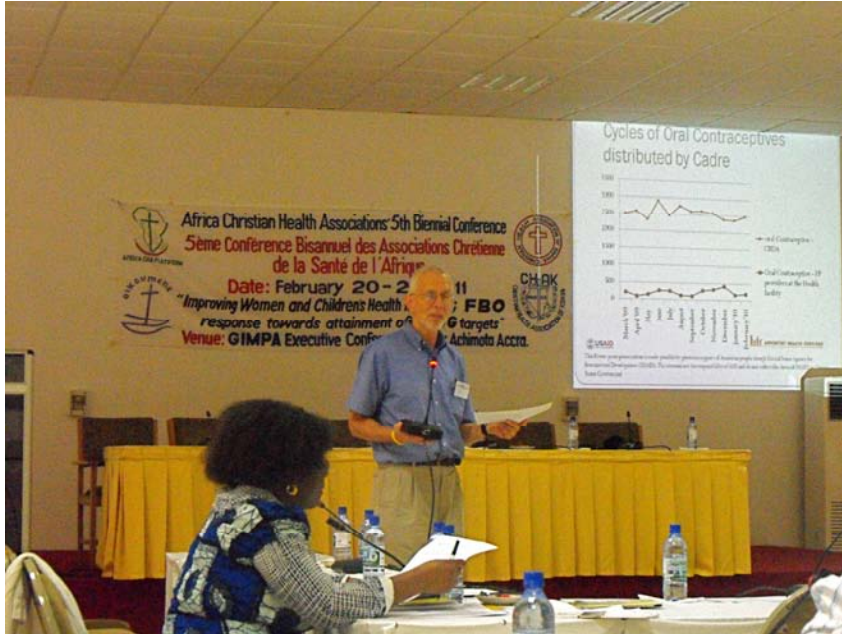
1. Understanding the household and community needs to improve productivity, and learning how to effectively connect the programme outputs to the needs.
2. Understanding the tasks required to produce the desired outputs, and how to build the Organisational competencies to perform these tasks.
3. Understanding how to effectively engage the households and communities in the decision processes so that there will be real “ownership” of the policies, strategies and programmes.

The role of the leader in this process is to act as a catalytic force in bringing together an action-learning team involving these diverse stakeholders. Over time as trust and confidence grows, the action learning team should be characterized by:

- A shared vision of a better future;
- A commitment to see the current reality as it is;
- An openness to new ideas;
- A willingness to challenge long standing assumptions
- An encouragement of innovation and experimentation;
- Acceptance of mistakes as learning opportunities;
- A shared responsibility for both the successes and failures; and
- A readiness to change old ways as new evidence emerges.

WORKSHOP 2: STRENGTHENING AND EXPANDING FAMILY PLANNING IN COMPREHENSIVE HEALTH SERVICES.

By Dr Douglas Huber from CCIH, USA



Douglas Huber (standing) delivering a presentation on Family Planning technology

Dr. Douglas Huber from Christian Connection for International Health and Jeannette Cachan from Institute of Reproductive Health (IRH) of Georgetown University, Washington USA presented on new developments and approaches to family planning. He said that:

- About 25% of fertile age women in Sub-Saharan Africa have an unmet need for family planning—i.e. do not want to be pregnant (to space or limit pregnancies), though not using a family planning method. The unmet need for family planning is higher in Sub-Saharan Africa than any other region of the world.
- The fastest, easiest way to reduce unintended pregnancy, abortion and maternal deaths is through family planning—health outcomes broadly embraced by Christian organisations as well as secular partners.
- Reducing infant and child mortality through healthy timing and spacing of pregnancy (HTSP) to achieve 3-5 year birth intervals is now recognised as a powerful means to improve health of children as well as mothers. Therefore, providing universal access to postpartum family planning for at least 18 months becomes the new standard of care. This has important implications for how we work, and Christian Health Associations should support these new standards of care to help achieve MDGs 4 & 5.

- Technical and service delivery updates were presented to participants, including the Standard Days Method supported by the use of Cycle Beads, an effective of supporting natural family planning.



Dr Jeanette Cahan (R) and Lauren from Institute of Reproductive Health of Georgetown University demonstrate the use of Cycle Beads in tracking fertility days in support of natural family planning during the Family Planning workshop at ACHAP Conference in Accra.

- The workshop provided case studies and new evidence-based materials to demonstrate success with integrating family planning into comprehensive health services and show how to accelerate uptake of family planning through task sharing at the community level. The materials can empower couples, communities, health providers and faith leaders (both clergy and laity) to provide information, education and services at the local level. These complement facility-based services and are vital to achieve expanded access to quality family planning in low-resource settings.

Participants prepared action steps they will undertake upon returning home, based on the learning from the workshop. Both Protestant and Catholic participants identified ways their organisations could advance family planning consistent with the values and beliefs of their faith communities. The workshop organisers, CCIH and IRH, will follow up with participants periodically in 2011 to document their progress with action items and steps towards achieving MDGs 4 & 5.

DAY 2 – FEBRUARY 22ND 2011

FACING THE MATERNAL HEALTH MDG CHALLENGE.

By Dr. Robert Mensah, UNFPA Country Director, Ghana

The keynote speaker was Dr. Robert K. Mensah, Reproductive Health Specialist, UNFPA, Ghana Country Director. Dr. Mensah focused his presentation on the **magnitude and causes** of maternal mortality.

He outlined some key actions for governments and the international community to take in order to reduce the rate of maternal mortality. Throughout the presentation it was emphasised that maternal mortality is not just a public health issue, but is also a matter of social justice. He observed that the health of pregnant adolescents and women has not been a priority for many governments despite the disastrous effects that maternal morbidity has had on communities. Multi-sectoral, human rights-based approaches are needed to address the root causes of women's vulnerability at this crucial stage in order to ensure that no woman dies while giving birth.

Magnitude and leading causes of maternal mortality

Maternal mortality is defined by the World Health Organisation as “the death of a woman while pregnant or within forty two days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes”.

The **leading causes** of maternal deaths worldwide were noted to be haemorrhage, infection, obstructed labour, hypertension and complications arising from unsafe abortions.

In addition, it was said that many deaths could be avoided by ensuring that pregnant women do not delay seeking help when they are in need, do not experience delays in accessing health facilities, and that the provision of professional care is not delayed when they reach the facilities.

The presentation noted that **Sub-Saharan Africa** is a region with a high maternal mortality ratio (MMR). The risk of a woman dying from pregnancy related complications in this region is about 1 in 14, compared to 1 in 10,000 in developed countries.

