

9th Biennial Conference Report

Conference Theme

Re-igniting Primary Health Care: The role of ACHAP

February 25 – March 1 2019 | Hotel Mont Febe, Yaoundé, Cameroon



Africa Christian Health Associations Platform (ACHAP)

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Abbreviations

ACHAP	Africa Christian Health Associations Platform
AMR	Anti-Microbial Resistance
CBCHS	Cameroon Baptist Convention Health Services
CCIH	Christian Connections for International Health
CHA	Christian Health Association
CHAG	Christian Health Association of Ghana
CHAK	Christian Health Association of Kenya
COP	Country Operational Plan
DQA	Data Quality Analysis
DSD	Differentiated Service Delivery model
FBHP	Faith Based Health Provider
HRH	Human Resources for Health
IPC	Infection Prevention and Control
JMS	Joint Medical Stores
MNCH/FP	Maternal Newborn and Child Health/Family Planning
NCD	Non-communicable Disease
NTD	Neglected Tropical Diseases
OFDA	Office of US Foreign Disaster Assistance
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PNFP	Private Not For Profit
RMNCH	Reproductive, Maternal, Newborn and Child Health
SDG	Sustainable Development Goal
SGBV	Sexual and Gender Based Violence
SLA	Service Level Agreement
TWG	Technical Working Group
UCMB	Uganda Catholic Medical Bureau
UHC	Universal Health Coverage
UPMB	Uganda Protestant Medical Bureau
VMMC	Voluntary Male Medical Circumcision
WASH	Water, Sanitation and Hygiene
ZACH	Zimbabwe Association of Church Hospitals

Executive Summary

Every two years, ACHAP holds a conference to reflect on regional and global health issues and priorities that have an impact on countries and communities served by faith-based health organizations. The 9th Biennial Conference and General Assembly of ACHAP was held in Yaoundé, Cameroon, with the theme *“Re-Igniting Primary Health Care: The role of ACHAP.”*

Pre-conference sessions focused on health service delivery towards PHC for UHC. Reducing missed opportunities in the continuum of RMNCH care through integrated approaches was identified as key to improving the quality of services for mothers and babies. Critical for infection prevention in health care settings and stopping anti-microbial resistance is WASH, which formed part of the discussions. Health kiosks or safe spaces for HIV/AIDS services in churches have further consolidated FBOs’ contribution to the fight against the pandemic.

In crisis situations, communities place a lot of trust in faith-based health interventions. An example is the DR Congo where IMA World Health continues to make a significant contribution to addressing the Ebola and conflict crisis in the region. Discussions during the conference also centered on creating optimal health systems, which are critical for UHC. Congregations were urged to engage in PHC as health promoting churches, especially in the area of NCDs.

Successful health care financing models for PHC towards UHC were presented by CHAs, many of which have worked with communities to come up with community health financing initiatives. The conference also identified issues and solutions to HRH for PHC towards UHC. Use of health technologies and information was key for increasing visibility and advocacy towards improved PHC.

The FBOs have over the years engaged in partnerships to ensure health care for all. Discussions on the PEPFAR transition to local primes directive proved exciting for CHAs keen on utilizing USG funding to tackle the burden of HIV/AIDS.

The WHO prioritises 18 NTDs and another two will soon be added to this list. Mental health accounts for 14 per cent of global burden of disease. The CHAs were urged to lend their hand in addressing these health challenges.

The conference climax was the signing of the Yaoundé Declaration, which affirmed the principles, ideals and values of PHC for UHC as the pathway to promoting Jesus Christ’s healing ministry that the CHAs champion.

About ACHAP

The Africa Christian Health Associations Platform (ACHAP) is an advocacy and networking platform for Christian Health Associations (CHAs) and Church Health Networks from Sub-Saharan Africa. The platform was established through the inspiration and support of World Council of Churches in 2007. On May 4, 2012, ACHAP attained legal registration as a regional Non-Governmental Organization (NGO).

1

ACHAP Board

ACHAP is led by a Board, which reports to the General Assembly. The Board drives policy, strategy and advocacy and is assisted by thematic Technical Working Groups (TWGs) comprising of various member CHAs.

2

ACHAP Mission

ACHAP's mission is defined as: "Inspired by Christ's healing ministry, ACHAP supports Church related health associations and organizations to work and advocate for health for all in Africa, guided by equity, justice and human dignity."

