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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 networks (CHN) from Sub-Saharan Africa and their development partners. ACHAP currently has 26 member organizations from 21 countries of Africa who provide a significant proportion of health services which range between 20-50% of the national health services.

Margaret Chan, Director General of the World Health Organization notes that; "Universal Health Coverage is the single most powerful concept that public health has to offer. It is inclusive, unifies services and delivers them in a comprehensive and integrated way based on Primary Health Care” Universal Health Coverage is firmly based on the WHO declaration of health as a fundamental human right and on the “Health for All” primary health care declaration of Alma Atta.

The FBO Health Sector in Africa

Faith-based organizations (FBOs) and particularly Church-owned/Christian health facilities, play a key role in providing health care in many parts of the world and particularly in Sub-Saharan Africa. According to the World Health Organization (WHO), FBOs in Africa contribute a substantial proportion of health services particularly in the remote rural areas. ACHAP estimates that 20% to 40% of health care services are provided by FBOs in several Sub-Saharan Africa countries.

[Graph: Contribution of Christian Health Networks to the National Health Sector in Select African Countries]

Contribution of Church Health Networks to the National Health Sector. Source: Frank Dimmock 2009.

In addition, FBOs serve in remote and rural areas where the public sector has difficulty attracting and retaining health workers. FBOs in most countries continue to remain under recognized for their immense contributions to the health sector and are often not integrated into planning and resource allocation for national health system.

ACHAP therefore serves as a voice for many FBO service providers in Africa and exists to facilitate joint advocacy for its members on regional and global health sector initiatives and agendas such as the need for universal health coverage, primary health care, health systems strengthening and HIV/TB/Malaria pandemics, public-private-partnerships and other health priorities such as the current Ebola crisis.
ACHAP members, acknowledging their unique dual role of advocacy and service delivery towards improving access to quality healthcare in general including universal health coverage therefore dedicated their 7th Biennial Conference and General Assembly meeting to the theme of: “The role of the faith based health services in contributing to universal health coverage in Africa”

The conference attracted 126 delegates from Africa, Europe and USA discussed global commitments and developments towards universal health coverage and the opportunities for faith based health services in scaling up their contribution towards UHC.

The conference objectives included:

- To strengthen the knowledge base of Africa Christian Health Associations and Church Health Networks and participants on global perspectives of universal health coverage
- To share country experiences in national health sector reforms towards universal health coverage and discuss strategic involvement of FBO health sector
- To identify and discuss approaches for sustainable health financing within the FBO health sector
- To discuss health systems strengthening and partnership opportunities for universal health coverage
- To provide an opportunity for ACHAP to hold its 7th General Assembly business meeting to review and adopt its five-year Strategic Plan for the period 2015 - 2019

The keynote address was delivered by Dr Custodia Mandlhate, WHO Country Representative for Kenya which covered global perspectives on the evolution of health services from the advent of primary health care in 1978 to the current focus on universal health coverage. She acknowledged the critical role of faith based health services in Africa; “The World Health Organization, which I represent here, recognizes the critical role played by Christian Churches in providing important health services particularly to the poorest and needy populations in Africa” (Dr Custodia Mandlhate, WHO Country Representative for Kenya.)
Prof. Khama Rogo from World Bank Group delivered a presentation on financing models for UHC in which he highlighted the various financing sources for health services that FBOs can leverage towards UHC in Africa. He further challenged FBO health facilities to strengthen governance and management to enhance efficiency. Bishop Michael Sande, Chairman of CHAK led the conference opening devotion in which he gave the Biblical foundation for the health ministry of the Church making reference to the Book of Ezekiel. He observed that individuals and families were getting impoverished by the burden of health care hence the conference theme was most relevant and timely. The official opening address was delivered by Dr Nicholas Muraguri, Director of Medical Services, Ministry of Health Kenya which was delivered by Dr Odongo, Head of Curative & Rehabilitative Services. In his address, the DMS provided Kenya progress with health sector reforms and the roadmap towards attaining universal health coverage.

The conference held a session on partner engagement for UHC which was addressed by Katherine Perry, PEPFAR Kenya Coordinator, Barbara Hughes Director of USAID Programs in East Africa and also chair of the Development Partners for Health in Kenya, Cynthia Macharia from GIZ who gave lessons on output based financing from Kenya and Philippines and Dr Amit Thakker chair of Private Sector East Africa Health Platform who gave an overview of public-private-partnerships in the East Africa region. Other key note speakers included Prof. Miriam Were a renowned globally celebrated public health specialist, Jean Duff from Joint Learning Initiative USA, Rick Santos President & CEO of IMA WorldHealth and John Blevins of Emory University who made a compelling case for effective institutional and community based health services for UHC.

The conference provided a rich and diverse program with experiences shared by representatives from CHAs from various countries of Africa and partners who support health programs in Africa. The main conference was proceeded by pre-conference technical workshops on;

- Ebola crisis response – by WCC and UNAIDS
- Reproductive health and Family Planning – by Evidence-2-Action Project, CCIH and IRH
- FBO Health Systems Strengthening for UHC – by CRS
The Vice-president of Astra Zeneca Healthy Hearts Africa programme, Samer Al Hallaq presented their new partnership initiative whose goal is to reach over 10 million people in Africa with Hypertension education, screening and management. CHAK is an implementing partner in the Health Hearts Africa pilot project which has started in Kenya.

The conference delegates released a conference statement which articulated the key recommendations and commitment on universal health coverage by CHAs in Africa. They committed to strive to promote the provision of comprehensive package of quality services, increased access and utilization of services and reduction of financial risks associated with accessing needed health services. At the conclusion of the conference, ACHAP held its Biennial General Assembly which endorsed ACHAP Strategic Plan 2015 – 2019 and re-elected the Board to serve a second two-year term. Karen Sichinga, the Board chair thanked the funding partners, the delegates and the host CHAK for making the 7th Biennial ACHAP conference a great success.

Outputs from Conference:

- Improved understanding of Universal Health Coverage among ACHAP members
- A conference statement of commitment and consensus on joint advocacy for universal health coverage in Africa by ACHAP members.
- ACHAP general assembly held and five-year strategic plan adopted

1. **DAY ONE, Monday, 23rd FEBRUARY 2015**

**EBOLA CRISIS RESPONSE; CRITICAL ROLES TO PLAY IN PREPAREDNESS, SCALE UP AND ADVOCACY.**

Moderated by the World Council of Churches- WCC.

It was said that partners such as the World Bank were putting emphasis on evidence and value for money, hence Christian Health Associations needed to demonstrate that they have systems that support transparency and that are not profligate. In addition Christian Health Associations needed to show their relevance and make cases for inclusion in government decision making by marketing their assets.

Faith based players were encouraged to collaborate across denominational lines in order to deliver on a large scale capacity, they were also encouraged to make evidence based cases to government, especially demonstrations of how they deliver health to the poorest of the poor. It was said that data on the service delivery of faith based players was limited and “silo-ed”. The Churches Health Association of Zambia said that they had designed their own forms which they use to collect information from lower-level institutions; they also have a team dedicated to monitoring and evaluation. They had employed data clerks to help collect information and moved to web based reporting from 2014.

The Joint learning initiative on faith and local communities said it was involved in strengthening the capacity of faith groups to collect and communicate data.
It was also said that the Christian Health Association of Ghana partnered with DANIDA to craft an Ebola response strategy without waiting for the government to approach them. CHAG showcased its reach to partners by mobilizing chiefs and traditional leaders to the Ebola needs assessment phase. The Christian Health Association of Malawi called for the use of telemedicine to support information dissemination in rural areas.

In Mali and Burkina Faso, it was said that the CHA’s involved religious leaders from across different faiths in training which led to behavior change in the fight to contain the spread of Ebola. The buy-in from religious leaders helped negate stigma

An audio tape was presented of Patricia Kamara from CHALiberia talking of the steps that they took in collaboration with government to mitigate against the Ebola outbreak that affected Liberia in early 2014.

Presentations on the Ebola Crisis response are available on the ACHAP website.
http://africachap.org/en/presentations/

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REPRODUCTIVE HEALTH AND FAMILY PLANNING, SHARING AND LEARNING FROM BEST PRACTICES FROM FAITH BASED INSTITUTIONS.

Moderated by CCIH, E2A and University of Georgetown.

The four pillars of comprehensive approach to prevention of mother-to-child transmission recommended by WHO were presented. They included preventing infection in women of child-bearing-age, preventing un-intended pregnancy among women living with HIV, preventing transmission from pregnant women to their infants and providing care and support for mothers living with HIV, together with their children and families.

Faith Based advise to couples who were sero-discordant (one infected with HIV while the other was not) was offered including praying together, deciding to be faithful to each other and fitting post/ante-natal, child immunizations, church services and community events into existing supportive services. Other issues discussed include engagement of men in family planning. It was said that men need to be involved because they are the prime decision makers in matters sexual in the family, in addition, involving men can lead to improvement in intra-spousal communication. Pastors who were invited to the pre-conference expressed support for family planning and requested for additional training to better equip them. It was also noted that pregnancies among women who were too old, too young resulted in maternal death or disability as well as abortions. In Ethiopia it was noted that religious leaders used their status to address social and religious misconceptions around family planning. The messages that went out included; family planning was not a sin, children should not die as a result of inadequate care and mothers should not die because of pregnancy. In Kenya, religious leaders have been trained to deliver messages on what child spacing is all about. In Uganda, religious leaders emphasize the health benefits of child spacing.
Natural Family planning methods from Uganda were also presented and they included Lactational Amenorrhea Method, Standard Days Method with CycleBeads, TwoDay Methods, and Billings.

The full presentations on reproductive health and family planning is available on the ACHAP website: http://africachap.org/en/presentations/

Participants at the ACHAP biennial conference

**FBOs systems strengthening for universal health access.**

Moderated by the Catholic Relief Services- CRS

The health systems strengthening pre-conference concentrated on the work that CRS does to strengthen the capacity of organizations which included

- Perform Health System bottleneck analysis
- Helping organizations develop concept notes
- Helping organizations develop full-fledged proposals

Other organizations that presented during the systems strengthening pre-conference included CHRESO ministries which runs an Orphan Home and OVC support programs
Chreso Ministries provides HIV and AIDS care, treatment and support services in 5 sites located in Central, Lusaka and Southern provinces of Zambia. According to CHRESO an effective system consists of 6 building blocks as shown below:

CHRESO also undertakes the following activities in order to strengthen its service delivery component.

- Technical support supervision
- Health financing to supported sites
- Collaboration with other implementing partners

The full presentation on systems strengthening is available on the ACHAP website: www.africachap.org/ http://africachap.org/en/presentations/
Tuesday 24<sup>th</sup> February 2015

**INTRODUCTION AND CONFERENCE OBJECTIVES**

Dr. Samuel Mwenda who is the General Secretary of CHAK, the host of the conference officially welcomed the guests and highlighted the Conference outputs which included:

- Improved understanding of Universal Health Coverage and opportunities for scaling up FBOs contribution.
- Issuing of a conference statement of commitment and consensus on joint advocacy for universal health coverage in Africa by ACHAP members.
- Holding the ACHAP General Assembly and adopting the five-year strategic plan.

**Keynote address**

**GLOBAL PERSPECTIVES OF UNIVERSAL HEALTH COVERAGE AND ITS RELATIONSHIP WITH PRIMARY HEALTH CARE (PHC).**

**By Dr. Custodhia Mandhlate**

Dr. Mandhlate gave a background of the phases that health services have undergone in Africa from the 60’s. She stated that the **first phase** from the 60-70’s was focused on expansion of an health units and hospitals. She said that healthcare services were affordable and that government invested in the health sector. The **second phase** from the 70’s was characterized by a decrease in access to capital. This resulted in a massive shortage of human resources and medicines. Traditional medicine grew and government priority became maintenance of existing infrastructure as well as the level of care. She added that the near-collapse of many healthcare systems prompted global discussions and led to the adoption of the known **1978 Alma Ata declaration on Primary Health Care**. She added that the **third phase** of healthcare delivery which started in the 80’s focused on addressing medical and social determinants of health. Hence the phase was characterized by targeted focus on key interventions that were deemed as most important or cost effective.

However due to external factors such as famines, wars, and economic mismanagement, many of the targeted focus goals were not met. Populations died from conditions like diarrheal diseases, malnutrition, malaria, leading to health mortality levels being unchanged. The fourth phase was characterized by the need to significantly reduce the public costs of services provision, leading to reductions in government health operations due to fewer demotivated and underproductive health workers and a re-introduction of cost recovery through user charges that had been phased out in many countries. The health services were characterized by poorer quality, aggravated by higher barriers to access of services and this led in many countries to worsening many of the health indicators.

Challenges facing Universal health coverage were enumerated, they included a high burden of communicable conditions, lack of access to essential health services and lack of proper systems that will ensure interventions are delivered.
In order to overcome the challenges enumerated, she advocated for a change of focus from provision of a basic package of services to provision of comprehensive services. Others included a shift in focus from mothers and children to a focus on ALL disadvantaged groups. From a focus on acute infectious diseases to a focus on health risks and challenges across all life cohorts.