Sierra Leone, Malawi, Angola, Niger and Tanzania were identified as the five countries in Africa with the highest rates of maternal mortality. Malaria and HIV/AIDS were identified as the two of the leading emerging causes of death in Africa.

Maternal mortality in Sub-Saharan Africa is compounded by the young age at which women start childbearing. Approximately 50% of first births in Sub-Saharan Africa are from among adolescents. **Young adolescents** who start childbearing are not only at an increased immediate risk of morbidity, as their bodies are often not adequately developed, but also at an increased lifetime risk of morbidity, as they tend to have more children than woman who start childbearing later.

Global efforts to reduce maternal mortality

It was said that since the 1970s, consensus building on key issues affecting maternal mortality has been captured in the document, *The Global Strategy on Women's and Children's Health*, launched by the United Nations Secretary General Ban-Ki Moon on 22nd September 2010.

The Global Strategy represents a crucial commitment by governments, the private sector, non-governmental organisations, philanthropic institutions, faith-based organisations and academic institutions to improve the health of women and children around the globe. The strategy adopts a human rights-based approach to health, which links the legal, social, economic, cultural and political well-being of women and children to specific health outcomes. In so doing, it compiles into one document many of the key lessons learned from initiatives implemented over the years.

Lessons learned:

- The MMR of a country tends to decrease when that country's economic development increases. However, reducing maternal mortality is not a question of available resources; it is a **question of priorities**. It was said that poor communities have succeeded in substantially reducing rates of maternal mortality because most of the solutions needed are simple and not expensive to implement.
- **Family planning** is crucial to reducing maternal mortality, for reasons of both delay and spacing. Mothers and babies are healthier when risky pregnancies are avoided. The risk of maternal mortality is higher for adolescents under the age of 18. Moreover, it is recommended that at least 2 years pass between births.
- Quality, skilled care by health professionals both during and after pregnancy is crucial for reducing maternal mortality. **Antenatal visits** to health facilities save lives, as does delivery by a skilled attendant.
- Timing is essential: the right women need to receive the right care at the right time. **Delays** in accessing health care result in a large proportion of maternal deaths.

Key actions for governments and faith-based organisations

- Governments were exhorted to provide and upgrade existing key social amenities that are directly linked to **health system strengthening** such as health facilities, communication networks, and transportation systems. Building maternity homes close to hospitals to keep pregnant woman for a few days before their delivery is a practice worth considering.
- **Statutes (whether customary or otherwise)** that restrict women's access to family planning services (e.g. requiring that a woman be married or that she have her husband's approval) should be challenged and removed.
- Governments should adopt policies, regulatory, social and economic, that strengthen a woman's control over her sexuality and pregnancy. No woman should die while giving life.
- **Traditional Birthing Assistants (TBAs)** should be given training in midwifery to be better prepared to respond in cases of emergency. Coverage and access to Basic Emergency Obstetric Care facilities should also be improved. For every 500,000 people, there should be at least four of these facilities as well as one for Comprehensive Emergency Obstetric Care.

Group Discussion

The international community should be aiming to eradicate the incidence of maternal mortality entirely, instead of by incremental percentages. Policies that aim to reduce maternal mortality in small

steps instead of aiming to **bring it to zero** embody the problematic rationale that prevents real achievement from being made. Eradicating maternal mortality completely is possible, but only if the enabling mindset is adopted and priorities are set accordingly.

One of these key priorities is to **increase surveillance** of maternal mortality, including monitoring of incidence and evaluation of programmes to gauge effectiveness. Stronger evidence-based advocacy is needed. Lessons can be learned from failed policies as well as those which are successful, so it is important to document all approaches. Not enough has been done to **accurately measure** the incidence of maternal mortality, particularly in developing countries. Indicators that reflect the realities on the ground should be developed and applied consistently. One suggestion to improve the collection of statistics is to measure maternal mortality on a yearly basis, which could capture a more realistic image of trends.

Another priority is to focus on increasing access and quality of **family planning** services, especially within **rural communities**. As Karen Sichinga, CHAZ Executive Director, said *“Strengthening family planning initiatives, particularly in the rural setting where the need to prevent unwanted pregnancies is highest, is key to reducing maternal mortality. Every \$1 investment in family planning saves the health budget \$4.”*

Many organisations are frustrated with the lack of progress that is being achieved to reduce maternal mortality, despite all of the knowledge available on best practices.

One reason for this is because medical approaches to maternal mortality are often applied without being linked to **poverty reduction strategies**. This compromises its effectiveness as poverty is among the greatest of barriers preventing women from accessing health care before, during and after pregnancy. Maternal mortality was reduced in Niger, for example, by implementing a poverty reduction strategy that made all antenatal care consultations free. This is a best practice that should be followed in countries that have not yet made antenatal services **free of charge**. Abolishing service charges would also be a way to increase the percentage of deliveries attended to by skilled professionals.

Lastly, effectively eliminating maternal mortality requires action not just by government, but also by community health workers and civil society. Only an integrated, multi-sectoral approach that addresses the root causes of maternal mortality will help to permanently reduce its incidence. **Empowerment** of girls and women in all ways, economic, legal and social, is key to their survival. More should be done to outlaw early marriage of adolescents and encourage girls to stay in school. Safe Motherhood Programmes are important initiatives that depend on public support and require collective engagement by all sectors of societies. Religious leaders have a responsibility to advocate government to support community programmes and protect the girls and women in their community.

CONFERENCE OFFICIAL OPENING CEREMONY

ACHAP 5th Biennial Conference official opening ceremony programme was guided by James Boateng from CHAG who served as master of ceremony introducing the programme and speakers. The session received remarks from CHAG Executive Director, Director Dr Gilbert Buckle and ACHAP Secretariat representative, Dr Samuel Mwenda. The key note addresses were delivered by the Chairman of the Board of CHAG and the Country Director for UNFPA, Dr Robert Mensah

The Executive Director of CHAG welcomed participants to Accra, Ghana and the conference. Dr Samuel Mwenda from ACHAP Secretariat gave an overview ACHAP and the objectives of the conference. .

The chairman of CHAG in his key note address pointed out several factors that work against the realization of MDG 4 and 5 in African countries. These include poor geographical and service accessibility, non-availability of adequate and qualified human resources, cultural practices that violate women's rights to health, and a lack of political will.