3

ACHAP Purpose

The purpose of ACHAP is to promote continued, effective and efficient engagement of church health services in Africa towards achieving equitable access to quality health care among members of the Platform and in Africa at large.

4

ACHAP Core Mandate

The core mandate of ACHAP is to facilitate joint advocacy, networking and communication among Christian Health Associations and other Church Health Networks and partners in support of the Church health work in Africa.

Conference Background

In 1978, World Health Organization (WHO) collaborated with the World Council of Churches to formulate the *Alma-Ata declaration*, which affirmed primary health care (PHC) as a vehicle to guaranteeing access to healthcare as a fundamental human right. The vision was to keep people healthy and productive within their communities.

The assumption was that majority of the health needs of communities could be met within a well-functioning primary health care system that would guarantee access to quality affordable health services – promotive, preventive and curative. Yet, to date, there are still fundamental gaps in providing access to affordable quality health services to vulnerable populations.

Historically, Christian faith-based health providers (FBHPs), including CHAs, financed their health programs and hospitals primarily through foreign aid (donated medical supplies, medicines, missionary/expatriate medical staff, etc.), and to a limited extent, out-of-pocket payment from patients, albeit heavily subsidized. However, due to recent changes in the global development paradigm, FBHPs/CHAs are facing reduced or discontinued donor support for both capital and recurrent expenditure.

This has culminated in a search for sustainable and alternative funding mechanisms to support the Church's mission in health. These include new models of health financing being tested by some FBHPs. Given the need for financial sustainability of the Church in health, ACHAP needs to explore/appraise the feasibility of innovative models for PHC.

CHAs contribute significantly in responding to demographic and epidemiological transitions, especially in fragile settings in sub-Sahara Africa and as such, serve as buffers of country health systems. Therefore, in implementing PHC for UHC, the role of CHAs cannot be overemphasized. In particular, ACHAP/CHAs have been instrumental in the provision of substantial portions of HIV/AIDS services including primary health care, pediatric HIV care, adolescent testing and treatment, prevention, stigma and discrimination and support services as well as promoting a vision of acceptance and inclusion across sub-Saharan Africa.

Generally, the faith-based health systems, spearheaded by CHAs, are noted for innovation, resource and cost efficiency with assets that can potentially be leveraged to optimize primary health services, sustainable HIV services, deliver public value, complement national health systems and ultimately work towards UHC. Accordingly, ACHAP recognizes the need for innovative partnerships and responsive and resilient health systems, especially in light of the need for re-engineering PHC towards achieving Universal Health Coverage/Sustainable Development Goals (UHC/SDGs).

Hence, the conference theme: **Re-igniting Primary Health Care: The role of ACHAP.**

Based on the foregoing, ACHAP needed to review its engagement in primary health care since 1978, identify our successes and failures, codify our collective learning, and develop innovative models that could be scaled up and that are attractive to both donors and governments, in order to make robust recommendations for improved investments for achieving universal health coverage.

Conference objectives

Promote FBO-government partnerships at country, sub-regional and regional levels.

Objective 1

Strengthen faith-based health systems of care that include PHC towards UHC

Objective 2

Explore financing models for PHC

Objective 3

Increase visibility and advocacy leverages

Objective 4

Consolidate ACHAP/CHAs innovative approaches in managing the HIV/AIDs epidemic and strengthen the capacity of ACHAP/CHAs for upcoming grant opportunities/acquisition, program management, financial accountability and transparency

Objective 5

Conference format

The conference format included breakout, plenary and workshop sessions.

Participants

- ACHAP members
- Development partners
- UN agencies
- Academic consortium
- WHO
- Ministry of Health officials from sub Saharan Africa
- Individual participants, well-wishers, students, and friends of ACHAP
- Private sector
- Health care suppliers

Acknowledgements

We remain grateful to all partners whose various contributions and support made the conference successful.

In particular, we recognize some key partners for their exceptional support: IMA World Health, American Leprosy Missions, World Vision, USAID's flagship Maternal and Child Survival Program (MCSP), Catholic Relief Services, CCIH, Global Water 2020, the World Council of Churches and UNAIDS.

We thank our host, the Cameroon Baptist Convention Health Services (CBCHS), for their continuous organizational efforts and support towards the success of the conference.

Opening Remarks



Representative of the Minister for Public Health at the conference (fifth from left) with ACHAP officials.