- From a focus on ensuring a healthy local environment around an individual, to investments ensuring healthy global, and local environments – we can use the ongoing Ebola Virus Disease epidemic response to emphasizes the need for this approach.

- From scarcity and downsizing of health services, towards planning for managed growth of services towards universal coverage with needed health services

- From government provided, top down services to building public private partnership that ensure most effective provision of services

- From a focus on primary care services, to investing in all levels of the health services based on the needs, with a functional referral system

- And finally, from a focus that Primary Health Care is cheap, to recognizing that health service investments are NOT CHEAP, but should provide good value for money.

The full summary of Custodia Mandhlate’s presentation can be found on the ACHAP website on the following link:

KENYA HEALTH SECTOR REFORMS AND ROADMAP TOWARDS UNIVERSAL HEALTH COVERAGE

By Dr. Izaaq Odongo

Dr. Izaaq Odongo, the head of the Department of Curative and Rehabilitative Health Services at the Ministry of Health, Kenya gave an overview of Kenya’s policy and legal framework, governing the country’s vision in health. He stated that the Kenyan constitution provides for the right to health, including the right to emergency care and reproductive health.

He also outlined the status of selected health indicators which included the following:

- Decline in Infant Mortality Rates from 77 per 1000 live births in 2003 to about 52 per 1000 in 2010
- Decline in Under Five Mortality from 115 to 74 live births over the same period
- Newborn Mortality Rate declined from 33 to 31 per 1000 over the same period.
- Full immunization against major illnesses improved from 58 per cent in 2003 to 83 per cent currently

Free maternity services in all public health facilities since 2013 has meant facility utilization has increased from 43 to 67 per cent. In addition, free primary healthcare in all public primary healthcare facilities has been introduced. The government had already signed a contract with suppliers to equip at least 94 major public hospitals across the country with modern diagnostic equipment. Furthermore, the government had introduced health insurance subsidies through the National Health Insurance Fund, targeting disadvantaged groups. Other measures undertaken include provision of Ambulances and recruitment of additional health workers.

The full summary on Kenya Health Sector reforms and roadmap can be found on the ACHAP website on the following link:

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**HEALTH FINANCING MODELS FOR UNIVERSAL HEALTH COVERAGE**

By Dr. Khama Rogo

Contact the author: krogo@worldbank.org

Dr. Khama Rogo gave an overview of the challenges facing health financing in low income countries, these includes additional investments from both domestic and International resources, • Equitable and sustained progress as countries transition from low- to middle-income status, • Inefficiencies in RMNCAH investments due to poor targeting and fragmented financing and a poor state of civil registration and vital statistics systems.

Key focus areas of the Global Fund:
- Mobilize and channel additional international and domestic resources required to scale up and sustain efficient and equitable delivery of quality RMNCAH services.
- Support the transition to long-term sustainable domestic financing for RMNCAH.
- Special focus on the scale up of Civil Registration and Vital Statistics to contribute to universal registration of every pregnancy, every birth and every death by 2030

**Commitments to the GFF by developed nations**
- CANADA
  $200 million
• NORWAY
$600 million
• UNITED STATES
Up to $400 million in leveraged resources through financing mechanisms and public-private Partnerships

• IDA- International Development Association
Low-interest loans and grants, leveraging up to $3.2 billion

He asked FBO’s to request for cooperation with Africa philanthropic organizations as well as adopt social franchising business models.

The presentation on health financing and innovative models for UHC can be found on the following link on the ACHAP website:

_______________________________________________________________________

MAKING THE CASE FOR EFFECTIVE HEALTH PROGRAMS AND UNIVERSAL HEALTH COVERAGE

By Professor Miriam Were
Contact the author: miriam@were.or.ke

It was noted that effective Community health coverage involves:
• A good understanding of health promotion
• A good understanding of disease prevention of both communicable and non-communicable diseases;
• Excellent health-seeking behaviors
• Proper use of health facilities
• Compliant responses to the use of medicines and other advises from health systems such as guidance on proper housing and living conditions
• Appropriate referral arrangements form the community to the link health facility and up to specialist services
• Proper handling of the determinants of health and disease in the community and in the relationships with appropriate sectors such as education, food production, water management and sanitation and sewerage services.

Structure of an effective community health service.
It was said that an effective community health services consisted of the following building blocks:

(a) A clear goal, mission and vision
(b) Clear Organizational clarity arrangements. This includes the description of a community, the community health committee training unit, the scheme of service for community level health personnel, the curriculum for training of community level health workers among others.
(c) Establishment of standards for quality assurance community health services
(d) Client satisfaction feedback mechanism.

The full presentation on effective health programs and universal health can be found on the following link on the ACHAP website:

ROLE OF COMMUNITY HEALTH SYSTEMS IN UHC

By Jean Duff
Contact the author: duffjean@gmail.com

It was said that the World Bank's twin Goals:
- Boosting shared prosperity
- Ending extreme poverty people living on less than $1.25 per day by 2030

The President of the World Bank Jim Kim has called for:
- Global movement around the twin goals
- Solutions big enough for the challenge
- Preferential option for the poorest of the poor
- Country level full engagement with faith communities

To achieve Universal Health Coverage, the World Bank is advocating a people centred integrated care, approach of:

1. Encouraging people to stay healthy and prevent illness
2. Detecting health conditions early
3. Treating disease
4. Helping with rehabilitation

Other measures include:
• Advances in prevention
• Priority on health-related attitude and behavior change
• Funding favoring local partnership
• Donors’ country partnership with substantial engagement of faith communities.
• PPP/ Multi-sector alliances
• Emphasis on effectiveness and efficiency-- evidence & value for money
Opportunities for Faith Groups to strengthen Public Sector Partnerships include;
• Documenting facilities and congregational assets, and health outcomes
• Collaborate across denominational and faith lines to deliver large scale capacity
• Faith-based health systems partner with faith leaders on social and community mobilization for prevention, emergency response
• Demonstrate outcomes for poorest of the poor
• Hold public and private partners accountable
• Make collective, evidence-based case to governments for faith-based delivery & community outreach.

Joint Learning Initiative on Faith & Local Communities
It was said that data on faith groups is limited and ‘silo-ed’. What could faith groups do so that their work is better communicated to policy makers and practitioners?

Joint Learning Methodology

Learning Hubs promoted by the Joint Learning Methodology were listed as follows:

(a) **Resilience**: Impact of faith groups on promoting individual and community resilience

(b) **Immunization**: Contribution of faith groups to delivery of vaccines and immunizations.

(c) **Sexual and gender based violence**: Local faith communities’ roles in prevention and Strengthen capacity of faith groups to care for community and to collect and communicate data protection.

(d) **HIV and Maternal health**: Impact of faith groups on HIV and Maternal health, with special attention to PMTCT and skilled birth attendants.

(e) **Capacity Building**: Strengthen capacity of faith groups to care for community and to collect and communicate data.

The Joint Learning Methodology is organizing a **Conference in July 2015** on Effective partnerships between public sector and faith groups towards ending extreme poverty. It will be co-hosted by the World Bank, USAID, DFID, German BMZ, and others, in collaboration with JLIF&LC

The full presentation of the presentation on joint learning methodology is available on the ACHAP website link: http://africachap.org/x5/Conference%20downloads/Evidence%20drivers%20for%20effective%20partnerships%20Jean%20Duff.pdf
SUSTAINING AFRICA’S HEALTH RESPONSE (DOMESTIC HEALTH FINANCING MOBILIZATION). WORLD AIDS CAMPAIGN INTERNATIONAL.

By Rosemary Mburu,
Contact the author: mburur@worldaids.campaign.org

It was reported that the Global Fund is working towards

- **Leveraging its resources** to encourage increased Government commitment to disease programs & related health systems strengthening
- Improving **data quality and accessibility** for both domestic and international health funding
- **Identify and address rigid budgeting practices, allocative inefficiencies** that are obstacles to the reallocation of revenues towards health
- Fostering **effective dialogue between local health and finance officials** through creating space for discussion by empowering health officials and ensuring that finance has a better understanding of health issues.
- Supporting countries in establishing **an acceptable “benchmark”** on a country by country basis & discussions/support on **innovative domestic resource mobilization tools**
- Nurture **political leadership**, the Global Fund is nurturing ongoing work on multi-dimensional **advocacy and messaging** to ensure health is given top priority at national and international **levels**. This includes revisiting and raising awareness on **economic arguments for health**, including how it makes macro-economic sense

**Challenges and opportunities:**

- **Value for Money:** As the resource landscape is changing, focus is now more on improving health program efficiency and effectiveness which calls for both “more money for health and more health for money.”

- **Domestic Advocacy:** a large part of any increase in public funding for health will need to come from governments, therefore need to develop a convincing business and advocacy case for increased / sustainable public commitment to programs

- **Sustainability:** Domestic public spending should continue as economic growth continues, however it will not be sufficient to address all the health needs. Therefore, still a need for external resources in the short to medium term as well as to explore Private Sector partnerships & other innovative mechanisms.

The full presentation on sustaining Africa’s health response can be found on the ACHAP website link:
OUTPUT BASED FINANCING AND EXPERIENCE FROM ASIA, AFRICA AND THE MIDDLE EAST.

By Cynthia Macharia,
Contact the author: Cynthia.macharia@giz.de

Learning from successful models in Afghanistan, Philippines, Kenya.

Output based financing was described as cash payment or financial incentives made after predefined results been attained and verified. It is payment conditional on measurable and verifiable actions being undertaken. It places considerable emphasis on performance and results.

Kenya:
Output-Based Aid (OBA) voucher program
The voucher program is a performance-based reproductive health program that incentivizes access to women’s healthcare. The main target areas of the program are safe motherhood, clinical family planning and gender violence recovery services.

Three different vouchers are available:

(a) **The Safe Motherhood Voucher**: entitles women to a variety of services from professional antenatal care, delivery services, and referral to hospitals when needed. Members of the target group have to pay Kshs. 200 (US $2.50) for a safe motherhood voucher. The costs it covers can amount to Kshs. 20,000 (US $200) and higher in case of complications.

(b) **The Family Planning Voucher**: entitles clients to long term contraception methods including monitoring, referral and consultation. This voucher offers a range of family planning procedures such as intrauterine contraceptive devices (IUCD) and both male (vasectomy) and female (bilateral tubal ligation) voluntary contraceptive surgery. The voucher costs Kshs. 100 (~US $1) and buys up to Kshs 3,000 worth of services.

(c) **The Gender Violence Services Voucher**: entitles victims to medical and surgical treatment as well as counseling. It is provided to clients free of charge.

Results: The prices of services are lower. US$ 20 (200 KES) compared to public health facilities ranging from US$ 60 to US$150. As a result, the program has provided clients with over 96,000 facility-based deliveries and over 27,000 long-term family planning methods.

Afghanistan
The objective of the model was to assist the Ministry of Public Health improve delivery of basic package of health services and increase equity in delivery of services.
• NGOs paid annual performance bonuses on the basis of delivering a basic package of health care for mothers and children and achieving agreed quality-of-care targets (based on balance score card).
• Poor performers risked contract termination.

Results showed improved quality of care, increased deliveries by skilled birth attendants; increased contraceptive prevalence and the utilisation of antenatal care.

**Philippines**
*(Conditional cash transfer)*

The objective of the model was using performance-based grants to encourage behaviour change among poor households to increase uptake of health services.

The intervention included households receiving cash transfers for meeting basic health conditions, including regular checkups for pregnant women and children under 5, and in-school deworming for school going children. Poor households were identified through proxy means testing. Health facilities were responsible for reporting on whether families have met the conditions for receiving their monthly payment.

Results showed an increase in uptake of prenatal care services by mothers, reduction in severe stunting for very young children and an increase in number of regular health check-ups for children below five years.

**Lessons learnt:**
(a) Output based financing can be used to improve the quality of health care services through enforcement of contracts.(adherence to pre-requisite quality standards)
(b) It can be used to increase access to healthcare services through innovative Public Private Partnership arrangements
(c) It can be applied to both the supply side and the demand side.

The full presentation on output based financing can be found on the ACHAP website link: [http://africachap.org/x5/Conference%20downloads/Investing%20in%20Africa%E2%80%99s%20Health%20Response%20%20Rosemary%20Mburu.pdf](http://africachap.org/x5/Conference%20downloads/Investing%20in%20Africa%E2%80%99s%20Health%20Response%20%20Rosemary%20Mburu.pdf)
National Health Sector Reforms for Universal Health Coverage in Africa

PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE IN ETHIOPIA

By Girma Borishie Commissioner- EECMY DASCC
Contact the author: girmab@eecmy.org

Ethiopia Evangelical Church Mekane Yesus, EECMY:
• A fast growing African Evangelical Lutheran Church.
• Has above 8500 established congregations organized in 24 Synods with close to 7 million members.