It also pointed out that in order to meet MDG 4 and 5, it was necessary for faith-based organisations to invest in empowering the communities they serve. The human potential galvanised through the promotion of social and economic justice would assist communities accelerate achievement of these MDG's. It was said that unless the potential of women is recognised and harnessed, achieving the MDG's would remain a dream.

Christian Health Associations were challenged to emulate the example of the teaching and service of our Lord Jesus Christ. They were challenged to bring change into an unjust and corrupt world. They were also encouraged to collaborate with other CHA's, as no one CHA alone is able to achieve all the MDG's .

He noted that the knowledge and skills residing amongst Christian Health Associations would help them overcome some of the stated challenges as well as forge consensus on the governance structure of the Platform. He was pleased to note that according to the conference programme a consensus statement, as well as an action plan for joint advocacy, would be made by CHA's centring on their efforts to scale-up maternal and child health services.



Conference participants keenly follow the proceedings during the conference official opening session

MEASURING THE ROLE AND CONTRIBUTION OF FAITH INSPIRED INSTITUTIONS IN HEALTH SERVICE DELIVERY.

By Dr. Jill Oliver, consultant, development dialogue on values and ethics, World Bank

Measuring market share

Calculating the contribution of faith-based organisations (FBOs) to national health sectors has been an issue of great debate. Attempts to accurately measure the **market share** of faith-inspired institutions, have been hampered by the **lack of robust evidence** on health care service delivery, due in part to the lack of a rigorous research methodology and a failure on behalf of stakeholders to collaborate and share information amongst each other.

Dr. Oliver explained that both FBOs and government departments have not been rigorous enough in their data collection, leading to estimations of faith-inspired contributions being variable. Most of the figures quoted for health provision are based on a **fragmented evidence base**. This has serious repercussions on policy development and can even serve to undermine FBO advocacy efforts.

A need to improve

In most countries, faith-inspired health provision is still **unaligned with national health systems** and, since FBOs straddle the divide between private and non-profit sector, many faith-based initiatives escape categorisation and thus do not feature in calculations. Consequently, market share estimates are often based on a small sub-set of data, including only those relating to national CHAs, which are not representative of the entire faith-based sector. In addition, national CHA estimates are, themselves, often approximated or gathered for the specific aim of advocacy. Rather than reflecting positively on CHAs, however, these estimates are often received with scepticism at the policy level and, at worst, are likely to be underestimated.

Recommendations for improving analysis

Health care service provision stakeholders should be seeking to improve on market share estimates by:

- Developing more rigorous research methodologies and to capture a more complete understanding of market share at the national level
- Complementing the market share approach with a deeper understanding of which **particular segments of the population** are being served by which service provider. For example, it is clear that CHA service delivery focuses mainly on the **rural poor**. A textured analysis which maps users, user preference and equity makes a strong case for the importance of CHAs.
- Focusing on evidence-based policy engagement, for example increased attention on documenting quality of provision, efficiency and sustainability
- Engaging with national and international partners. Multinational organisations and universities have research centres and programmes that would be able to help CHAs in their task of quantifying and qualifying the contribution of their sector.

Group discussion

A challenge noted was how to improve upon documentation of efforts and the development of **indicators**, particularly with regard to the **qualitative** aspects of health care service delivery.

It was pointed out that CHAs often provide health services that are aimed at prevention and promotion, and this aspect of their contribution is difficult to measure. Most of the work takes place in communities, outside of formal health facilities, for instance home-based care.

This is an extremely important contribution for which indicators are difficult to develop and monitor. Similarly, simple indicators that focus on numbers of facilities or hospital beds in an attempt to measure market share fail to appreciate the fact that faith-based health facilities are often preferred over facilities run by other providers despite having perhaps a smaller physical presence.

A suggestion for improving upon documentation and data collection is to ensure participation of data collection officers from CHAs during the formulation process of **District Health Plans**. Representation from members of the faith-based sector during this crucial stage is key to their contribution being recognised and not omitted amidst all of the other stakeholders competing for recognition and prominence. Maintaining a presence throughout the planning, implementation and monitoring phases will also help CHAs conduct their own analysis in order to improve estimates of market share.

CHAs are aware that their weak documentation is a problem that they need to address and they are willing to engage with international organisations in order to strengthen data collection, monitoring and evaluation. The World Bank would be interested in such a project with the aim of assisting faith-inspired organisations in their research and data generation.

RETURN TO PRIMARY HEALTH CARE: ENSURING ACCEPTABLE MATERNAL AND CHILD HEALTH SERVICES AT THE COMMUNITY LEVEL.

By Gilbert Buckle, Executive Director Christian Health Association of Ghana and Dr. James Duah, Medical Superintendent, Kings Medical Centre.



Dr James Duah (pointing) takes participants through his presentation

Dr. Gilbert Buckle and Dr James Duah highlighted some of the key factors that influence the quality and efficacy of primary health care (PHC) systems at community level.

It was said that the influence of **attitudes and perceptions** on the success of PHC interventions is often underestimated. A number of initiatives implemented by CHAG aimed at improving maternal health care demonstrate the profound impact that cultural norms and perceptions embedded in the community can have on whether a pregnant woman chooses to seek institutional care or not. A lesson drawn from these interventions was that, along with accessibility of health facilities, affordability and availability of skilled care, cultural attitudes and preferences are a crucial determinant of PHC use and must consequently be considered in policy guidelines development aiming at health system strengthening.

These cultural perceptions can manifest themselves in different ways, and are often very **subtle or hard to predict** for policymakers not familiar with the particular culture of the community in which they are trying to implement a PHC programme. Healthcare workers in Ghana, for example, encountered this issue when trying to increase the number of hospital deliveries in a certain region. In order for the initiative to succeed, it was found necessary to modify the normal hospital procedure for delivery to include the traditional method, whereby the mother delivers in a squatting position. Within the community, this traditional method was regarded as being superior and once it was incorporated into hospital procedures, hospital deliveries became **socio-cultural accepted**; attendance increased and maternal mortality was eliminated.

Behaviour change is a very difficult task to accomplish, and requires a combination of awareness-raising and **adaptation of interventions** to the local context. A community might be very resistant to a certain idea due to preconceptions they hold about the causes of ill health. Malnutrition, for example, can be thought to result from a curse rather than poor diet. In this case, educating the population and protecting malnourished individuals requires behaviour change that is brought about by recognising community perceptions and establishing acceptable systems to address the problems. This might, for instance, require building community centres that are distinct from hospitals where malnourished people can be brought for treatment in a context that is acceptable for the population.