The Minister of Public Health, Cameroon

H.E. Mr. Malachie Manaouda

Cameroon is honored to receive this first major African health event in 2019. I invite all the participants of this conference to feel comfortable and take advantage of this meeting to strengthen their health strategies. I also thank CBCHS, a long time legendary partner of the Ministry of Health, for the practical supervision at the local level of the organization of this conference.

The importance of faith-based organizations in health care is well established in African countries. For this reason, in Cameroon, special attention is paid to faith-based health organizations for their significant contribution in terms of health coverage and of quality of services.

Still in the ultimate concern to strengthen primary health care, by the firm will of the President of the Republic of Cameroon, His Excellency Paul Biya, Cameroon is currently finalizing the preliminary stages for the start of universal health coverage. I can reassure you that faith-based health providers will be key partners in the implementation of this new initiative.

In fact, born of the will of the first missionaries as a social support of evangelization and a tool for taking charge of health, faith-based health providers are aimed at the most deprived and are represented in the most remote areas with a good implantation (of the order of 40 per cent) in the health mapping of African countries.

They are reliable partners of the state because of their active participation in the implementation of health policies. They also support the achievement of the Sustainable Development Goals concerning health. Their strengths lie in their expertise, their know-how and the know-how of their staff; their reputation and their credibility by the quality of services they offer and the accompaniment (presence of chaplains). Churches are showing their face of love, compassion and solidarity through their medical work.

But this is not without difficulties such as insufficient human resources, insufficient equipment and insufficient subsidies. Distinguished participants, I believe that our role as the State, and especially with the support of our TFPs, will be to work together and overcome these main weaknesses.

As well, I invite churches to work on raising awareness among their communities so that they can support and accompany their medical works. Their effectiveness will be strengthened if they are encouraged in a quality approach.

To minimize their weaknesses, I invite faith-based health providers to organize themselves in a network or to consolidate their current platforms in the search for complementarity, exchanges of skills, and continuous training. Also, they must consolidate their partnership with the State and with all the various health partners to ensure continuity and sustainability of quality health services offered, using a diversity of care packages, an adequate technical plateau.

Dear participants, yes, faith-based health organizations have become, through their visible and wholesome interventions, privileged partners in public health. The Church's contribution to health is a community contribution strongly encouraged by the Bamako Initiative and by the State of Cameroon, and I can assure you that the support of the State, which is very sensitive to your efforts, will continue intensifying.

With that, I declare the ACHAP 2019 Biennial Conference open.

I wish you all very fruitful deliberations.

Have a nice stay in Cameroon and in Yaoundé.



ACHAP Chairman

Mr. Peter Yeboah,

It is a pleasure, a privilege and an honor for me to welcome you all, on behalf of the Africa Christian Health Associations Platform (ACHAP), to the 9th ACHAP Biennial Conference here in the beautiful city of Yaoundé!

ACHAP is a family of Christian Health Associations and Church health related networks in sub-Saharan Africa. We are inspired by Christ's healing ministry to work and advocate for health for all guided by the principles and values of equity, justice and human dignity.

It is estimated that collectively, the ACHAP network provides trusted, compassionate, quality healthcare at lower or equivalent cost to over 50 per cent of the population in sub-Saharan Africa.

Therefore, we are major stakeholders and global actors in health.

Since the foundation of ACHAP in 2007, it has been a biennial ritual to meet, deliberate and discuss matters that promote the development and sustainability of Christian Health Services in sub-Saharan Africa. At these conferences, we foster the sharing of experiences; promote strategic shifts in FBO approach to health; form development partnerships and network among groups and partners with a shared mission of saving lives and livelihoods; and promote health and healing to millions of people.

Naturally, therefore, at such a privileged meeting, it becomes obligatory to celebrate our achievements, recognize the changes and challenges confronting faith-based health providers, and renew our vows to serve humanity with joy and introspection.

Yet, this year's conference is different, with historical significance. We recognize and celebrate our contributions and role as co-creators and champions of primary health care!

Global context and the African situation

Friends, over the past two decades, the global health landscape has undergone rapid transformation. The world has made great progress against several of the leading causes of death and diseases.

Life expectancy has increased dramatically: infant and maternal mortality have declined, we've turned the tide on the HIV epidemic, and malaria deaths have halved. Ladies and gentlemen, we could list many more successes.