PROGRAM PRIORITIES
Ethiopian Inter-Faith Development Dialogue and Action (EIFDDA) whose focus is on health services
  • Livelihood Development: Food security, emergency relief, climate change, natural resource management, renewable energy.
  • Education, Child & Youth Development
  • Health and HIV/AIDS

In Ethiopia, there is no Christian Health Association established although there are some collaboration between stakeholders. The major consortia dealing in health are:

(a) A Consortium of Christian Relief and Development Association (CCRDA), whose focus is on long term development interventions.

(b) ACT Alliance Ethiopia Forum (AAEF) whose focus is on life saving emergency works (food, health, shelter).

The Primary Health Care Unit in Ethiopia is divided into the following units.
  • Primary Hospital
  • Health centre
  • Health post

Each primary health care unit comprises five health posts, one health center, and a primary Hospital.

  • Each health post is staffed with two health extension workers (HEWs) and is responsible for a population of 3,000 to 5,000 people.

  • A health center has an average of 20 staff and provides both preventive and curative services. It also serves as a referral center for patients coming from health posts and a practical training institution for HEWs. They have an in-patient capacity of 11 beds. Rural health centers serve populations up to 25,000 persons, while urban health centers serve up to 40,000 persons.
A primary hospital provides inpatient and ambulatory services to an average population of 100,000. A primary hospital has an average inpatient capacity of 35 beds and a staff of 53 persons.

**Ethiopias policies towards achievement of Universal Health Coverage**

While Ethiopia has not promulgated any official statute with regards to supporting UHC, the government non-theless has put in place policies that support UHC, these include:

(a) The Ethiopian Constitution which provides all Ethiopians with access to public health and education, clean water, housing, food, and social security.

(b) The Health policy which states that shall invest in the development of an equitable and acceptable standard of health service system that will reach all segments of the population within the limits of recourse.

(c) The health finance strategy which among other things states that user fees need to be revised according to the ability of the people to pay for the services they receive, and adjusted by increases in the cost of living. Although there is always a cost for health services, out-of-pocket (OOP) payments at the time of service delivery may not be required. Some disease categories, population groups, and program entities are exempt.

(d) Ethiopia Essential health package (EHSP) which provides that a minimum standard of care that fosters an integrated service delivery approach essential for advancing the health of the population. EHSP services are to be offered at district hospitals, health centers, and health posts. The package covers family health, communicable diseases, hygiene and environmental sanitation, essential curative care and chronic diseases, and health education and communication.

**Some indicators in mortality rates show that:**

- Infant mortality rate is reduced to 58/1000 in 2014.
- Neonatal mortality rate is reduced to 29/1000 in 2012.
- Fertility rate reduced to 4.1/mother in 2013

STUDY FINDINGS ON CATHOLIC ENGAGEMENT IN UNIVERSAL HEALTH COVERAGE IN AFRICA

By Dr. Jill Olivier, University of Capetown
Contact the author: jiloil@gmail.com

Multi-country ethnographic case study 2013-2014: Ghana, Malawi, Cameroon

• Method: Documentary and policy analysis, stakeholder analysis, individual in-depth interviews mainly with health workers and managers.
  The main barriers to Sexual and Reproductive Health access are systemic not theological

Systems strengthening could be more effective than direct Sexual Reproductive Health (SRU) program intervention (e.g. SRH policy less of an access barrier than staffing and referral. Health Systems interventions need prior knowledge of the specific nature of Faith Based Health systems otherwise the interventions can have unintended consequences.

The faith based health providers face a number of policy challenges in implementing sexual reproductive health policies which include balancing between:

(a) National policies and
   (i) Religious and moral theology
   (ii) Multiple funder’s policies
   (iii) Social policy

They also have a highly centralized and hierarchical governance structure as well as information and authority flows. Others include:

(a) Weak operational information systems: e.g. No one has the power to insist, hence little accountability.
(b) Weak financial safety nets: Each facility sinks or swims on own accord
(c) Limited accounting of contribution of Faith Based Health Providers

Issues needing attention:

(a) Being advocates of the unique challenges that the faith based health facility is facing, eg. post-abortion care
(b) Becoming specialists of care to rural population and documenting this.
(c) Demonstrating creative financial models for the provision of health services to the rural areas.
(d) Demonstrating your contribution in terms of percentage is to national health system is important.
(e) Demonstrating your resilience and responsiveness is also key, further demonstration of your capacity at specific times and in specific places help others appreciate your contribution to the national health system.
The full presentation on Catholic engagement in Universal Health Coverage can be found on the ACHAP website link:
tems%20for%20Improving%20UHC%20by%20Dr%20Jill%20Olivier%20UCT.pdf

Innovative models for community healthcare financing; successes and challenges, FBO/Country experiences.

COMMUNITY HEALTH FINANCING IN UGANDA

Experience from the Uganda Catholic Medical Bureau- UCMB
By Dr. Sam Orach
Contact the author: sorach@ucmb.co.ug

It was said that Innovation in Community Health Financing should aim at:
• Increasing funding for health care while reducing the burden on the individual or family (Financial protection)
• Keeping cost-sharing / user fees low
• Increasing population coverage and reduce social exclusion
• Increasing the service package covered
• Enable health providers break even or have surplus
• Increase the population’s voice / control over health care
• Enable sustainability of the financing scheme

Providers are non-government facilities, these include:
• Uganda Catholic Medical Bureau (UCMB) and
• Uganda Protestant Medical Bureau (UPMB)

Three types of providers:
• – Provider-based or Provider-managed
• – Community-based or Community-managed
• – Managed by an independent agency (micro-finance)

Benefits experienced include
• Communities report reduction in catastrophic health expenditures in households enrolled in CHIS
• Members do not delay in seeking medical care when sick – better health seeking behaviors among CHIS members
• The relationship between communities and health service providers reported to have
significantly improved – more participation in health facility decision making

• Relatively reduced rate of patients escaping from hospitals – better completion of payment for treatment

**Challenges encountered include:**

• Premiums often do not cover operational and administrative costs e.g.: Community mobilization efforts, Staff salaries, Office operating costs
• Replicability in absence of external support to bridge operational costs is difficult especially in regions of higher poverty levels.
• Lack of costing studies to guide reimbursement claims and setting of premiums
  - Poor enrolment rates / penetration rates as a result of poor population understanding and appreciation of health insurance.

**Innovations from Community Health Financing**

Community Health Financing is itself an innovation, amidst inadequate government funding of health care. Possible innovations to improve on it include, introduction of performance-based financing (PBF) in it which will lead to providers and scheme members being more responsive to the priorities agreed upon. It will also encourage members to join and form community saving and lending schemes.


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**COMMUNITY HEALTH FINANCING IN ZAMBIA**

Experience from CHAZ

By Dr. Dhally Menda

Contact the author: dhally.menda@chaz.org.zm

**Community Managed User Fees**

Relied mainly on out-of-pocket payments at the point of contact with providers.

The community was involved in:

• Setting user fee levels,
• Allocating funds,
• Carrying out general management and oversight

The community carried out performance based financing, and some of the effects included a bonus of between US$ 55-68 per month, which was used to procure medical equipment, stationery and laptops as well as undertake renovation, drill boreholes as well as buy torches, scales and registers for the under 5’s, sensitization efforts.
Provider based Health Insurance
Involves a voluntary membership to the hospital and a pre-payment of a one-time annual fee. It involves the community in supervision. The success of this model include an increased ownership of the health centre by the community, increased resources for health and an uptake of health services.

Challenges
- Health Facilities do not feel accountable to communities
- Community over stepping boundaries and want to supervise the facility.

The full presentation on Community health financing can be found on the ACHAP website link: http://africachap.org/x5/Conference%20downloads/Community%20Healthcare%20Financing%20the%20Zambia%20Experience%20%20Dally%20Menda%20CHAZ.pdf

INNOVATIVE MODELS FOR COMMUNITY HEALTH FINANCING FROM ZIMBABWE
By Mrs Vuyelwa Chitimbire.
Contact the author: chitimbire@zach.org.zw

- In 2005, the Results Based Management System was introduced to link finances to service delivery.
- After the announcement of the budget estimate by the Ministry of Finance, funds are leased quarterly to sector Ministries as funds accumulate.
- The Zimbabwe Revenue Authority is the parastatal responsible for revenue collection.
- The Auditor General monitors the use of government resources on quarterly basis.

The National Health System had 3 overall goals:
1. Good Health
2. Responsiveness to the expectations of the population
3. Fairness of financial contribution

Three interrelated functions are involved in order to achieve this:
- The collection of revenues from households, companies or external agencies;
- The pooling of prepaid revenues in ways that allow risks to be shared – including decisions on benefit coverage and entitlement; and purchasing - the process by which interventions are selected and services are paid for or providers are paid.
- The interaction between all three functions determines the effectiveness, efficiency and equity of health financing systems.

The Zimbabwe health financing system is financed from multiple sources, including:
- Tax based (Fiscus)
- Donor Financed
SUCCESSES FOR ZACH INCLUDE

- Donor Funding $10 million
- Well-wishers Membership - $29 000 pa
- User Fees (Health Services Fund)
- Varied small grants (direct to institutions)

CHALLENGES INCLUDE

- Poverty
- Low Health Financing
- Type of facility and service delivery (Not Clearly Defined)
- User Fees - Determined by Government
- Government Policies such as provision of Free Health Services which more often than not are political in nature and do not consider sustainability of the ventures

The full presentation on Community health financing can be found on the ACHAP website link:
Wednesday, Day Four
Health systems strengthening for UHC

The Role of Communities and Civil Society in Health Systems Strengthening

By Alfonso Rosales
Contact the author: arosales@WorldVision.org

- Community-based systems are still poorly represented in health system and health system strengthening frameworks
- There is a tendency to view communities as clients of clinical services, and not active participants in the health system
- New approaches and ways of thinking are needed to connect as a whole rather than as discrete elements

World Vision has many project models that are highly inclusive of the community

- Promotes community ownership of programs
- Combats attrition
- Some WV programs require more robust evaluation to link provided services to health outcomes.
- WV models are commonly used for individual-level interventions, not systems-wide interventions.

The full presentation on communities and civil society in health systems strengthening can be found on the ACHAP website link:
http://africachap.org/x5/Conference%20downloads/Where%20is%20the%20c%20in%20health%20systems%20strengthening%20by%20Dr%20Alfonso%20Rosales.pdf
THE ROLE OF PERFORMANCE BASED INCENTIVES
By Bill Clemer - IMA
Contact the author: williamclemmer@imaworldhealth.org

In a context where a country was undergoing war, an NGO run health care system with different reporting mechanisms, different geographical regions, different MnE structures was viewed as an ineffective one as was the case with the S.Sudan one.

However, the Ministry of health consolidated all NGO’s dealing in health under 3 major donor groups, DFID, USAID and World Bank as shown below:

The new administrative structure by the MoH in Sudan was as follows:
The restructuring principles were as follows:

- One Donor Per State
- One Fund Manager Per State (IMA, JHPIEGO, CA)
- One Lead “NGO” Agent per County
- Harmonization of salaries between NGO and government workers

Performance based contracts were given as Block Grants to Health Facilities and paid out monthly on a sliding scale based on performance. As a result, for those indicators that were linked to payments (i.e. Child Consultations and, ANC1) there was a positive correlation between performance and incentives.

It was said that if UHC is ever going to be successful, then performance and payment need to be linked.

The full presentation on models for community healthcare financing by Uganda can be found on the ACHAP website link:
http://africachap.org/x5/Conference%20downloads/The%20role%20of%20Performance%20Based%20Incentives%2oby%20Dr%20Bill%20Clemmer%20IMA.pdf
TECHNOLOGICAL INNOVATIONS AND HEALTH INFORMATION SYSTEMS
By Rev. Mark Lancaster
Contact the author: Mark.Lancaster@ehrinternational.com

The two most relevant technical innovations of our lifetimes that can help us improve clinical care for patients in Africa are:

1) The advent of the internet and
2) The growth of the mobile telephone industry and its growing networks.

These two innovations can allow every sector of society to benefit through their use—including health care. Unfortunately, two factors exclude many using these innovations in places like Kenya and across Africa: 1) cost and 2) technical complexity.

Server based Electronic Medical Records (EMR) have proven to be expensive to maintain due to upgrade and travel costs while cloud based systems could operate on simple platforms like a US$100 tablet or phone with a data plan. In addition cloud based record systems are capable of producing a cost print out and have mechanisms to assure of financial and inventory control. These include features such as bar coding of patients, drugs and supplies, photos of patient conditions, surgeries and treatments.

Security features include:
• Only employees given permission to can access facilities data.
• User specific PIN Numbers required to submit and save data entries.
• System automatically logs you out after being idle for 10 minutes

The cloud based system makes healthcare affordable and accessible for every hospital and every clinic without the facilities having to fork out large amounts of money to upgrade and maintain existing software and hardware.

The full presentation on technological innovations and health information systems can be found on the ACHAP website link:
HEALTH TECHNOLOGY AND HEALTH INFORMATION FOR UNIVERSAL HEALTH COVERAGE.

By Dr. Beatrice Murage - Savannah Informatics
Contact the author: Beatrice.murage@savannahinformatics.com

It was said that Africa was undergoing various transitions that impact on players in the healthcare industry including decentralization of government, Economic growth, a private sector focused on development and increased literacy due to having access to higher education as well as mobile and internet increase in penetration.