Changing behaviour requires **building trust** and investing in sources of trust that are recognised and approved by the community. In terms of maternal mortality, traditional birth attendants (TBAs) have a high amount of **social capital** and can be instruments of positive change when proper investment is given to their training. In certain areas, TBAs are responsible for up to 90% of referrals to hospitals. It has been shown that recognising the importance of TBAs and ensuring that they are trained in antenatal care, risk management, infection prevention, care of newborns, postnatal care and family planning, among other issues, can have an immediate effect on the health and well being of mothers and newborns.

Group discussion

Although promoting training in traditional birthing practices has clear benefits for the community, a concern is that emphasising traditional practices contradicts the message given by prominent international organisations, such as the World Health Organisation, that these methods should be discouraged in preference of **formal hospital care**. It was noted that on the global policy level, there

was not enough appreciation of the very important role that TBAs still play in communities and the beneficial impact they have not only on health outcomes, but also on behaviour change.

At the same time, it was recognised that the role of the TBA does differ from the role of the midwife, gynaecologist and obstetrician. If a woman prefers to be assisted by a traditional assistant, then this is her right and it should be respected. However, it is crucial that the TBA is sufficiently trained to know when a situation is outside of his or her control and requires emergency care.

Improving community care and **establishing the balance** between adopting traditionally accepted methods and encouraging formal care by qualified professionals requires more research to be done into community dynamics. TBAs, for example, are not considered as qualified professionals and the value they add to reducing maternal mortality has consequently not been adequately addressed. CHAs should make it a priority to **highlight the contribution** that traditional methods make to safe motherhood.

Day 3. FEBRUARY 23rd 2011

BUILDING PARTNERSHIPS FOR IMPROVED MATERNAL AND CHILD HEALTH SERVICES.

By Dr. Susan Brems, Senior Deputy Assistant Administrator, Bureau for Global Health, USAID & Ari Alexander, Deputy Director, Centre for Faith Based and Community Initiatives USAID

USAID procurement reforms and opportunities for capacity building of local organisations

The keynote speakers were Ari Alexander and Dr. Susan Brems, both from USAID Washington DC. Their presentations emphasised on the importance of collaboration between USAID and faith-based organisations and described the recent reforms that the USAID had undertaken to improve relations with host communities and be more accessible to local organisations to facilitate access to funding for local indigenous organisations.

Background

They reported that USAID currently works directly with about 108 organisations in Africa including World Vision, CRS and IMA World Health (FBOs), which are regarded as prime partners. It provides approximately \$300 million annually to many global organisations directly. USAID also funds initiatives by other organisations through contracts and sub grants. USAID is aware that Faith-Based Organisations (FBOs) are concerned about development issues. As such, USAID holds periodic meetings to enable faith-based organisations to voice their opinions concerning issues such as earthquakes, floods, tsunamis and provision of clean water, HIV/AIDS and human rights.

It was noted that in the last decade, maternal and child health had been relegated to a second tier concern by donor agencies and implementing partners due to the global concern for HIV/AIDS.

However, the US government's action plan on issues relating to maternal and child health have been strengthened by President Obama's Global Health Initiative (GHI) which combines the US President's Emergency Plan for AIDS Relief (PEPFAR) and the Centre for Disease Control (CDC) programmes.

GHI focuses on systems strengthening, based on principles of country ownership and collaborative partnerships, and offers support for the adoption of country-owned approaches.



Susan Brems from USAID Bureau for Global Health and Ari Alexander (on her left) from the White House Faith Based & Neighbourhood Initiatives address ACHAP 5th Biennial Conference held on February 20-24, 2011 in Accra Ghana. With them is Rick Santos President of IMA WorldHealth (extreme right) and Dr Dhally Menda, CHAZ Director of Programmes (extreme left)

Enhancing presence of USAID in-country: capacity building and leadership development

From a survey that it carried out, USAID said that country or local organisations considered it as an unapproachable entity. As a result, the institution has taken steps to change that image and make it more approachable for smaller and local FBOS. This will be achieved through amending its policies and guidelines, as well as through the manner in which it interacts with local community members. To this end, the USAID has established local capacity development schemes, which are being piloted in five of the USAID missions. These schemes are designed to make USAID staff reflect on the approach in which it engages the communities that it works with, building local capacity and fostering the growth of local organisations in the countries in which they are based. In addition, USAID has also established Leadership Initiative to help new local officers work alongside foreign service nationals.

Approval and response to Requests for Proposals (RFPs) from local organisations is based on competition. Small local organisations can strengthen relationships with USAID, and increase their chances of receiving funding, by:

- Having stronger internal controls, such as by having records of financial audits, making accounts records/reports available for inspection, registering with their government, and abiding by all necessary by-laws and organisational requirements as stipulated by country laws.

- Respond to RFA (Request for Application), RFP (Request for Proposal) and APS's(Annual Programme Summary): Organisations are advised against submitting unsolicited proposals since these are rarely considered.
- Check updates on the USAID website: www.grants.gov for any RFAs postings/announcements

Group discussion

Participants said that it appeared as though USAID did not fully appreciate the unique space that FBOs occupy in the health sector and the comparative advantage that these organisations have over others. A problem thus occurs whereby FBOs are not able to access funding, either because RFPs have not been designed in a way that is open to FBOs, or because funding dynamics give preference to larger NGOs against whom FBOs cannot compete, as they are, by their nature, less visible or operate with a more limited technical capacity.

Furthermore, concern was raised regarding the practice of international NGOs registering as local organisations and competing with local organisations for in-country grants targeting local organisations. This gives these international-turned-local organisations an unfair competitive advantage over the FBOs and serves to prevent smaller, existing local organisations from receiving funds.

It was also pointed out that there is a tendency for USAID to prefer awarding grants to government initiatives, despite governance and accountability challenges. Without funding, FBOs cannot cope with the service demands to fill the gaps. USAID was asked to consider working with local FBO's in supplementing government initiatives instead of focusing entirely on government-managed programmes.

Rigidity of funding agreements was highlighted as a bottleneck in optimising the benefits from utilisation of the funds. Examples were provided in which the project funding available exceeded the actual implementation cost, yet due to the restrictive conditions of the grant it was not possible to re-allocate the excess funds to another area of need.

Heads of CHAs were told of the need to improve on documenting their successes and value-addition to the health sector. More work also has to be done to raise their profiles and increase their exposure.