While there are clear trends at the global level, with some countries making impressive gains, progress has been uneven. There are substantial variations across regions and countries. Nowhere is this contrast more striking than in sub-Saharan Africa where communicable, maternal, nutritional, and newborn diseases continue to dominate, and still remain the top drivers of health loss, especially in lower-income countries.

At the risk of being repetitive or sounding alarmist, sub-Saharan Africa continues to bear the larger share of the global burden of disease, with avoidable intraregional differences in diseases, injuries, and risk factors.

Evidence shows that HIV/AIDS, malaria and tuberculosis (TB) account for the overwhelming majority of deaths in Africa.

Added to these are a range of neglected tropical diseases (NTDs); the rise of non-communicable diseases is also contributing to avoidable fatalities.

Friends, the situation is further exacerbated by weak health systems, slow economic growth, rapid urbanization and environmental change, which all amplify the impact of communicable diseases.

Worst of all, the spate of wars, past and ongoing conflicts, which lead to large scale displacements, hunger/famine and malnutrition, obstruct the delivery of preventive and curative health services in some settings.

This debilitating situation continues to aggravate health inequalities, affecting the most vulnerable and marginalized populations who already face disadvantages – namely women, children, the elderly and the poor.

Context of re-igniting PHC and UHC

Friends, in the new context of the 2030 global agenda for Sustainable Development, particularly Sustainable Development Goal 3.8, which seeks to achieve universal health coverage as a means of ensuring healthy lives and promoting well-being for all individuals at all ages in all places around the world;

A renaissance in universal and people-centered approach to primary health care is deemed essential in providing health for all, and addressing the abysmal health indicators affecting sub-Saharan African countries, especially the most vulnerable.

Therefore, being a global actor, ACHAP shares in the ideals of the Sustainable Development Goals (SDGs), which represent an ambitious vision of the healthier, more prosperous, inclusive and resilient world we all want.

In the spirit of social justice and towards the pursuit of health equity, we recognize the urgent need to anchor our health system in a robust primary health care framework including services to improve the overall health of the people and their access to health services whilst protecting them from exposure to related financial hardship.

In many ways, the prospects of a strong and sustainable primary health care systems as the basis for personal health, community stability, economic development and national security that promote resilience against public health threats including infectious disease outbreaks and other natural or man-made shocks is not in doubt.

Connection to conference theme

Friends, beyond these imperatives and ideals, there is the need for reality checks:

Our primary health care is underdeveloped and underfunded in many countries, and facing severe workforce recruitment and retention and systemic challenges. Amid these challenges, there is fragmentation, duplication and inefficiencies in our fragile health systems undermining progress

As co-creators, historic champions, advocates and staunch supporters of PHC and UHC, ACHAP has a sacred role and moral responsibility in this discourse. We must therefore deepen our understanding of what is necessary to bring the PHC vision forward.

We need to recalibrate and amplify our efforts or we will not even come close to reaching many of the health-related targets either by 2030, 2050 or 2090. Hence, our theme for the Conference: Re-igniting Primary Health Care: The Role of ACHAP.

Recall of conference objectives

Accordingly, the conference shall, amongst others, explore the following objective: Promote partnerships and cooperation at all levels. Building strategic partnerships is an important step towards leveraging the enormous reach, experience and expertise of the global health community to accelerate progress towards PHC/UHC.

We believe that doing things in splendid isolation is not a sustainable pathway for achieving UHC. As ACHAP, we promote collaboration not conflict, cooperation not competition, and partnership not partisanship.

Hence, we look forward to harnessing models of strengthened partnership between CHAs and governments as well as development partners.

Faith-based health system and sustainable financing

Ultimately, in the light of PHC and UHC imperatives, and given the myriad of talents, experiences, expertise, goodwill, and assets here gathered, we should be able to find answers to the following questions:

1. How do we strengthen faith-based health systems to be responsive, resilient and sustainable in order to deliver on its mission of providing access to quality, equitable and affordable comprehensive/holistic health services especially for the poor, needy and marginalized segments of the society in sub-Saharan Africa?
2. In particular, what feasible, innovative and sustainable financing models are available for scaling up PHC towards attaining UHC?

Friends, regardless of all the innovative ideas to be generated, we must be mindful of the need to promote, preserve and protect our Christian ethics, principles and moral values in the provision of health services.