IT innovations have offered solutions for affordable healthcare financing models around the Globe, including:
- Interoperability between clinical and health insurance systems.
- Knowledge sharing between academia and industry
- Collation of medical information such as disease registries

Learning from one of the country’s largest healthcare providers the National Health Insurance Fund, we find that challenges found in managing claims can be solved by having innovative I.T solutions.

The solutions and challenges found in the value chain can be summarized as follows:

The full presentation on health technology and health information can be found on the ACHAP website link:
HRH PARTNERSHIPS; EXPERIENCE WITH WORKING OVERSEAS THROUGH SHORT TERM MISSIONS

By Bruce Compton
Contact the author: BCompton@chausa.org

CONTEXT

Over the past two decades, the number of short-term international trips for the provision of health services, as well as for personal and professional formation, has dramatically increased. Catholic health care has seen a significant increase in the number of these types of experiences. While such experiences provide an opportunity for Catholic health care to continue its mission of reaching out to the poor, sick and vulnerable, there are consistent concerns about the value and effectiveness of these trips. Most volunteers and supporting organizations assume that the developing countries and their populations are benefiting from these trips. However, there is little evidence that this is the case aside from anecdotes, often very compelling ones, of lives saved and services appreciated. With Catholic health care providing significant human and economic investment in health service trips, it is essential to gain a better understanding of these activities and to consider if and how they can provide the maximum benefit for all involved.

The Catholic Health Association conducted a research project in 2014 to identify leading practices in short-term medical mission trips which focused on the effectiveness of short-term medical missions to improve the health of host communities and provide positive formational experiences for volunteers.

With over 500 respondents, the research is most likely the largest existing dataset on short-term medical missions. It was followed by 18 in-depth interviews with a cross section of the survey respondents.

Survey participants collectively had been on a minimum of 949 trips over the past five years. The “most recent” trips that were reported on included approximately 2,300 volunteers traveling to 45 countries at an estimated cost of $3.45 million. Organizers estimated that about one-fourth of this amount is spent in the host countries. CHA member organizations sponsored about 40 percent of these trips. Many CHA member hospitals and health systems did not directly sponsor medical mission trips, although they may provide indirect support. Overall, participants expressed great satisfaction with mission trips. They considered them to be extremely valuable for volunteers (91 percent), for Catholic health care (78 percent), and for host communities (75 percent).

It was discovered that partners’ role was viewed largely as that of facilitating logistics, 88% • Assisting volunteers with their activities, 72%, defining the goals and activities of the trip, 69%. Funding was viewed as the greatest challenge in creating effective volunteer mission trips. In addition, Partner organization should be involved from the outset in establishing goals, not just be a provider of logistical support • Trust-building and program planning take time • Establish an...
MOU • Regularly review mutual goals and activities and ensure long-term institutional commitment.

The full presentation on short term missions can be found on the ACHAP website link:

http://africachap.org/x5/Conference%20downloads/Shortterm%20international%20medica
l%20mission%20trips%2oby%20Bruce%20Compton%20CHAUS.pdf

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IMPROVING SUPPLY CHAIN FOR ACHIEVING UNIVERSAL HEALTH COVERAGE

Experience from MEDS-
By Pascal Manyuru
Contact the author: pmanyuru@meds.or.ke

The Mission for Essential Drugs and Supplies (MEDS) is a Faith Based, not-for-profit trust of the Christian Health Association of Kenya & Kenya Catholic Conference of Bishops (KCCB), established in 1986. Among its functions include Supply chain: provision and distribution of reliable, quality and affordable Essential Medicines, medical/non-pharmaceuticals and clinical laboratory supplies.

1. Capacity Building & Client Support Services: to improve the quality of patient care through training, mentorship field visits, capacity building and professional assistance

2. Pharmaceutical Quality Control Laboratory services: A quality Control Laboratory that ensures stringent quality assurance, mechanism for quality products.

MEDS SUPPLY CHAIN AND DISTRIBUTION LEVEL IN 2013
PAST CHALLENGES INCLUDED:
- Coverage consisted of faith based members only
- Low forecasting accuracy
- Limited stocking levels
- Rented warehouse space
- Few partnerships.

MEDS modified its approach and adapted a market approach to doing business, helped by a long-serving board as well as support from traditional partners as well as incorporating feedback from its traditional market clientele.

As a result, MEDS today serves over 2,000 health facilities in Kenya and Africa including governments, community based organizations and learning institutions which results to fruitful partnerships. It has a high forecasting accuracy due to automated processes and systems. It oversees faster stock movement which leads to better customer service. MEDS recently acquired its own 10,000 square feet warehouse that ensures good storage and efficiency processes. Online ordering is now available with a 3-5 working day turnaround time of clients orders. Clients are able to track the status of their orders, be informed on out of stock situations and have access statements of accounts.

With regards to Universal Health Coverage, the supply system at MEDS has helped reduced product costs by enabling bulk procurement. Reduced ordering costs by housing a One stop shop for clients, Increased availability/access of medicines & medical supplies with a wide variety and reduced the prevalence of counterfeits, it has also reduced medication errors due to training initiatives.
Challenges remain with Essential Medicines & Medical Supplies out of reach to poor & marginalized communities, free and liberal market bring with them an influx of counterfeit and substandard drugs.

The full presentation on supply chain can be found on the ACHAP website link: http://africachap.org/x5/Conference%20downloads/Experience%20from%20MEDS%20Kenya%20by%20Pascal%20Manyuru.pdf

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**IMPROVING SUPPLY CHAIN FOR ACHIEVING UNIVERSAL HEALTH COVERAGE.**

Experience from Gradian Health.

By Lina Sayed

Contact the author: lsayed@gradianhealth.org

There has been less attention paid to the distribution chain required for capital equipment. Very often, equipment arrives at a hospital broken or unable to function in that infrastructure. Additionally, it arrives with a training plan or a service contract.

Gradian Health Systems, aims to create an effective distribution ecosystem for our equipment while working with in-country partners that share that mission. We ensure that we distribute the right equipment coupled with the right price in order to create value within our distribution chain. Our work with Joint Medical Stores in Uganda is an example of a successful collaboration that brings value to the hospitals.

When defining the capital equipment distribution chain, we start with customs and clearance and follow each machine through in-country transport to installation and training and continue the support through ongoing maintenance and service. In an effort to create this chain, we seek partners and efficiencies in the distribution chain so we can support our hospitals and users.

This is best handled with in-country expertise. Joint Medical Stores, in Uganda, has the local knowledge and experience needed to assess hospital needs and infrastructure and is best suited to support their network of hospitals effectively. JMS and Gradian share a mutual mission of wanting to support hospitals in an effective way that improves healthcare. With local servicing of machines through JMS biomedical technicians, there is less down time on the machines and enhanced technical and clinical training.

This partnership with JMS has allowed us to sell but also support hospitals in Uganda in a sustainable and effective way where everyone is incentivized to support this machine.

The full presentation on improving supply chain is available on the ACHAP website:


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AFRICA CHRISTIAN HEALTH ASSOCIATIONS PLATFORM 7TH
BIENNIAL CONFERENCE REPORT
QUALITY THROUGHOUT THE SUPPLY CHAIN

By Leontenin Ruttenberg IDA
Contact the author: lruttenberg@idafoundation.org

The IDA foundation was established in 1972 with a vision of creating a world with accessible quality healthcare products for all. It boasts customers in 140 countries and handles quality assurance, tendering amongst suppliers, stock keeping among other services.

IDA serves the unmet need in:
• HIV/Aids, Tuberculosis, Malaria
• Emergency response
• Reproductive, maternal, newborn and child health
• Neglected tropical diseases
• Non-Communicable Diseases

IDA’s strength lies in filling the gap in ensuring quality control.

Why is quality assurance needed?

National Drug Regulatory Authority not always able to guarantee quality
WHO Prequalification focuses on HIV/AIDS, tuberculosis, malaria
Stringent Drug Regulatory Authorities have in-country focuses (e.g. USFDA)

Complete product range & Comprehensive quality system spanning the entire supply chain

IDA Quality: Filling the gaps

IDA ensures:
(a) Quality in product & stock keeping
(b) Quality in demand forecasting
(c) Quality in distribution
The full presentation on quality through supply chain can be found on the ACHAP website link:


DECENTRALIZATION AND DEVOLUTION OF HEALTHCARE, EXPERIENCE FROM UGANDA

By Dr. Tonny Tumwesigye- UPMB
Contact the author: ttumwesigye@upmb.org.ug

Prior to decentralization, Uganda’s health landscape was characterized by:

- Over-centralization of power
- Overburdened state
- Excessive bureaucracy
- Lack of responsiveness to local needs
- Lack of accountability to local population
- Poor service quality
- Inequity in resource allocation
Devolution in Uganda

- MOH headquarters divested all service provision to regional & national hospitals and was significantly reorganized & reduced in size.
- All staff, except those at the national & regional hospitals, have been transferred to 112 districts
- Semi-autonomous district & hospital boards- devolved much responsibility of operating lower health units, such as health centers and dispensaries, to lower levels of local government under Ministry of Local Government

Faith Based sector in Uganda

Health facilities run by faith-based organizations, constitute 40% of health sector outputs, perceived to offer better services than non-faith-based facilities.

Districts are main public partners in health service delivery & are principle actors in dialogue with faith-based PNFP representatives in process of improving health care.

Financing of Not for Profit facilities

**Financing of PNFP Facilities – 2013/14**

*From UCMB and UPMB data*

60 – 80% of donor funds are for HIV/AIDS, TB and Malaria

**Successes of devolution:**

- General increase in patient attendance in hospitals, although in some cases decline was reported
- Decentralization was lauded with improved HWs supply & distribution
- Salary payments more predictable salary payments with some possible improvements in motivation & retention
- Some Health Workers also preferred to work in areas of origin which increased retention although could promote discrimination among HWs
• Decentralization an instrument for shifting attitudes, developing, deepening skills, competencies, & engaging multiple stakeholders in the development process.

The full presentation on decentralization and devolution can be found on the ACHAP website link:
http://africachap.org/x5/Conference%20downloads/Uganda%20experience%20by%20Dr%20Tonny%20Tumwesigye%20UPMB.pdf

THE CAMEROON EXPERIENCE.
From the Ecumenical Council of Protestant Churches of Cameroon

By Leonard Onana Mbanga
Contact the author: leonardonanambanga@yahoo.fr

State of maternal and neo-natale deaths in Cameroon
The government of Cameroon put in place a 5 year strategic plan to secure adequate contraceptives. The government has also put in place a national reproductive health plan which was reviewed in 2012. A national strategic plan on reproductive health is already in place (2010-2015). The plan will further be reviewed in line with the current realities at the end of 2015. There are strategic strategic plans targeting mother to child transmission, Malaria as well as nutrition are near finalization.

The national multi-sectoral program to fight against maternal and neo-natal deaths is the principal national program in reduction of these kinds of deaths. Launched in 2013, it offers a framework for the coordination, promotion and strengthening multisectoral engagement in order to achieve synergy towards remedying of the situation.

Nearly 80% of maternal deaths are caused by haemorrhages, post-partum infections, eclampsia and ectopic pregnancies.

The rate of under 5 deaths stood at 146% in 1998 and reduced to 144% in 2004 (TRA 0,33%), it further depreciated to 122% in 2011, and remains fixed at 76% in 2015. The principle causes of neonatal deaths are, prematurity birth, asphyxia, infections, or congenital malfunctions.

In general, children’s deaths are caused by Malaria, diarrhea, Pneumonia and HIV/AIDS, these fatal infections thrive largely because of malnutrition which is the cause of nearly a third of all neonatal deaths. Malnutrition rates hover around 33% in Cameroon.

Faith based organizations are playing their part in the reduction of maternal and neo-natal deaths, working hand in hand with the government and in line with the national program to fight against maternal and neonatal deaths. The government has supported the establishment of two faith-based universities which train medical specialists as well as several training colleges that offer bridging courses. In addition, the government has invested in renovation of equipment and infrastructure.
The full presentation on the state of maternal and neo-natal care in Cameroon can be found on the ACHAP website link: http://africachap.org/x5/Conference%20downloads/Experience%20de%20Cameroun%20par%20Leonard%20Onana%20CEPCA.pdf

The CHAD Experience

From the Protestant Health Association of Chad
By Djekadoum Ndilta
Contact the author: djekadoumo@gmail.com

The National Policy on Health has as its objective the provision of quality health services to the population in order to accelerate the reduction of mortality and morbidity towards attainment of the Millenial Development goals Politique Nationale de santé 2007 à 2015

Maternal health indicators:

- Rate of utilization of services- 24%
- Contraceptive prevalence- 1.6%
- Infant mortality: 98%
- Maternal mortality: 1084 per 100,000 live births.

In Chad, faith based organizations that offer health services are two. The Catholic based, UNAD (National Union of Diocesan Action) and the Evangelical Association of Tchad.