A number of suggestions were made regarding specific actions that USAID could undertake in order to strengthen the capacity of FBOs:

- USAID country offices need to evaluate the strength of presence and influence of FBOs in their community and increase support for FBO initiatives based on these evaluations;
- USAID should consider funding strategies for small FBOs, which are in need of funding and which can be excellent partners, but which are overshadowed by larger organisations;
- USAID should provide forums for FBO's to showcase their potential, in terms of ability to carry out project deliverables as well as for the FBO's to better communicate to USAID their strengths and funding needs;

- It was said that the new USAID monitoring and evaluation policies are still designed for large projects and there is a need to develop modalities that are more appropriate for smaller projects and grants;
- There should be a more rigorous policy to check the backgrounds of organisations applying as local organisations, since they may be owned by foreigners even though they are registered locally;
- More focus should be put on funding projects with long-term focus, side by side with funding traditional partners such as governments. There is a particular need to support FBO initiatives that strengthen the **supply-chain** of medicines, so that the commodity supply does not become paralysed when a government programme breaks down.

EPN STUDY ON AVAILABILITY AND PRICING OF MEDICINES FOR CHILDREN IN THE CHURCH SECTOR.

By Donna Kusemererwa and Elisabeth Goffin-EPN



Donna Kusemererwa takes participants through the presentation

Donna Kusemererwa the Executive Director of the Ecumenical Pharmaceutical Network (EPN) and Elisabeth Goffin its Communications Officer, presented the results of a study carried out by EPN on the availability and pricing of paediatric medicines in church health facilities in Chad, Kenya and

Uganda. They also outlined some key facility level factors that impact on medicine availability and pricing.

This cross-country study revealed that significant variations exist between countries in the availability and pricing of some 29 medicines surveyed. Comparison of these variations has made it possible to determine certain factors that impact directly on how medicines are stocked and priced, which in turn can be translated into specific policy recommendations. Some lessons to be drawn from the EPN study relate to centralised purchasing mechanisms for drugs, dangers of over reliance on government and international initiatives, the importance of paediatric guidelines and a need for stronger internal decision-making and procurement processes.

The EPN study clearly showed that a well-managed **centralised purchasing system** for all church health facilities to use for purchasing is an important mechanism which results in better availability and pricing of drugs. The Mission for Essential Drugs and Supplies (MEDS) initiative in Kenya is an example of a centralised purchasing system that has succeeded in improving the availability and affordability of drugs by allowing for bulk-buying of essential supplies. Buying in bulk results in more competitive prices and the creation of stocks, which enhances availability.

Moreover, the procurement of drugs and supplies is a process that is prone to corruption and each purchase thus wastes capital, pushing prices for drugs up even higher. A centralised purchasing system that is organised, well managed and **transparent** would be able to reduce expenditure even more by lessening fraud and corruption. A policy recommendation is for such a system to be established on the national level and for church health facilities to compel their members to use it for purchasing drugs and supplies.

As well as reducing costs and improving stocks, a centralised system for church health facilities would lower **dependence on government**. In many African countries, government controls the supply of medicines. The availability of drugs thus suffers whenever there are problems with governance, government irregularities or political instability. In many cases, church-based supply chains are not equipped enough to cope with shortages when government supply lines become paralysed or are incapacitated for one reason or another.

This problem is especially true with regard to **anti-retroviral (ARVs) and anti-malarial** drugs, the majority of which are supplied to African countries through international initiatives, such as the Global Health Initiative, which prefer to partner with governments rather than civil-society or faith-based facilities. The argument often made by international organisations for giving preference to government bodies, is that the faith-based sector is not developed enough to cope with the provision and management of drugs and medical supplies. Contrary to this assertion, however, evidence from the EPN study shows that church-based operations are largely successful at providing essential medicines and that, despite all of the funds dedicated to ARVs and anti-malarial, it is this **parallel system** established by governments and international organisations that is most prone to shortages. Faith-based facilities are urged to carry more research into this area and advocate for policies which reduce their dependence on government and international supply chains.

A third conclusion from the study is that there are not enough church-based health facilities that **have guidelines on how to treat and manage children**. Across the three countries, only 35% of health care facilities had specific guidelines to support health workers care for children. This points to a lack of appreciation for children as patients with a physiology distinct from that of adults; doses of medicines designed for adults cannot simply be cut in half for children, and children require different kinds of care. Studies have shown that the highest causes of mortality and morbidity among children can be **easily treated** and prevented when children are given the right care at the right time, suitable to their

physiology and needs. Healthcare workers should be better supported through the development of guidelines that outline how to care for child patients.

A fourth policy recommendation is that decisions pertaining to the purchasing of drugs in health facilities should be made by a **committee** or a team, rather than by the head of facility or other individual. Even in a small health facility, it is possible to create a group that collectively decides which medicines should be purchased and in what amount. This would make the decision about what kinds of drugs and what quantity less subjective and more likely to reflect the realistic need.

Lastly, **lack of funds** was cited in all three countries as the primary reason for shortage of essential medicines in church health facilities. This is partly due to inefficient supply and procurement chains, which require all facilities to buy independently rather than collectively. It is also due to a lack of diversity in funding sources. In the case of Uganda, for example, church-based health facilities depend to a very large extent on credit from the government. This was a factor constraining the ability of these facilities to purchase as and when required. Church-based health facilities are therefore recommended to, firstly, buy in bulk as this lowers the unit cost, and also to strengthen **internal resource mobilization** initiatives to ensure that their functioning is not linked on one source of funding.

The study contained a number of interesting results regarding the availability of essential drugs, for instance zinc, of which there is often a shortage. Church-based health facilities should carry out more **research** in their own procurement and supply systems to identify weaknesses and improvements.

Group discussion

Poverty was again highlighted as the reason why facilities had inadequate supplies of medicines. Health facilities are urged to carry out their own independent research projects to determine solutions to the problems they encounter.

Due to budget constraints, the EPN study was not able to survey all medical sites and especially the ones located in remote areas. However the findings of the study suggest that health facilities in hard to reach areas suffer from at least the same problems, and probably several others. Church-based health facilities hold a competitive advantage over other service providers in that they draw their mandate from their capacity to work in hard-to-reach areas as well as poverty stricken areas. It is therefore crucial that more information made available about the supply chain and affordability of paediatric medicines in these areas.

ADDRESSING HUMAN RESOURCES FOR HEALTH CHALLENGES IN THE SCALE UP OF MATERNAL AND CHILD HEALTH SERVICES.