Future outlook

Dear friends, beyond our past achievements and challenges, we must be humbled by the work that remains. When every minute, women and children die mostly from preventable causes; when we see endless possibilities of saving lives that remain mostly neglected by unfair practices, professional negligence and inaction and policy failures; when our hearts continue to agonize over avoidable deaths, diseases, disabilities and discomfort; then it's our call to duty as Christian health workers.

Friends, when we see poor health as the cause of extreme poverty and unfulfilled destinies, then our Christian calling and voices of conscience prompt us that we have a lot of work to do.

Intuitively, our challenges, needs and expectations of our clients are pointers for innovation and sustainability.

So, whilst ACHAP would always advocate for equitable share of global and national resources for health, perhaps, it is time to face realities, wean ourselves off from complaints and lamentations. We should contemplate feasible local actions.

We need to consolidate and expand our gains. It is time to explore prospects and potentials for achieving sustainable PHC and UHC in the midst of these challenges.

In all these, we remain encouraged by these scriptures:

"Behold I make all things new." (Revelation 21:5)

"As thy days, so shall thy strength be." (Deuteronomy 33:25)

Friends, these are imperatives that enjoin us to explore new paradigms, fresh perspectives, innovative approaches and collective action for the organizational and financial sustainability of a new faith-based

health system. Hence the need to: “Reignite PHC.

So despite our present challenges and circumstances, we believe in providence. We know our Lord God Almighty will provide for us.

Yet, we need a rethink, a repositioning, retooling and a resolve as instructed by St Paul in Philippians 3:14, which encourages us to press forward progressively for the goal of high calling of our Lord Jesus Christ

Let us continue working with each other, building on the foundation laid by early missionaries and pioneers of PHC; and serve as the light and salt of the health sector! We must uphold FBOs’ timeless legacy of service and sacrifice, and uplift the visibility of Christian health services in this historic era!

For ACHAP, the needs of the poor and needy are a call for fidelity to our vocation; perpetual bond of service to humanity, a seal of our social contract and an acclamation of the virtue of determination, endurance and resilience to serve as health workers in the Lord’s vineyard.

For now, we need:

- A refocused passion that reflects the needs of our clients
- A renewed presence and visual identity to lead the national and international stage
- A rejuvenated purpose that would inspire our clients, our staff and the community to push for more.

Your excellencies, distinguished guests, friends, **the future is bright for PHC. ACHAP is great and stronger than ever before, and ready to set new standards, push the limits** and promote new boundaries for re-igniting primary health care towards attaining UHC.

We remain grateful to all partners whose contributions and support has made the conference organization successful. In particular, we recognize some key partners for their exceptional support: IMA World Health, American Leprosy Missions, World Vision, USAID, MCSP/JPHIEGO, Catholic Relief Services, CCIH, Global Water 2020, and World Council of Churches.

We thank our host, the Cameroon Baptist Convention Health Services (CBCHS), for their continuous organizational efforts and support for the conference.

To all the distinguished friends, partners and colleagues, here gathered, ACHAP deeply appreciates your passion and support for this historic conference. May this conference, grant us new perspectives, new paradigms and renewed commitment as we collectively seek better health for sub-Saharan Africa and the world at large by Re-igniting PHC and UHC.

On this memorable occasion, once again, I welcome you to the 9th ACHAP Biennial Conference.



Director, Cameroon Baptist Convention Health Services (CBCHS),
Conference host organization

Prof Tih Pius

CBCHS is very pleased to welcome you to the ACHAP 9th Biennial Conference here in Yaoundé, Cameroon, a country that is referred to as Africa in miniature. Your massive presence here today is testimony of your commitment to the well-being of the people you represent.

The CBCHS is grateful to CEPCA and to all sister churches, especially the Presbyterian Church in Cameroon and the different partners that accompanied us in the planning of this conference. We acknowledge your support and invite you to share with us in the success of this memorable event. We are honored to co-host this conference with you. On your behalf, I would like to thank ACHAP for choosing Cameroon to host this biennial conference for 2019.

Allow me first of all to present to you CBCHS as the host of this conference. The CBCHS is a non-profit faith-based health services delivery organization that was established by American Baptist Missionaries from the USA as an arm of the Church in 1936. It evolved and was handed over to local leadership in 1975.

From this modest primary health care post in 1936, in a small community in the North West region, CBCHS is today a major health care provider reaching over 10 regions of Cameroon with compassionate quality services that focus on community health care.