Principal indicators of maternal mortality rates in Tchad include:

(a) Pre-natal clinic visits
(b) Percentage of assisted births
(c) Contraceptive prevalence
(d) Pentavalent vaccination
(e) Percentage of caesarian sections operations
(f) Ratio of maternal deaths.

Advantages of faith based hospitals in Tchad
- Reknown for offering health services with a human touch.
- Coverage of upto 14% of all healthcare services in Tchad.

Weaknesses
- Low numbers of personnel, by speciality and by numbers.
- Lack of equipment and infrastructure
- Lack of data
The full presentation on the Chad experience can be found on the ACHAP website link:

http://africachap.org/x5/Conference%20downloads/Experience%20de%20Tchad%20par%20Ndilta%20Djekadoum%20AEST.pdf

E- LIBRARY PROGRAM FOR PRIMARY HEALTH CARE

By Dr. Bruce Dahlman
Contact the author: bruce.dahlman@aimint.org

Motivation for Development of the Digital African Health Library

It was said that health workers in Africa shoulder:
• 25% of the global disease burden
• 11% of the world’s population
• 3% of the global health workforce
• 1% of the health care resources

Post-graduates and faculty in two East Africa training programs embraced the use of smartphones as a tool to assist clinical decision making to provide best care. Patients significantly benefited because the smartphone brought answers to clinicians’ questions to the point of care.

The goal of the digital health library is to ensure that the format is portable and available where one see patients, it has a single search engine for all resources, it is also easy to set up and use. Among the resources that the health library will carry include: An oxford manual, a family medicine manual, WHO handbooks among others.

The full presentation on the E-library for Primary Health Care is available on the ACHAP website at:


STRENGTHENING PPPS AND INTER-FAITH PARTNERSHIPS FOR UHC.

Example from the Christian Health Association of Malawi

By Dr. Mwai Makoka
Contact the author: mwaimakoka@yahoo.com

The Christian Health Association of Malawi (CHAM) an umbrella association for both Catholic and Protestant churches' health facilities. Its current membership includes: 40 hospitals, 90 health centres with maternities, 45 health centres with OPD and 12 training colleges. It provides 37% of health services and trains 80% of mid-level health professionals. 90% of CHAM health facilities are located in rural areas, some of which are hard-to-reach.
CHAM has a partnership with the government of Malawi which looks as follows:

**Government= Constitutional obligation**

**Churches= Biblical mandate**

<table>
<thead>
<tr>
<th>Government</th>
<th>CHAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pays salaries for CHAM health workers and tutors</td>
<td>• Provides infrastructure and other assets</td>
</tr>
<tr>
<td>• Seconds tutors to colleges</td>
<td>• Provides training and health services</td>
</tr>
<tr>
<td>• Provides health care and training with minimal fiscal burden (i.e., without meeting full capital and recurrent costs)</td>
<td>• Provides operational management</td>
</tr>
<tr>
<td></td>
<td>• Receives subvention from Government (salaries)</td>
</tr>
<tr>
<td></td>
<td>• Charges some user fees</td>
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</table>

**Shared responsibility, risk and benefits**

Challenges in implementing Public Private Partnerships.
- Lack of continuous monitoring of the MOU and SLAs with timely implementation of corrective measures has undermined the MOU
- Shrinking fiscal space making the Government look for an alternative arrangement with even less fiscal responsibility
- Free services in public facilities reducing people’s “willingness to pay” in CHAM facilities
- Dwindling direct support to CHAM facilities from overseas benefactors – more reliance on local resources

The full presentation can be found on the ACHAP website link:

[http://africachap.org/x5/Conference%20downloads/Malawi%20Experience%20by%20Dr%20Makoka%20CHAM.pdf](http://africachap.org/x5/Conference%20downloads/Malawi%20Experience%20by%20Dr%20Makoka%20CHAM.pdf)
THE TANZANIAN EXPERIENCE,
From the Christian Social Services Commission
By Dr. Josephine Balati
Contact the author: jbalati@cssc.or.tz

The Christian Social Services Commission (CSSC) is a network of over 897 church health facilities which include hospitals, dispensaries and health training institutions. It also draws membership from 255 church secondary schools.

Public Private Partnerships in Health
• The Government imposed restrictions on private health care services delivery in 1977 and reintroduced them in 1991.
• New policies promote increased participation of the private sector in provision of health services.
• Only 10.3% (2012/13) of the total government budget is allocated to health sector hence the need to leverage private sector resources in order to complement government efforts.

Public-Private Partnerships (PPPs) in the health services delivery are part of the implementation of health care programmes under the MoH, they cover reproductive and child health, HIV and AIDS, Malaria, TB.

Regulatory Framework for Public Private Partnerships in Tanzania, success and constraints.
## Partnership for universal health coverage; action points

- Government budget, donor funding, as well as household contributions were all targeted as sources of funding to reduce the budget gap.

- Need to reduce the budget gap in the health sector by mobilising adequate and sustainable financial resources; a need to reduce reliance on external/donor support; need to complement the government efforts and need to leverage private sector resources.

- Increase understanding of advantages of PPPs through increased advocacy for PPPs at all levels

- Strengthen PPP implementation to improve the provision of health and social welfare services

### Human Resource - Capacity and Utilization

#### Success and constraints

<table>
<thead>
<tr>
<th>Area</th>
<th>Success</th>
<th>Constraint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Secondment</td>
<td>Some doctors work in church based service providers through secondment</td>
<td>- No effective monitoring of the quality of staff&lt;br&gt;- No harmonisation of reward systems&lt;br&gt;- Increasing staff turnover</td>
</tr>
<tr>
<td>Staff Salaries</td>
<td>The government pay salaries for seconded staff in FBO facilities (Designated and Referral hospitals)</td>
<td>- Staff outside secondment receive different (low amount) of pay&lt;br&gt;- Relatively poor reward for staff employed by faith based service providers&lt;br&gt;- Inability to attract and retain qualified staff.</td>
</tr>
<tr>
<td>Capacity</td>
<td>Some qualified doctors working in government hospitals get part time jobs in private hospitals. This improves capacity of the private sector</td>
<td>These doctors have more than one master. This reduces efficiency, commitment and accountability. Patients have to bear the costs</td>
</tr>
<tr>
<td>Training</td>
<td>Joint Training, there training offered by government as well as private sector</td>
<td>Not systematically planned/well coordinated; sometimes depend on personal relationships and networking</td>
</tr>
</tbody>
</table>
The full presentation on the experience from the Christian Social Services Commission can be found on the ACHAP website link:

http://africachap.org/x5/Conference%20downloads/Tanzania%20Experience%20by%20Dr%20Balati%20CSSC.pdf

INTER-CHA AND INTERFAITH PARTNERSHIPS.
By John Blevins Emory University
Contact the author: jblevins@emory

Leveraging the unique role and function of FBOs
• Capitalize on the trust that has developed between FBOs and local communities to build stronger, comprehensive, integrated HIV prevention efforts built not on stigmatization but on unconditional love.
• Develop the capacity for FBOs to advocate for improved healthcare for all citizens and hold governments accountable.
• Maximize the existing organizational infrastructure of faith-based health systems to reach communities impacted by HIV, including vulnerable, hard-to-reach, and most at-risk Populations (MARPs).

Inter-CHA activities
• Mentorship for Health Systems Strengthening
• The Faith, Health Collaboration and Leadership Development Program

Interfaith
• Interfaith-Centre on Social Justice and HIV
• PEPFAR Consultation
• Executive Leadership Institute on Advocacy

Inter-CHA Partnerships
Mentorship for Health Systems Strengthening
• Draw on CHA knowledge, technical capacities, and wisdom
• Mentorship of a smaller CHA by a larger CHA
• Components include; Self-assessment, tailored curriculum developed in response, on-site mentorship, learning, and site visits.

Faith, Health Collaboration and Leadership Development Program
Program involves:
• Support referral into treatment and retention in care for PLHIV
• Inclusion of clinical staff from HIV clinical programs (both CHA and non-CHA) on teams
• Probing for Social determinants of health disparities and HIV vulnerability (e.g., poverty, stigma, and gender inequities), Leadership development.
• Community assets mapping and determining religions influence.

On Social Justice and HIV
• Build on the theological beliefs, teachings, and practices of religious traditions (focus on Christianity and Islam) in support of compassion for all people living with or affected by HIV and advocate for access to comprehensive services for everyone, including hard-to-reach and vulnerable communities.

On executive Leadership Institute on Advocacy
• Build national-level (through-out Kenya), networks of religious leaders from various traditions and build their capacity to advocate for effective HIV services within the country coordinating mechanisms. 62 national religious leaders (Christian, Muslim, and Hindu) working in the area of HIV/AIDS are targeted to be interviewed. Training curriculum developed.

The full presentation on inter-CHA and interfaith Partnerships can be found on the ACHAP website link:


HEALTHCARE IN CONFLICT AND CRISIS SETTINGS
Experience from the Protestant Health Association of Mali- APSM – By Jeremie Sagara.
Contact the author: jsag1_sd@yahoo.fr

From January 2012 to January 2013, two thirds of Mali was occupied by Jihadists aided by the national movement for the liberation of Azawad. 2013, marked the year that international intervention happened to stop the advance of the jihadists at Konna. In September 2013, Mali got a democratically elected President, elected with over 77% of the votes cast.

In OCTOBER 2014 the first declaration of Ebola was announced at Kayes in Mali. Mali registered 8 cases and 7 of those died. By 18th January 2015, Mali had been declared an Ebola-free country.

Consequences of the crisis:
• Massive displacement of people from the north towards different regions in the south as well as to neighboring nations.
• Displacement of the church from the North towards the south.
• Destruction of the church and cultural artefacts.
• Destruction of the places of worship in occupied zones.
• Amputations, violence against pregnant women, departure of traditional partners, destruction of medicines including HIV/AIDS testing kits

Experience of the Protestant Health Association of Mali.
The APSM was created in 1992 as an apolitical, non-denominational, non-profit making organization. Its mission includes carrying out actions in the field of health and education that will contribute towards the socio-economic development of the most vulnerable parts of the population (women and Children), in Mali.

Health interventions carried out by APSM
Conducting of baseline studies, signing of conventions with different actors, strengthening of capacities of beneficiaries of grants, monitoring and evaluation of programs.

Partners
• The stromme foundation- Norway
• ERIKSJALPEN: Sweden
• TEARFUND: UK
• Ministry of Education

Projects that APSM has undertaken in the past.

« NIONO CHOLERA ZERO PROJECT »
Results:
• 178 village health representative teams were formed
• 178 sanitation committees and clean up committees were put in place.
• 15 boreholes, 40 latrines and 120 irrigation points set up.
• 890 sanitation kits distributed including wheel barrows, shovels and rakes

HIV/AIDS CONCERNS ME PROJECT
Results:
• 60 church leaders trained together with their spouses.
• 5 175 people reached with information education and communication materials
• 1050 voluntary testing cases with 10 being identified as positive.
• 19 people living with HIV/AIDS supported with food, and lodging which includes 9 orphans.
• 600 memory cards supporting preventive behaviour have been distributed, focus on remaining chaste, and committed to one sexual partner.

PROMOTION OF CHILDREN'S RIGHTS PROJECT
Results:
• 30 000 children and parents sensitized on their rights.
• 60 childrens clubs established.
• 172 tv programs, 22 magazines carrying stories on childrens stories and 7 radio stations doing the same.
EBOLA ZERO PROJECT
Results:
- 62 religious leaders trained on preventive strategies,
- 25 community health groups formed,
- 21 trainers trained,
- 170 hand washing stations established,
- 60 sermons preached by Imams, preachers and pastors, 40,000 people reached with the message of Ebola.

Lessons learnt
It is important that beneficiaries as well as partners participate in designing program objectives.

Christian organizations stand a better chance of winning when they work in collaboration.

The full presentation on healthcare in conflict settings in Mali can be found on the ACHAP website link:


______________________________________________________________

HEALTHCARE IN CONFLICT AND CRISIS SETTINGS DRC
By Dr. Dennis Matshifi- SANRU
Contact the author: denismatshifi@sanru.org

The DRC health system is structured as follows:
• 50% of Health Services provided by FBOs / NGOs
• 50% of Health Facilities owned by (FBOs)

**Actions carried out by SANRU**

- Revitalizing Primary Health Care services (*pre-natal clinic, well child clinic, family planning, post-natal care, vaccination, etc...*)
- Health education / C-IMCI
- Water and Sanitation
- Training of health teams

**Challenges faced:**

- Geographic targeting by donors without harmonization with MOH and Implementing FBO or NGOs
- Sustainability of health zones activities after project is finished
- Staff instability (turn over for better salary)
- Political instability of the Country
- Poverty
- Under-age mothers
- Inadequate infrastructure

**OPPORTUNITIES**

- Existence of well-defined health care system
- Coexistence between NGOs and Government
• Existence of government policies and procedures
• Global awareness
• Community participation

The full presentation on healthcare in conflict settings in DRC can be found on the ACHAP website link:

http://africachap.org/x5/Conference%20downloads/Experience%20du%20RDC%20par%20Dr%20Denis%20Matshifi%20SANRU.pdf

EXPERIENCE FROM THE CHRISTIAN HEALTH ASSOCIATION OF LIBERIA.