This session was organised by the Capacity Project funded by USAID through IMA World Health and CORDAID. The session was moderated by Frank Dimmock from PCUSA in Lesotho. Presentations on HR with 3 country perspectives were presented by a panel comprising of;

- Mr. Stenford Zulu, Human Resource Manager, Christian Health Association of Zambia (CHAZ)
- Dr. Jane Kahabi, Technical Support Officer, Christian Social Services Commission, Tanzania (CSSC)
- Dr. Eburnabo Eburnas, Eglise du Christ au Congo, Département des Oeuvres Médicales (ECC)

Frank Dimmock gave an overview of HRH challenge in Africa and invited the panellists to share country perspectives on how they were dealing with the challenge. Stenford Zulu discussed the importance of human resource management (HRM) for scaling-up maternal and child health care services in the context of Zambia. His presentation was then followed by Dr. Jane Khabi, Technical Support Officer, CSSC, who discussed the 'Three Pillars of Intervention' strategic model through which the CSSC works to accomplish its mandate. The last presentation was given by Dr. Eburno Ebunas, Eglise du Christ au Congo, Département des Oeuvres Médicales, who discussed HRM and maternal and child health in the Democratic Republic of Congo.

HRM entails all the practices and procedures implemented to attract, maintain and develop employees. It includes all the activities involved with hiring, salaries and capacity building of employees, including training.

ROLE OF HUMAN RESOURCE MANAGEMENT (HRM) IN ENHANCING MATERNAL AND CHILD HEALTH.

By Stenford Zulu, CHURCHES HEALTH ASSOCIATION OF ZAMBIA (CHAZ)

Mr Zulu reported that the scaling-up of maternal and child health care in Zambia faces two primary challenges, which HRM is able to address.

1. Capacity building of staff: having qualified staff at professional and technical levels who are motivated and able to perform their duties (community health workers, non-health workers and secretariat)
2. Staff retention: reducing staff attrition rates and encouraging better performance.

The **James Cairns Training Institute**, owned and operated by CHAZ, is one of the HRM mechanisms contributing to the **capacity development** of staff serving in Mission hospitals in rural and remote areas. Specific training on maternal and child health for midwives, Traditional Birth Attendants (TBAs), and other qualified health care workers includes courses on Prevention of Mother to Child Transmission of HIV (PMTCT), drugs and provision of medical kits, and malaria prophylaxis, and awareness campaigns. Training is conducted through seminars, short courses led by Ministry of Health experts, as well as longer courses run through certain universities.

With regard to **staff retention**, health care facilities worldwide struggle with problems of low motivation among their staff, unfavourable work environment, comparatively low salaries and high attrition rates. In order to address these problems, CHAZ introduced two initiatives: the **Zambian Health Workers Retention Scheme** in collaboration with the Ministry of Health, and a **Performance Based Funding programme (PBF)** for midwives. Both of these initiatives were made possible by a **Memorandum of Understanding (MoU)** between CHAZ and the **Zambian Ministry of Health**.

The **Health Workers Retention scheme** has three main objectives: (a) to attract and retain medical professionals in rural areas, (b) increase the number of health professionals graduates by increasing the number of tutors to the Nursing Schools so that the schools can increase student intakes, and (c) address the critical shortage of staff in hard to reach rural health facilities.

Individuals selected for the scheme are given a monthly allowance and benefit from a vehicle loan and house renovation payments. They also receive an end of contract bonus upon completion of the 36-month consecutive scheme contract.

The **PBF programme** is a concept currently being governed and piloted by the Ministry of Health and the World Bank. It aims to improve the provision of health care services by rewarding midwives for high performance. Evidence suggests that integrating a system of **incentives** into HRM policies increases motivation and helps lower staff attrition rates.

THE ROLE OF THE CHRISTIAN SOCIAL SERVICES COMMISSION (CSSC) IN SUPPORTING FAITH-BASED ORGANISATIONS (FBO) IN TANZANIA

By Dr. Jane Kahabi, CSSC, Tanzania

The CSSC is an ecumenical body founded by the Tanzania Episcopal Conference (TEC) & the Christian Council of Tanzania (CCT). It works closely with the government of Tanzania to provide the community with equitable quality services in health and education. As such, its objective is to support the delivery of social services by church institutions in Tanzania through collaboration, advocacy, lobbying, capacity building and the compassion and love for Christ.

The three focus areas constituting the CSSC's '**Three Pillars**' of action are **health, education and cross-cutting interventions**, (this last one involves gender, governance, environment and other population-related priority areas). This tri-partite approach recognises that sustainable solutions to community problems require **multi-sectoral action** based on the understanding that health and education are linked to each other, as well as to other economic, political, cultural and social factors. Any attempt to improve the quality of, and access to, health care and education must address the wider context in which these issues are placed. As such, **advocacy, partnership building and capacity development**, supported by resource mobilisation, evidence gathering, and communications activities, are coordinated across focus areas in an attempt to enhance efficacy.

The CSSC still faces **challenges** relating to a lack of financial support from the government (despite having entered into a Service Level Agreement with the Ministry of Health and Social Welfare), lack of human resources at the district level and in rural communities, limited resources for educational activities, weak linkages with local government initiatives, and a lack of priority by the government to engage in public-private partnerships. To overcome these challenges, the CSSC plans to strengthen internal resource mobilisation to diversify funding sources, lobby for increased professionalism at the district level, strengthening links with government and other non-governmental initiatives on health and education, improve internal data management systems and discuss challenges with national bodies and councils.

SANRU PROGRAMME: BUILDING THE CAPACITY OF HUMAN RESOURCES TO IMPROVE MATERNAL AND CHILD HEALTH IN THE DRC.

By Dr. Eburnabo Eburnas, Church of Christ, DRC

HRM is of particular importance to the faith-based health sector in the DRC, where competent medical staff are available, but with inequitable distribution in the different areas. The **SANRU programme** was implemented with the aim of redistributing staff to under staffed areas, increasing morale and addressing the competition that faith-based health care providers often face from the private sector. Since 2007, the

SANRU programme, which is a collaborative initiative by the Church of Christ, USAID and IMA World Health, has improved the quality and quantity of prenatal consultations, assisted deliveries, family planning services and vaccination coverage rates.