With a staff strength of close to 5,000 permanent workers, CBCHS operates seven tertiary hospitals, 30 intermediate hospitals, 52 primary health centers, a pharmaceutical procurement, production and distribution unit, a HIV/AIDS care and prevention program, training schools for health personnel, residency programs for surgeons and internal medicine, a center for clinical pastoral education and a comprehensive program that addresses the health and socio-economic needs of persons living with disabilities.

These are just some of the services we offer. Our services range from primary health care services to specialized hospital-based services. We recently received government authorization for an institute of health sciences which is already operational.

The CBCHS became a member of ACHAP in 2015 and we are happy to belong to this platform. Your excellency, ladies and gentlemen, we are especially happy for the timely theme of this conference – **Re-igniting Primary Health Care: The role of ACHAP**. I consider it timely for two reasons:

1. CBCHS was one of the many FBOs in Africa south of the Sahara to recognize that access to health care for all can best be achieved through primary health care, following the Alma-Ata Declaration in 1978. This explains why as early as 1980, CBCHS launched a community-based primary health care program targeting the poorest of the poor underserved communities in Cameroon.

The program has worked with hundreds of communities to put in place primary health care posts with the full participation of the communities concerned. Members of the communities have been trained to take ownership and management of these services.

There have been numerous challenges in sustaining this level of care in the district health system of a country like ours. However, as basic as PHC services have been, they have saved millions of lives.

The ACHAP 9th Biennial Conference brings back to the spotlight the PHC concept which has not been given appropriate attention in our health sector strategies. The conference is held on heels of the

commemoration of the 40th year of the Alma-Ata Declaration which took place in 2018, during which similar calls were made for governments to re-ignite PHC.

2. This theme 'Re-igniting Primary Health Care: The role of ACHAP' comes at a time when our country Cameroon is working towards UHC. The health sector in Cameroon has adopted a 10-year strategic plan, 2016-2026, with the development of health districts as a strategic priority and UHC as the ultimate goal.

In reality, UHC supposes that health care be available, accessible and affordable at all times for the populations. These are indeed the fundamentals of PHC. Our wish therefore is that Cameroon capitalizes on all the gains from the conference and uses them to fast-track Cameroon's progress towards UHC for the interest of all.

This conference will demonstrate in strong terms through the oral and poster presentations and all other interactions that PHC is a catalyst and foundation of sustainable health to all who need it. Our key expectation as hosts is that the conference should come up with strong recommendations and renewed commitment from all parties towards the re-igniting of PHC in countries south of the Sahara which is a region with low health budgets and yet has a high disease burden.

Health care is a basic human right and should be available to the individual and family at all times. This is not a privilege or a favor.

Your excellency, ladies and gentlemen, we are here for business. Yes, business that is centered on the welfare of our respective populations. The churches are the light of the community. The churches know very well that Jesus went through the streets preaching the gospel and healing people at the same time. All who came to Him received healing. He did not turn anyone back. Churches have that mandate to offer exemplary health care to all with genuine compassion. Over the years, Christian faith-based health providers have financed health programs from patient fees and limited external assistance in the form of medicines, missionaries, medical staff, etc.

Government support has not been available to faith-based organizations, at least in Cameroon, despite their huge contribution in implementing government health priorities. Faith health systems have not only spearheaded innovative strategies to offer quality care at the grassroots level but also have used their limited resources in an accountable manner to reach more populations. To implement PHC for UHC, governments of countries in Africa must not ignore the role of FBOs. The MOH in various countries need to partner with experienced FBOs and work towards UHC.

Your excellency and distinguished guests, conference attendees, let me take this moment to once more appreciate all who participated directly or indirectly in the organization of this conference, especially all the members of the local organizing committee. We thank the ACHAP Coordinator and the Secretariat for the day-to-day support and for the resources mobilized towards this conference.

We thank the Government for facilitating the visa process and offering protection to all the participants from abroad. We acknowledge the contribution of all the organizations that supported us, be it materially, financially and technically to make this ACHAP Biennial Conference a success in Cameroon.

We thank MOH, WHO and other key organizations including MOH for accepting to chair this high-level conference and we hope to count on your support during the implementation phase of the resolutions of the conference. Thanks also to the authors of abstracts, those who will make presentations and those who offered to exhibit relevant medical equipment and supplies during this conference.