By Patricia Kamara
Contact the author: patriciakamara@yahoo.com

When Ebola first was first reported in Liberia, there was confusion, fear and misconceptions about the disease. Because of fear, parents abandoned their parents when they fell ill and vice versa, no one wanted to come to the aid of anyone who showed signs of illness.

CHAL undertook a research with an aim of preventing the disease, they found out that it was important to have a general awareness conducted on the disease; CHAL held a one day seminar with officers in charge of all their member units and looked at signs and symptoms of the disease. They also partnered with IMA to write a proposal that included creating awareness in 3 counties which bordered Guinea and Sierra Leone. CHAL conducted training in awareness among its facilities in the 3 counties. As a result of the training, staff started going back to work; CHAL got some protective materials too from local partners.

Lessons learnt
Slowing down transmission of Ebola was dependent on working with the community in order to identify the patients and how health workers can protect themselves as they are offering care. CHAL has trained over 200 General Community Health Volunteers, these are people who are well known and used to disseminate key messages about Ebola. CHAL will continue encouraging handwashing as well as ensuring that every health centre has a triage of questions focusing on taking temperatures and asking specific questions and specialized treatment based on responses on the questions. Most partners have supported the acquisition of the triage set-up involving prevention infection prevention control measures to patients suspected to have Ebola.

You can listen to the full message on the ACHAP website:
https://soundcloud.com/achaplatform/experience-from‐liberia‐by‐patricia‐kamara‐chal

You can also read the message of a survivor of Ebola in Liberia on:
DECENTRALIZATION OF HEALTHCARE, SUCCESSES AND CHALLENGES
Experience from the Christian Health Association of Kenya.
By Dr. Samuel Mwenda.
Contact the author: gs@chak.or.ke

The Kenyan constitution provides for the right to health care services. The Bill of Rights states that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Article 43 states that a person shall not be denied emergency medical treatment.

The Kenya Health Policy is organized into 4 tiers.
• Community services
• Primary care services – Dispensaries, Health Centres and Maternity Homes of Government and Private entities
• County Referral Health Services – Hospitals
• National Referral Services including FBOs and the private sector.

Role of FBOs in Devolved Health Sector
• Health services delivery through the 4 tiers following the set policies & guidelines
• Training of health workers through FBO & Hospitals
• Community based health promotion and disease prevention
• Participate in the County and National health referral system
• MEDS to offer an efficient, competitive and reliable supply chain for health commodities
• Partner and collaborate in planning, implementation and monitoring of health programs
• Support medical emergency response initiatives.

Issues of concern to FBO’s
• Continued access to Essential Public Health commodities – Vaccines, TB Drugs, HIV test kits, ARVs, ACT
• Enabling policy environment
• Health care financing: NHIF, Government policy of free maternity deliveries and PHC services.
• Inclusion in planning and resource allocation
• Access to Donor funding – bilateral & multi-lateral
• Recognition of existing FBO – MoU with MOH and inclusion in HMIS at county and national level
• Increased burden of taxation, licensing and regulation

The full presentation on decentralization can be obtained on the ACHAP website:
EXPERIENCE FROM THE CHRISTIAN HEALTH ASSOCIATION OF NIGERIA

By Daniel Gobgab CHANigeria
Contact the author: dgobgab@channigeria.org

Decentralization is a process of transitioning from a governance structure in which power is concentrated at the central or national level to one in which authority to make decisions and implement them is shifted to lower level government or agencies. Decentralization can be administrative (transfer of civil servants and public functions to the lower level), fiscal (devolution of decision making powers), or a mixture of any of these.

The Nigerian Health system is divided up as follows:

- The federal Ministry of Health
- The Ministry of Health in every State and the Federal Capital territory Department for Health
- Parastatals under the Federal and State Ministries of Health
- All local government health authorities

The State Government manages the various General Hospitals (secondary health care);
The state provides technical assistance to the local government PHC services.
The Local Governments focuses on Primary Health Clinics (primary health care), which are regulated by the federal government through the National Primary Health Care Development Agency.

On December 9, 2014, Nigerian President signed into law the National Health Bill. The new law is intended to provide a framework for the regulation, development, and management of a national health system in Nigeria.

The National Health Act creates a Basic Health Care Provision Fund to provide Nigerians with access to basic health care services as a strategy to universal health coverage.

Success of decentralization

- Health services has been taken to the grass root with community participation through ward and village health committees coordinated by the health department.
- Funding for health at all levels is being done through annual budgets.
- Decisions on health of communities are jointly done by standing ward and village health committees promoting ownership.
- Environmental health, water and sanitation are key components of health at the community level.

Awareness creation and sensitization of the public on key public health issues through engaging all stakeholders e.g. Ebola virus disease control and reducing prevalence of HIV/AIDS.
Joint monitoring of health service delivery between communities, CBOs and local council authorities is enhancing accountability.

**Challenges:**

(a) **The Lack of Political Will:** Despite pronouncements to the contrary, state governments do not want to devolve all powers to the local level.

(b) **The Management Challenge:** Many local governments have limited financial and human resources and inadequate governance capacity to fulfill the mandate thrust upon them. This makes the states micromanage affairs at the local government level.

(c) **The Challenge of Unrequited Expectations:** ‘Decentralization’ is not the panacea that it is touted to as it is only limited to the “de concentration” of authority and services to the local level, without the devolution of revenue-generating and decision-making authority necessary for true decentralization (there is an active debate ongoing now in Nigeria about financial autonomy at the LGC).

**Way forward**

Strengthen the role of local governments in improving public health management. Close monitoring of the implementation of the new National Health Act towards realization of UHC for poor Nigerians.

The full presentation on the Nigerian experience can be found on the ACHAP website link:


**DECENTRALIZATION/DEVOLUTION OF HEALTHCARE- EXPERIENCES FROM UGANDA.**

By Dr. Tonny Tumwesigye
Contact the author: ttumwesigye@upmb.co.ug

Drivers of decentralization in Uganda included:

- Over-centralization of power
- Overburdened state
- Excessive bureaucracy
- Lack of responsiveness to local needs
- Lack of accountability to local population
- Poor service quality
- Inequity in resource allocation

Uganda adopted a “devolution” type of decentralization where the district had absolute powers for management of district resources
In 1997 there was a decentralization policy introduced under Local Government Act and has since undergone several amendments. The role of the ministry of health includes:
- Separation of policy from operations - after decentralization, central government, through MOH is responsible for;
- Resource allocation and hospitals
- Policy formulation,
- Setting of service standards and
- Quality assurance,
- Provision of training and Human resource guidelines,
- Technical supervision,
- Responses to epidemics and other disasters, and
- Monitoring and evaluation of health services

**Financing of local government**
Currently, Local Governments in Uganda obtain their finances from four main sources:
- Locally generated revenue, such as market dues, trading licenses, rent, and rates;
- Government grants;
- Donor and project funds for specified activities; and
- Fund-raising from well-wishers.

**Successes of decentralization**
- General increase in patient attendance in hospitals, although in some cases decline happened.
- Prescribing patterns varied, with improvement in some indicators, while others showed no change or even worsened
- Decentralization was lauded with improved HWs supply & distribution
- Salary payments more predictable salary payments with some possible improvements in motivation & retention
- Some HWs also preferred to work in areas of origin which increased retention although could promote discrimination among HWs.

**Challenges**
- Uganda still heavily dependent on external support, with insufficient local resources to the health sector.
- Faced with competing priorities in other sectors, the health budget is considerably low.
- MOH system no longer nationally unified, district health officials no longer have the same geographic mobility and access to promotion, making it significantly more difficult for poorer rural districts to attract qualified personnel.
Opportunities

- Experiences of implementation of decentralization policy indicate that it is insufficient to strengthen institutions & to increase access to services if this is not accompanied by increases in people’s incomes.
- Decentralization an instrument for shifting attitudes, developing, deepening skills, competencies, & engaging multiple stakeholders in the development process.

The full presentation on models on decentralization in Uganda can be found on the ACHAP website link:

http://africachap.org/x5/Conference%20downloads/Uganda%20experience%20by%20Dr%20Tonny%20Tumwesigye%20UPMB.pdf

EXPERIENCE FROM THE CHRISTIAN HEALTH ASSOCIATION OF LESOTHO.

By the Christian Health Association of Lesotho - By Lebohang Mothae

Contact the author: lebomoth@ymail.com

In Lesotho there are three levels of government:

- Central level
- District level (10 administrative districts)
- Local level with local councils.

Hospitals

They are categorized as tertiary, district, primary and local hospitals
The hospitals have hospital boards as the governing body and the hospital management team that comprises of heads of department assisted by the sub committees such as quality assurance and infection control committees.

Decentralization in Lesotho.

Systems and structures were put in place in 2007 upon partnership with GoL and health sector reforms

- Basic Service package, equipment and essential medicines list, financial management system, staffing pattern etc
- Governance and leadership, financial and human resources management decentralized
- Typology of facilities determined with clear ToRs was set up.

Achievements

- Access and utilization of healthcare services increased
- Direct linkages with the communities and interest groups – community participation enhanced
Ownership and support of facilities by local communities - Commitment and dedication improved
Service quality improved

Challenges
- High levels of poverty and unemployment – income and other resources base limited
- Lack of capacity and no clear terms of reference for local authorities – source of conflict
- Lack of competencies in areas of management and governance
- Lack of coordination at District and local levels – results in underutilization of available local resources and poor supervision of facilities

The full presentation can be found on the ACHAP website link:

HIGHLIGHTS FROM BREAKOUT SESSIONS.

Maternal and Child Health

Ethiopia: From the Central Synod Family Planning EECMY- Ethiopia .
By Melesse Desalegn. Contact the author: mallasaa@yahoo.com

The goal was to contribute to the improvement of family planning services availability and accessibility at five districts through community based service provision, mobilizing religious leaders, and by establishing a proper referral system between the community based intervention and facility based services.

The served community was categorized in three major religious denominations: Christian, Muslim and traditionalists.

Misconceptions concerning family planning include:
- Pills are accumulated in the uterus,
- The loops(IUD) goes to the brain
- One cannot do hard work with implanol inserted.

Messages included in the family planning training include:
- Using family planning is not sin
- Children should not die because of lack of adequate care
- Mothers should not die because of pregnancy and delivery

Results:
Conducted 65 social gatherings and church meetings organized by kebele and community leaders in which FP/RH issues are discussed. Those gatherings reached a total of 6696 men (2313) and
women 4383 with FP/RH message • Collected and distributed 335 copies of different IEC/BCC materials on FP counseling including leaflets, brochures, posters and booklets. IEC materials was obtained from PI/Ethiopia and distributed to the HEWs and health centers • Conducted a community based awareness on all FP methods and reached 55235 clients which is more than double the planned number of clients to be reached this quarter.

Muslim ladies are now permitted to enter in mosque with Implanol in their arms. All women got freedom to use modern FP officially. Many people have been reached through health education and counseling for FP methods. The number of clients has also increased, the number of IUCD insertion at all the health centers was also started. Voluntary Surgical Contraception was also achieved from far and remote areas indicating that the Project is deep rooted within the community.

Solutions
Solutions • Continuous awareness creation at different levels • Model satisfied client witnesses • Religious leaders speaking about modern FP methods • Couple counseling.

The full presentation can be found on the ACHAP website link:


EXPERIENCE FROM THE CHRISTIAN HEALTH ASSOCIATION OF KENYA

By Jane Kishoyian
Contact the author: jkishoyian@chak.or.ke

The goal of the 2 year family planning project was to reduce unmet needs for family planning and improve maternal and child health outcomes. It ran from 2014-2016 and was implemented by CHAK in its 8 affiliated health facilities in Nyanza and Eastern regions
Main interventions included:

- Delivery of FP services at community and facilities
- Commodity management
- Generate demand for FP services
- Information dissemination (IEC materials, social media and community talks)
- Community mobilization and engagement
- Outreach activities.

Tools:

- National FP guidelines
- MEC Wheel (medical eligibility criteria)
- Religious leaders reporting tools and referral forms
- CHWs reporting tools and referral forms
- Training manuals for CHW – MoH
- Training manual for religious leaders – adopted from WHO
- Supportive supervision check list

Messages

- Special messages the religious leaders are sharing with the community
- FP saves lives
- What is FP/child spacing
- Importance of FP
- FP methods
- Dispelling myths and misconceptions about FP.

The full presentation on models for community healthcare financing by Uganda can be found on the ACHAP website link:

NATURAL FAMILY PLANNING- NATURAL PLANNING PROJECT

Experience from the Uganda Catholic Medical Bureau- UCMB

By Opota Komagum Janet
Contact the author: jkomagum@ucmb.co.ug

Natural family planning
The objective of the program was for Quality couple-friendly fertility awareness-based method (FAM) services to be utilized by women and their partners. The program ran for one and a half years, starting 2014 January.