Despite a high number of students graduating from universities who are qualified to work as nurses or doctors, many choose to work abroad or in big cities rather than in the rural areas where they are needed most. Conditions of poverty, lack of infrastructure and low morale have been fuelling the **brain-drain**, with disastrous consequences for maternal and child health care. For example it has been shown that without the qualified staff available when needed, there is low follow-through on pre-natal consultations, lower percentage and quality of assisted deliveries, and low counselling in the use of contraceptives. This results in higher rates of maternal and newborn mortality. Furthermore, the lack of availability of continuous training for health care workers means that their knowledge gained at university level is not regularly updated. This is another barrier preventing women and children from accessing quality health care.

In terms of **capacity building**, SANRU focused on training resident doctors at the central, provincial and operational levels in family medicine. This included post-training follow up visits to monitor HRM. The programme also provided funding for transportation vehicles, subsidies, building and repair of infrastructure. Moreover, SANRU re-established cold chain facilities which improved the storage of medicine and vaccines.

Lessons learned from the implementation of SANRU highlight the importance of **scholarships and subsidies** for continuing training and offering incentives for qualified staff to stay and work for family health in rural communities. **Post-training visits** are also important as monitoring can prevent a problem from occurring. Thirdly, **development models** to health care are more cost effective and efficient than other short-term disaster alleviating models. One of the main reasons why SANRU succeeded is that it addressed the underlying socio-economic reasons for ill health in the community. Another reason contributing to its success is the emphasis put on working in partnership with a wide variety of governmental, civil society and international organisations.

Group discussion

Creating and enforcing **training bonds** to keep newly trained personnel in areas of need was noted as a particular challenge facing many CHAs. Legal bonds, through use of a contract, have been implemented to a certain amount of success. Another suggestion of a **social bond** was raised, whereby a trainee's family and friends are invited to share in the post-training celebration and to recognise the responsibility that the trainee has just taken to serve those most in need.

STRENGTHENING THE MANAGEMENT AND LEADERSHIP CAPACITY OF HEALTH CARE PROVIDERS IN AFRICA: THE JOHNSON & JOHNSON (MDI) APPROACH.

By Rene Kiamba, Family of Companies Contribution Fund manager, Sub-Saharan Africa, Johnson & Johnson

Good management skills are essential for the functioning of a health sector. This is especially true of the health care sector in Sub-Saharan Africa where operations are often weakened by a shortage of financial

resources, medicine, infrastructure and technology compounded by weak governance structures and a growing disease burden.

The keynote speaker for this session, Rene Kiamba, explained how important it is to have trained managers in Africa who are able to navigate the difficult conditions with which they must work and ensure that limited resources under their stewardship are efficiently handled. This is why Johnson & Johnson has been working in partnership with universities and research foundations in Africa to develop a **training course for managers**, the Management Develop Institute (MDI), to help them develop the leadership competencies much needed in their post.

The need for an establishment such as MDI was highlighted by a report which revealed that 75% of HR managers in Kenya, Ethiopia, Tanzania and Uganda **lacked the knowledge and skills** to carry out the numerous HRM functions. This is because there is a trend to promote a competent member of the medical staff, such as doctors or nurses, to managerial positions in district offices or the Ministry of Health based on acumen in clinical and surgical skills, which has no relation to managerial and leadership skills. These individuals thus assume managerial position without being trained in leadership. These leadership skills include, for example, financial and operations management, monitoring and evaluation, resolving conflict, negotiating and delegating. These are competencies that can be developed through training and experience. It is on this premise that MDI launched its programme in Sub-Saharan Africa, which is taught mainly by local staff drawn largely from the relevant technical and geographic context.

As such, the MDI is a **community health programme** for health workers in managerial positions. It is expected that after the participants complete the training, they are able to return to their facilities and provide better services to the people in their community. *Johnson & Johnson* has also developed a system to measure the impact of the programme, thereby determining its success and enabling improvement to be made to the curriculum where necessary.

Until 2010 the programme focused on developing leadership skills specifically in the field of HIV/AIDS. In 2011 it was decided that MDI should take a new strategic direction, aiming to strengthen not just capacity with regard to HIV/AIDS but to better equip managers more generally to address national health care priorities and the health needs of the population. This reflects the **broader goals** of MDI and its partners, of replacing emergency health plans with more sustainable long-term interventions, integrating and coordinating public health programmes led by both government and NGOs, and investing in innovations and research to maximize outcomes.

Several training sessions are scheduled to take place in 2011 in east, west and southern Africa. For more information on these courses, visit the following website <http://www.anderson.ucla.edu/mdi.xml>

Group discussion

Participants welcomed the MDI programme as a way of enhancing **public-private partnership**, which is often an under-utilised tool. It was emphasised that private sector companies are able to contribute positively to the work being carried out by faith-based organisations, and they are willing to increase collaboration. Companies are attracted to organisations that **show initiative** and can demonstrate a desire to take concrete action.

With regard to the **content** of the MDI training programmes, suggestions were made as to what would be useful for FBOs to see incorporated into the modules. For example, it was noted that managers of CHAs

often **struggle to raise resources** from both government as well as from within the faith-based sector, and to design business plans that are attractive to donors. Managers in this sector would like these issues to be addressed in the curriculum. Participants were reminded that the content of the MDI course modules is adapted according to the target audience and the country in which it is to take place. There is, therefore, always scope to include areas of need

Participants expressed the need for MDI to facilitate access to the training opportunities for health workers from Church health facilities and CHAs.

Ends

SPONSORSHIP

The conference was made possible through the support of the following partners:

- **ICCO**
- **CORDAID**
- **MISEREOR**
- **DIFAEM**
- **WCC**
- **THE WORLD BANK**
- **JOHNSON & JOHNSON**
- **CCIH – sponsored the facilitators for the Pre-Conference Workshops**
- **EPN – provided the Conference Bags**

ANNEX 1 : CONFERENCE PROGRAMME

Time	21 st February 2011	22 nd February 2011	23 rd February 2011	24 th February 2011
0830-1000	<p>Pre-conference Workshops</p> <p>Workshop Session 1:</p> <p><u>Workshop I:</u> Strategic Leadership principles & tools for Health System transformation (part one – Prof Henry Mosley, CCIH/John Hopkins School of Public Health</p> <p><u>Workshop II:</u> Strengthening & expanding Family Planning in comprehensive health services: new approaches (part one) - Dr Douglas Huber (CCIH) and Victoria Jennings (IRH/Georgetown University)</p>	<p>Technical Session 1:</p> <ul style="list-style-type: none"> Theological imperative for Christian health services to assist in the enhancement of the health care of women and children – Prof. Dr. Deji Isaac Ayegboyin, AACC Facing the maternal health and child health MDG challenge – UNFPA Country Director, Ghana 	<p>Technical Session 4:</p> <p>Building Partnership for improved maternal & child health services (GHI/PEPFAR UN, GAVI, IHP)</p> <p>Key note address – Dr Susan K. Brems, Bureau for Global Health, USAID – ‘USAID Procurement reforms’</p> <p>Ari Alexander – <i>FBO initiative under President Obama; opportunities for capacity building of local organizations’</i> /Panel session with above Agencies</p>	<p>ACHAP General Assembly Meeting Session 1</p>
1030-1200		<p>Official Conference Opening Ceremony</p> <p>CHAG, ACHAP, UNFPA, MOH</p>	<p>Technical Session 5:</p> <p>Access to essential health commodities for maternal and child health - EPN</p>	<p>ACHAP General Assembly Meeting Session 2</p>
1200-1330	LUNCH			
1330-1500	<p>Workshop Session 2</p> <p><u>Workshop I:</u> Strategic Leadership principles & tools for Health System transformation (part two – Prof Henry Mosley, CCIH/John Hopkins School of Public Health</p>	<p>Technical Session 2:</p> <p>Assessing the faith based health sector; discussion on information streams, gaps and research tools required – Jill Olivier</p>	<p>Technical Session 6:</p> <p>Addressing the HRH challenges in the scale up of maternal & child health services – IMAWH, Cordaid, CHAs-HRH-TWG</p>	<p>ACHAP General Assembly Meeting Session 3</p>
1530-1700	<p><u>Workshop II:</u> Strengthening & expanding Family Planning in comprehensive health</p>	<p>Technical Session 3:</p> <p>Return to PHC ensuring acceptable maternal and child health services at the</p>	<p>Technical session 7:</p> <p>Strengthening management & leadership capacity of health care providers</p>	<p>Conference closure.</p>

	services: new approaches (part two) - Dr Douglas Huber (CCIH) and Victoria Jennings (IRH /Georgetown University)	community level: CHAG	in Africa; MDI approach – Johnson & Johnson	
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ANNEX 2: LIST OF PARTICIPANTS

NAME	ORGANIZATION	EMAIL
Anglebert Mbengwa	ZACH	mbengwa@zach.org.zw
Juma Mkanda	ZACH	mkanda@zach.org.zw
Prosper Sapathy	ICCO	prosper.sapathy@icco.nl
Josephat Kakoma	CHAZ	josephat@kakoma@chaz.org.zm
Erika Pearl	IMA	erikapearl@imaworldhealth.org
Frank Dimmock	CHAL	fdimmock@gmail.com
Jonathan Kiliko	MEDS	jkiliko@meds.or.ke
Charles Kimani	MEDS	ckimani@meds.or.ke
Andrew Karani	CHAK	karani@chak.or.ke
Eya Mwenifumbo	CHAM	mwenieya@yahoo.com
Juma Augustine	CHAS	jummaug@yahoo.com
Ernest Nwaigbo	AHN	enestica@yahoo.com
Karen Sichinga	CHAZ	karen.sichinga@chaz.org.zm
Devina Patel	CCIH	devina.patel@ccih.org
James Mireri	EPN	jmireri@epnetwork.org
Djekadoum Ndilta	BAC	ndilta@yahoo.fr
Henry Mosely	CCIH	hmoseley@jhsph.edu
Richard Santos	IMA	ricksantos@imaworldhealth.org
Sarla Chand	IMA	sarlachand@imaworldhealth.org
Elisha Sanoussi	UEEPN	Elisha_nassara@yahoo.fr
Mukaire Joy	CHAS	joymukaire@yahoo.com
Ari Alexander	USAID	aalexander@usaid.gov
Rose Kumwenda	CHAM	rosek@cham.org.zm
Sebastien Dackpa	ASSOMESCA	dackpasebastien@yahoo.fr
Ebunabo Ebunas	ECC-DOM	jbebunas@yahoo.fr
Susan Brems	USAID	sbrems@usaid.gov
Geertje van Mensvoort	Cordaid	gen@cordaid.nl
Cleto Maclut	CHHS	cletopasquale403@hotmail.com
Jacinta Mutegi	KEC	jmutegi@catholicchurch.or.ke
Gladys Mburu	MEDS	gmburu@meds.or.ke
Stella Etemesi	KEMRI	stella.etemesi@gmail.com
Peter Jaden	CHAS	lojaden@gmail.com
Albert Petersen	DIFAM	albpetersen@googlemail.com
Donna Kusemererwa	EPN	dkusemererwa@epnetwork.org
Dhally Menda	CHAZ	dhally.menda@chaz.org.zm
Stenford Zulu	CHAZ	stenford.zulu@chaz.org.zm
Jeanette Cachan	Georgetown Uni	cachanj@georgetown.edu

Craig Hafner	IMA	craighafner@imaworldhealth.org
Claudia Zambra	WFDD	claudiazambra@wfdd.us
Daniel Gobgab	CHAN	gobgab@yahoo.com
Ray Martin	CCIH	martinrs@aol.com
Wilma Rozenga	ICCO RO, CEA	wilma.rozenqa@icco.nl
Nick Shaiyen	CHAN MEDI-PHARM	nick.shaiyen@gmail.com
Matthew Azoji	CHAN MEDI-PHARM	matthew.azoji@gmail.com
Elisabeth Goffin	EPN	egoffin@epnetwork.org
Lauren Van Enk	Georgetown Uni	lev9@georgetown.edu
Chitimbire VTS	ZACH	chitimbire@zach.org.zw
Jane Kahabi	CSSC	jkahabi@cssc.or.tz
Douglas Huber	CCIH	DouglasHuber77@yahoo.com
Samuel Mwenda	CHAK	mwenda@chak.or.ke
Aaron Wright	CHAL	jawrightlib@yahoo.com
Akpene Nyomi	WCC	akpenen@gmail.com
Deji Issac	AACC	dejigboyin@yahoo.com
Jill Oliver	World Bank	joliver@worldbank.org
Melissa Kaminker	ACHAP/WCC	melissa@chak.or.ke
Michael Mugweru	ACHAP	chas@chak.or.ke
Patrick Kwakfut	CHAN	kwakfut2@yahoo.com
Peter Asiiimwe	UCMB	pasiimwe@ucmb.co.ug
Peter Yeboah	CHAG	yebpeter@yahoo.com
Gilbert Buckle	CHAG	gilbertbuckle@yahoo.com
James Boateng	CHAG	yawjboat@yahoo.com