How Natural Family Planning addresses the problem
Women need options that suit their individual situations and local context. The inclusion of FAM options within a FP/RH service package allows health systems to address the diverse needs of its population and expand access to safe, low cost FP methods. • NPP is expanding access to FAM at the facility and community level; UCMB coordinates and serves 32 Hospitals i.e. 25% of all Hospitals in Uganda, 57% of all PNFP Hospitals and 251 Lower level Units • FAM package includes: Lactational Amenorrhea Method, Standard Days Method with CycleBeads (new), TwoDay Method (new), and Billings. • Strengthening couple communication through tested curriculum: The Faithful House.

FAM Methods in NPP

<table>
<thead>
<tr>
<th>METHOD</th>
<th>EFFECTIVENESS with context use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Days Method (SDM)</td>
<td>95%</td>
</tr>
<tr>
<td>TwoDay Method (TDM)</td>
<td>96%</td>
</tr>
<tr>
<td>Lactational Amenorrhea Method (LAM)</td>
<td>98%</td>
</tr>
<tr>
<td>Billings Ovulation Method</td>
<td>98-99%</td>
</tr>
</tbody>
</table>

Implementation activities
Training & Service Delivery • Providers equipped to inform and counsel clients on FAM options at the facility and community level

Awareness Raising activities include:
• Expert couples sensitizing community through home visits and health talks at group gatherings. Radio spots introduce new FAM and where to find services.

Progress to date:
Recruited 2,319 new FAM users in year 1 (compared to the project target of 1,080 clients) • Generated demand for FAM services in the communities and health facilities over 14,000 people.
Special messages:
Benefits of Natural Family Planning, scientific effectiveness of modern FAMs, their availability via radio talk shows. Prioritizing reaching out to men and inviting their participation alongside their partner.

Challenges

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Possible solutions</th>
<th>Lessons Learnt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Few trained providers compared to client demand and geographic coverage</td>
<td>- Train more providers at facility and community level, even outside project sites</td>
<td>- Need buy-in from facility management to value FP services as part of full package of health services</td>
</tr>
<tr>
<td>Lack of FAM awareness &amp; misconceptions about effectiveness</td>
<td>- Continue awareness creation and effective service provision</td>
<td>FAM is acceptable and appreciated by many users once accurate information and quality services are available</td>
</tr>
<tr>
<td>Delays in project start-up &amp; short implementation timeline</td>
<td>- Explore self-study training for expansion after project ends</td>
<td>Ensure project design allows for rapid start-up when implementation timeline is short</td>
</tr>
</tbody>
</table>

Interventions planned:
Continue to strengthen capacity of FAM providers and Faithful House facilitators through supportive supervision • Implement Knowledge Improvement Tool (KIT) to strengthen capacity of FAM providers and assess counseling capacity • Develop capacity to serve as a center of excellence in FAM for other programs in Uganda interested in FAM integration Interventions Planned Meeting with MOH District Health Team • Conduct meetings with stakeholders to share project results.

The full presentation on models for community healthcare financing by Uganda can be found on the ACHAP website link:
http://africachap.org/x5/Conference%20downloads/Natural%20plan%20project%20UCMB.pdf

CLOSING REMARKS
It was said that reflections on Universal Health Coverage has reminded participants that there are portions of the population which cannot overcome the barriers to health services. The marginalized, poor and voiceless give Christian Health Associations even more reason to exercise their divine call of going out to heal the sick. CHA’s were challenged to engage in the post MDG setting including eliminating the reality of unreached populations.
CHA’s were challenged to reach out to African tycoons as one way of harnessing external resources towards achieving universal health care. They were also challenged to reach out to the private sector in order to yield dividends. CHA’s were asked to:

(a) Strengthen their information systems so that data can better inform their decisions
(b) Strengthen their visibility as competent, competitive, reliable, transparent and credible health sector players in Africa.
(c) Strengthen partnerships with the government and the private sector by re-examining the frameworks that guide these partnerships.

The chairlady also asked members to increase their impact through the technical working groups so that their collective work is visible in-between biennial conferences. Votes of thanks were given to the Kenyan government, the World Council of Churches, IMA World Health, World Vision, Institute for Reproductive Health, Charlie Goldsmith Associates, IDA Foundation, Catholic Relief Services, Emory University, Christian Connections for International Health, Evidence to Action, AstraZeneca and all organizations who supported the conference in one way or the other.

GENERAL ASSEMBLY

MINUTES OF ACHAP BOARD MEETING HELD ON 26TH MARCH 2015 AT THE SAFARI PARK HOTEL

Members present.

(a) Karen Sichinga- Board Chair  
(b) Dr. Samuel Mwenda (CHAK)- Board vice chair  
(c) Dr. Mwai Makokha (CHAM)- member  
(d) Dr. Gobgab Nanshep (CHAN)- member  
(e) Leonard Onana (CEPCA)- member  
(f) Doris Mwarey ACHAP secretariat  
(g) Michael Mugweru- ACHAP secretariat.  
(h) Mirfin Mpundu – (EPN)- member

Members absent

(a) Dr. Sam Orach (UCMB) - member

AGENDA

1. Evaluate ACHAP conference  
2. Evaluating meeting schedules
3. Evaluating constitutional changes.
4. Advisory group for platform
5. Improve communication
6. Conference statement
7. Appointments of board members to TWG

1. MINUTE 1/2/15

Evaluating ACHAP Conference

Board chair noted that organization was well done. She congratulated the secretariat. It was noted that this conference had more contacts in Nairobi than in Lusaka and the previous meeting in Ghana. It was noted that invitations to potential partners was done late. It was suggested that sharing of themes for next biennial conference be done mid-year in order to give partners adequate time to fundraise. It was also noted that choosing a theme that resonates with donors is key. Identification of a theme for the 2017 conference in Lesotho was important. Therefore we needed to hold discussions with our partners on potential themes.

Areas of improvement

1. Time keeping: It was noted that presentations went beyond the allocated time. Hence in the future we need to put moderators who can be respected by speakers
2. Evaluation forms: We did not issue an evaluation form which would have carried themes for the next conference. Include

2. MINUTE 2/2/15

Evaluating meeting schedules

It was said that the board needed documentation to support discussions, minutes of last board meeting and audited accounts need to be circulated at least a month before the next biennial conference. A board meeting to discuss finances and outputs of the secretariat needs to happen at least two weeks before the next biennial conference. It was noted that IMA could help the board with a template to help capture board deliberations. It was suggested that the board meets two times per year. The meeting held during the biennial conference (February 2015) was considered as the first meeting of 2015. It was suggested that the board holds the next meeting via skype on the first week of October 2015, and the next meeting after that one during the last week of February 2016. The ACHAP secretariat was tasked with reminding board members of upcoming board meetings.

(a) Generic advocacy message: The secretariat was tasked to develop a generic powerpoint presentation for use by board members.

(b) Communication portal: The secretariat was tasked with exploring an online portal where board minutes and information could be stored for ease of retrieval.
3. **MINUTE 3/2/15**

**Constitutional changes**

For the suggestion of changes to the ACHAP constitution as discussed during the biennial conference, it was suggested that the board suggest amendments and request the next general assembly adopt the amendments.

4. **MINUTE 4/2/15**

**Advisory Committee**

It was suggested that the ACHAP board take on an advisory committee, to help bring together a partner round table as well as to advocate on specific needs of the secretariat and members. In addition the advisory group would help keep linkages with other partners alive and extend the reach of the marketing efforts. The following members were suggested as members:

**From the U.S**
(a) Ray Martin- former head of CCIH  
(b) Rick Santos- IMA  
(c) Frank Dimmock- Presbyterian Church of USA

**From Europe**
(a) Sally Smith- WHO  
(b) Bob Vitillo- Caritas International  
(c) Bruce Compton- CHA USA  
(d) Dr. Gisela Schneider- Difaem  
(e) Sue Parry- World Council of Churches.

**From Africa**
(a) Nick Shaiyen- CHAN- Medipharm.

Sue Parry was chosen as a convenor and Rick Santos was tasked with providing a draft T.O.R

5. **MINUTE 5/2/15**

**Improving communication**

Board members shared their email and telephone numbers to facilitate more direct communication from the secretariat.

6. **MINUTE 6/2/15**

**Appointment of board members to TWG**
It was suggested that board members get involved in Technical Working Groups as follows:

1. Mwai Makoka would lead the TWG on Maternal and child health.
2. Yoram Siame (representing Karen Sichinga) would lead the TWG on Advocacy and Communication.
3. Dr. Sam Orach would lead the TWG on HIV/AIDS

The board members were tasked with identifying constituent CHA’s as members of their TWG’s.

7. **MINUTE 7/2/15**

**Conference statement**

The Secretariat was tasked to craft a statement that captured the commitments of CHA’s towards achieving universal health coverage as well as specific actions in relation to their areas of concentration in the pre-conferences

**A.O.B**

- It was agreed that ACHAP should open a bank account.
- It was also agreed that a letter of appreciation would be drafted by the secretariat to all the partners who supported the conference.
- Sam Kapembwa from CHAZ was seconded to help ACHAP with taking minutes.
- CEPCA: It was noted that Rev Ngando was leaving his position at CEPCA and the board asked Leonard Onana to continue representing Cameroon on the ACHAP board.

There being no other business. The meeting was closed at 5:30pm

Secretary

__________________________

Mike Mugweru

Chairperson

__________________________

Karen Sichinga
ACHAP BIENNIAL CONFERENCE PROGRAM

ACHAP 7TH BIENNIAL CONFERENCE PROGRAM

“The role of the faith based health services in contributing to universal health coverage in Africa”

VENUE: SAFARI PARK HOTEL; NAIROBI (BOUGAINVILLE HALL)

DATES: ARRIVAL SUNDAY; FEBRUARY 22, 2015 TO THURSDAY FEBRUARY 26, 2015

The conference objectives:

• Opportunity for ACHAP members to interact and gain an understanding on global perspectives and updates on universal health coverage.
• Involvement of the FBO sector in national health sector reforms towards universal health coverage
• Exchange and learning on country approaches, reforms and challenges in raising prepaid revenues, pooling risk, and purchasing services
• FBO sector involvement in designing national health insurance models and integration with health systems.
• Methodologies for measuring key outputs and outcomes of universal-coverage reform
• Members will hold its general assembly meeting and adopt its five-year strategic plan for 2015 - 2019

Outputs from Conference:

• Improved understanding of UHC among ACHAP members
• A conference statement of commitment and consensus on joint advocacy for universal health coverage in Africa by ACHAP members.
• ACHAP general assembly held and five-year strategic plan adopted.
<table>
<thead>
<tr>
<th>Date</th>
<th>Activity/Time</th>
<th>Speaker/Facilitator</th>
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<tbody>
<tr>
<td><strong>Sunday, February 22, 2015</strong></td>
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<tr>
<td>6:00pm–9:00pm</td>
<td>Arrival of delegates</td>
<td>Hotel/CHAK (host member)</td>
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<td>Conference Registration</td>
<td>Registration Desk</td>
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<td><strong>Monday, February 23, 2015</strong></td>
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<tr>
<td>7:00am–8:30am</td>
<td>Late Registration</td>
<td>Registration Desk</td>
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<td>Pre-Conference Workshops &amp; Meetings</td>
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<td></td>
<td>1. Ebola Crisis Response; critical roles to play in preparedness, scale-up and advocacy Ebola (Hall: Mt Kenya A)</td>
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<td>2. Reproductive Health &amp; Family Planning workshop sharing and learning from best practices from faith based institutions (Hall: Mt Kenya C)</td>
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<td></td>
<td>3. FBOs systems strengthening for universal health access (Hall: Mt Kenya D)</td>
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<tr>
<td>9:00–4:30pm</td>
<td>Networking Reception Cocktail at the Mamta Poolside</td>
<td>Workshop Coordinator(s):</td>
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<tr>
<td></td>
<td>1. Ebola Crisis Response; critical roles to play in preparedness, scale-up and advocacy Ebola (Hall: Mt Kenya A)</td>
<td>Sue Parry, WCC &amp; Mike Mugweru, ACHAP</td>
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<td></td>
<td>2. Reproductive Health &amp; Family Planning workshop sharing and learning from best practices from faith based institutions (Hall: Mt Kenya C)</td>
<td>Salwa Bitar,E2A, Mona Bormet, CCIH &amp; Lauren VanEnk (IRH)</td>
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<tr>
<td></td>
<td>3. FBOs systems strengthening for universal health access (Hall: Mt Kenya D)</td>
<td>Jean Claude Kazadi, CRS &amp; Doris Mwarey (IMA/ACHAP)</td>
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<tr>
<td>5:30–7:30pm</td>
<td>Presentation on “Healthy Heart Africa” program</td>
<td>Courtesy of AstraZeneca</td>
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<td></td>
<td><strong>Introductions and Conference Objectives</strong></td>
<td>Ian MacTavish, AstraZeneca</td>
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<td><strong>Tuesday, February 24, 2015</strong></td>
<td>8:15 –8:45am</td>
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<td></td>
<td><strong>Entertainment</strong></td>
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<td><strong>Opening Prayer</strong></td>
<td>Dr. Samuel Mwenda</td>
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<td></td>
<td><strong>Opening Prayer</strong></td>
<td>General Secretary CHAK</td>
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<td></td>
<td><strong>Welcome and Opening Remarks</strong></td>
<td>CHAK /Simon</td>
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<td></td>
<td><strong>Key note Address</strong></td>
<td>Mr. Karen Sichinga</td>
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<td></td>
<td>“Global perspectives of UHC and relationship with Primary Health Care (PHC)”</td>
<td>CHAK Board Chair</td>
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<td></td>
<td><strong>Official Opening (Country Overview – Kenya)</strong></td>
<td>Dr. Custodia Mandlhate</td>
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<td></td>
<td>“Kenya health sector reforms' roadmap towards achievement of UHC”</td>
<td>The WHO representative to Kenya</td>
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<td></td>
<td><strong>Group Photo and Tea Break</strong></td>
<td>Dr. Nicholas Muraguri</td>
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<td></td>
<td><strong>Health financing models for UHC; an overview</strong></td>
<td>Director of Medical Services MOH</td>
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<td><strong>Public sector example:</strong></td>
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<td></td>
<td><strong>National Health Insurance Fund (NHIF) Kenya</strong></td>
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<td></td>
<td><strong>Prof. Dr. Khama Rogo World Bank/IFC</strong></td>
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<td><strong>Simeon Ole Kirgotty NHIF - CEO</strong></td>
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**AFRICA CHRISTIAN HEALTH ASSOCIATIONS PLATFORM 7TH BIENNIAL CONFERENCE REPORT**
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<thead>
<tr>
<th>Date</th>
<th>Activity/Time</th>
<th>Speaker/Facilitator</th>
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<tbody>
<tr>
<td>12:00–1:15pm</td>
<td>Making the Case for effective health programs and UHC (Panel)</td>
<td>Prof Miriam Were (Phd)</td>
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<td></td>
<td>• Role of community health systems in UHC (15 mins)</td>
<td>Jean Duff</td>
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<td>• Evidence drivers for effective partnerships between faith groups and public sector (15 mins)</td>
<td>Partnership for Faith and Development, USA</td>
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<td></td>
<td>• Partnership with Private Sector (15 mins)</td>
<td>Dr Amit Thakker, Chair EAHF</td>
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<td></td>
<td>• Sustaining Africa’s Health Response (Domestic Health Financing mobilization) (15 mins)</td>
<td>Rosemary Mburu Global Fund</td>
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<td></td>
<td>• Q&amp;A (15 mins)</td>
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<td></td>
<td>(Moderator: Rick Santos; President IMA World Health)</td>
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<tr>
<td>1:15–2:00pm</td>
<td>Lunch Break</td>
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<td>2:00–3:00pm</td>
<td>Partner Engagement for UHC (Panel)</td>
<td>Katherine Perry</td>
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<td></td>
<td>• PEPFAR; Engagement with FBOs &amp; CSOs (15 mins)</td>
<td>PEPFAR Kenya Coordinator</td>
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<td>• Partner coordination in health; lessons from DPHK (Development Partners for Health in Kenya) (15 mins)</td>
<td>Barbara Hughes USAID Kenya</td>
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<td>• Learning from successful models; Output based financing &amp; experiences from Asia (15 mins)</td>
<td>Cynthia Macharia GIZ Health Sector Programme</td>
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<td></td>
<td>• Q&amp;A (15 mins)</td>
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<td></td>
<td>(Moderator: Dr Samuel Mwenda; CHAK)</td>
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<tr>
<td>3:00–4:00pm</td>
<td>National health sector reforms for universal health coverage in Africa (Panel)</td>
<td>Girma Borishie, EECMY-DASSC</td>
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<td>• Progress towards UHC in Ethiopia (15 mins)</td>
<td>BUFMAR /MOH Rep</td>
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<td>• UHC efforts and successes in Rwanda (15 mins)</td>
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<td>• Study findings on Catholic engagement in UHC in Africa (15 mins)</td>
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<td></td>
<td>• Q&amp;A (15 mins)</td>
<td>Dr Jill Olivier</td>
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<td>(Moderator: Dr Daniel Gobgab, CHAN)</td>
<td>University of Capetown</td>
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<tr>
<td>4:00-5:00pm</td>
<td>Innovative models for community healthcare financing; successes and challenges</td>
<td>Dr Sam Orach, UCMB</td>
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<td>FBO/Country experiences from: (Panel discussion)</td>
<td>Dr Dally Menda, CHAZ</td>
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<td></td>
<td>• Uganda (15 mins)</td>
<td>Ms Vuyelwa Chitimbire, ZACH</td>
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<td>• Zambia (15 mins)</td>
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<td>• Zimbabwe (15 mins)</td>
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<td>• Q&amp;A (15 mins)</td>
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<td>(Moderator: Yoram Siame, CHAZ)</td>
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<tr>
<td>5:00-5:15pm</td>
<td>Closure</td>
<td>Master of Ceremony</td>
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<td>5:15-6:00pm</td>
<td>Tea Break &amp; Networking</td>
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<tr>
<td>6:00 – 7:30pm</td>
<td>ACHAP Human Resources for Health Technical Working Group Dinner Meeting</td>
<td>Samuel Nugblega, Craig Hafner</td>
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**Wednesday, February 25, 2015**

<p>| 8:15–8:30am          | Introduction to Days Agenda &amp; Recap of Previous Day                          | Master of Ceremony                                       |
|                      | Health Systems Strengthening for UHC (Panel)                                 |                                                         |
|                      | • Community health systems strengthening (15 mins)                           | Alfonso Rosales                                         |
|                      | • Performance Based Contracting: Case of S.Sudan (15 mins)                   | Bill Clemmer                                             |
|                      | • Technological innovations and health information systems                    | IMA World Health                                         |</p>
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<th>Date</th>
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<tr>
<td></td>
<td><strong>Improving supply chain for achieving UHC; (Panel)</strong></td>
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<td><strong>Experiences from:</strong></td>
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<td></td>
<td>• Kenya 20 mins</td>
<td>Pascal Manyuru, MEDS</td>
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<td>• Uganda (20 mins)</td>
<td>Dr Bildard Baguma, JMS &amp; Linda Sayed, Gradian Health Systems</td>
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<td>• IDA Foundation (20 mins)</td>
<td>Leontien Ruttenberg, IDA Foundation</td>
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<td></td>
<td>• Q&amp;A (15 mins)</td>
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<td></td>
<td><strong>(Moderator: Dr Mirfin Mpundu, EPN)</strong></td>
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<tr>
<td>10:00-10:30am</td>
<td><strong>Tea Break</strong></td>
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<td>10:30–11:15am</td>
<td><strong>FBO contributions to improved MCH at country level (Panel)</strong></td>
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<td><strong>Experiences from</strong></td>
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<td></td>
<td>• Uganda (20 mins)</td>
<td>Dr Tonny Tumwesigye, UPMB</td>
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<td>• Cameroun (20 mins)</td>
<td>Leonard Onana Mbanga, CEPCA</td>
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<td>• TCHAD (20 mins)</td>
<td>N’dilta Djekadoum, BAC</td>
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<td>• E-library program for primary health care (20 mins)</td>
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<td>• Q&amp;A (20 mins)</td>
<td>Bruce Dahlman, INFAMED</td>
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<td><strong>(Moderator: Lauren Van Enk, IRH)</strong></td>
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<tr>
<td>11:20-1:00pm</td>
<td>Strengthening PPPs and inter-faith partnerships for UHC, Examples from:</td>
<td>Dr Mwai Makoka, CHAM</td>
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<tr>
<td>(Hall: Mt Kenya D)</td>
<td>• Malawi (20 mins)</td>
<td>Ben Nyakutsey, CHAG</td>
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<td>• Ghana (20 mins)</td>
<td>Josephine Balati, CSSC</td>
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<td>• Tanzania (20 mins)</td>
<td>John Blevins, Emory University</td>
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<td>• Inter-CHA and inter-faith partnerships (20 mins)</td>
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<td>• Q&amp;A (20 mins)</td>
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<td></td>
<td>(Moderator: Dr Douglas Huber, CCIH)</td>
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<tr>
<td>Lunch (1:00 – 1:45pm)</td>
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<td>2:00-3:40pm</td>
<td>Healthcare in conflict and crisis settings, experiences from:</td>
<td>Jeremie Sagara, Protestant Association of Mali</td>
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<tr>
<td>(Hall: Main Hall)</td>
<td>• Mali (15 mins)</td>
<td>Denis Matshifi, SANRU</td>
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<td>• Democratic Republic of Congo (15 mins)</td>
<td>Dackpa Sebastien, ASSOMESCA</td>
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<td>• Niger (15 mins)</td>
<td>Patricia Kamara, CHAL</td>
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<td>• Liberia (skype if unable to travel) (15 mins)</td>
<td>Charlie Goldsmith, Goldsmith Associates</td>
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<td>• Sudan Experience (15 mins)</td>
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<td>• Q&amp;A (15 mins)</td>
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<td>(Moderator: Susan Duberstein, IMA World Health)</td>
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<tr>
<td>2:00-3:40pm</td>
<td>Decentralization/devolution of healthcare, successes and</td>
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<td>(Hall: Mt Kenya D)</td>
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<td>Date</td>
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<td>Challenges - experiences from:</td>
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<tr>
<td></td>
<td>• Kenya (20 mins)</td>
<td>Jacinta Mutegi, KCCB</td>
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<td>• Nigeria (20 mins)</td>
<td>Dr Daniel Gobgab, CHAN</td>
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<td>• Uganda (20 mins)</td>
<td>Dr Tonny Tumwesigye, UPMB</td>
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<td>• Lesotho (20 mins)</td>
<td>Patricia Lebohang Mothae, CHALe</td>
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<td>• Q&amp;A (20 mins)</td>
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<td>(Moderator: Dr Cyprian Kamau, CHAK)</td>
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<td>3:50-4:40pm</td>
<td>Highlights from breakout sessions:</td>
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<tr>
<td>(Main Hall)</td>
<td>• MCH Contributions (10 mins)</td>
<td>Lauren Van Enk, IRH</td>
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<td>• PPPs and inter-faith collaborations (10 mins)</td>
<td>Dr Douglas Huber, CCIH</td>
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<td>• Conflict &amp; crisis situations (10 mins)</td>
<td>Susan Duberstein, IMA WH</td>
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<td></td>
<td>• Decentralization and devolution (10 mins)</td>
<td>Dr Cyprian Kamau, CHAK</td>
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<td>• Q&amp;A (10 mins)</td>
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<td>(Moderator: Mr Jonathan Kiliku, MEDS /Master of Ceremony)</td>
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<tr>
<td>4:40-5:00pm</td>
<td>Summary of key conference messages on FBO contributions to UHC in Africa</td>
<td>Dr Robert Kasyaba, UCMB</td>
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<tr>
<td>5:00-5:20pm</td>
<td>Appreciation of conference sponsors and closing Remarks</td>
<td>Mrs Karen Sichinga, ACHAP Board Chair</td>
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<tr>
<td>5:20-5:30pm</td>
<td>Announcements</td>
<td>Master of Ceremony</td>
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<td>5:30–6:30pm</td>
<td>Tea Break and Networking</td>
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<td></td>
<td><strong>Thursday, February 26, 2015</strong></td>
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<td>ACHAP members General Assembly</td>
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<td>8:00–8:30am</td>
<td>Opening Prayer &amp; Devotional</td>
<td>Pasteur Didier Ouedraogo; ACS</td>
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**AFRICA CHRISTIAN HEALTH ASSOCIATIONS PLATFORM 7TH BIENNIAL CONFERENCE REPORT**
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<tr>
<th>Date</th>
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<tbody>
<tr>
<td>8:30–8:45am</td>
<td>Welcome Remarks</td>
<td>Mrs Karen Sichinga</td>
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<td>ACHAP Board Chair</td>
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<tr>
<td>8:45-9:00am</td>
<td>Members’ roll-call</td>
<td>Mike Mugweru</td>
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| 9:00 –10:00am| Secretariat updates:  
|            | • 2013/2014 period  
|            | • ACHAP Strategic Plan  
|            | • ACHAP TWGs; way forward (15 mins)                      | Doris Mwarey        |
|            |                                                         | Theresa Nyamupachitu, IMA |
| 10:00–10:30am| Tea Break                                              |                     |
| 10:30– 11:00am| Matters arising and question & answer session from members | Dr Samuel Mwenda   |
| 11:00-11:15am| Approval & Launch of ACHAP Strategic Plan (2015 – 2019) | Mrs Karen Sichinga  |
|            |                                                         | ACHAP Board Chair   |
| 11:15–11:45am| 2015– 2017 ACHAP board elections                       | Frank Dimmock (Moderator) |
| 11:45-12:30pm| Introduction of new board and remarks by incoming board  |                     |
| 12:30-1:00pm| Vote of thanks and closure                              |                     |
| 1:00 – 1:15pm| Closing Prayer                                          | Sue Parry, WCC      |
|            | Announcements                                           | Master of Ceremony  |
| 1:15-2:30pm| Lunch and Networking                                    |                     |
### Delegates List

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<td>UK/Kenya</td>
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