We are grateful to have many of you who travelled from far and near to sit in this conference. We cannot forget the different media firms who have supported us by way of publicizing this conference.

And finally, we pray the Almighty God to grant you a happy stay in Yaoundé, a successful conference and a safe return to your homes and to your families. Long live Africa Christian Health Associations Platform. Thank you.

Pre-conference Workshops

Workshop 1: **Operationalizing Integrated RMNCH Approaches to Reduce Missed Opportunities and Improve Quality of Care**

Facilitators: *Dr. Monique Wubbenhorst, Dr. Neeta Bhatnagar, Mona Bormet, Dr Jacqueline Wille*

Organizations: *USAID, JPHIEGO, CCIH*

Dr. Monique Wubbenhorst began by introducing the Maternal and Child Survival Program (MCSP) as a USAID flagship intervention supporting the agency's goal to prevent maternal and child mortality worldwide.

She pointed out that governments did not have the capacity to provide all the health care needed in their countries. Health services offered by FBOs helped bridge this gap.

The FBO health services were popular due to lower costs, respect and love for the communities that they served. Offering high quality health services, the FBOs served hard-to-reach areas with compassion.

The USAID was committed to assisting FBOs to provide these health services and continue to share best practices and lessons learned. This would ensure more women and children were reached with cost effective and high quality PHC services across the continuum of care.

The workshop was therefore aimed at improving care on the day of birth and beyond and ensuring continued collaboration with FBOs to improve maternal and newborn health outcomes along the continuum of care.

A long with helping families and mums, USAID funding was also aimed at helping countries grow to self-reliance and recognize, prioritize and raise funds to self-support on pressing health issues.

The continuum of care

During this session moderated by Mona Bormet, Dr. Neeta Bhatnagar expressed her passion to see every woman and child healthy, happy, alive and kicking. To achieve this, it was important for health care workers to maximize routine contacts and key interventions across the continuum of care for improved maternal and newborn health.

Health care providers should therefore seize the opportunity to tell women how to get better health outcomes for themselves and their babies during contact with them.



Women's experiences and memories of childbearing stay with them for a lifetime and are often shared with other women, contributing to a climate of confidence or doubt around childbearing. There was therefore need to ensure women had good health care experiences so they could pass positive messages to other women.

There is need for an enabling environment, adequate equipment, health systems strengthening and support supervision to ensure high quality services. Opportunities exist for integration of primary health care services at every health contact with women and babies across the continuum of care, which should be maximized.

The day of birth and beyond

In her presentation, Dr Jacqueline Wille pointed out the main interventions during this point in the continuum of care as well as the common gaps in the services given to mothers and newborns.

The day of birth was critical for several reasons, including the fact that for some mothers, it could be the only time they were seen in a facility. It was therefore critical to improve services on the day of birth.

Interventions needed by mother and baby, and common obstacles to these interventions were also discussed. The participants also discussed how to strengthen routine day of birth services.

A role play was done to demonstrate activities on the day of birth, moving from triage to labor and delivery, then postnatal care and discharge. Participants observed closely to note gaps in service provision and make suggestions or provide solutions to these gaps.



Participants in a role play during the workshop.

Questions and discussions summary

- Cord clamping and separation is to be delayed according to the WHO guidelines to reduce risk of anemia in the new born.
- The number of ANC contacts have been increased from four to eight in the WHO guidelines because four visits failed to prevent maternal and child mortality and morbidity.
- If breast milk does not flow after child birth, the baby should be placed on the breast and continue to breastfeed in order to initiate milk ejection through suckling reflex. Some women may have severe post-partum hemorrhage and may not be able to produce milk immediately after birth, but this is soon resolved through continuous suckling.
- Participants sought to know the role of men in the child bearing process and how they could be motivated to be more supportive in the process. It was noted that there was evidence of engaging and involving men, but a lot still needed to be done. Men should also be invited to the ANC for education and counselling on how and where exactly they were expected to intervene in the process.
- The Maternal and Child Survival Program (MCSP) did engage community health workers (CHWs) to

Reflection and development of action plans

Participants were asked to form groups according to the organizations they came from to develop an action plan/commitment to improve date of birth walk-throughs in their facilities. Participants then moved to a marketplace with tools and resources for date of birth care to take home.

Workshop 2: WASH in Health Care Settings

Facilitators: Lindsay Denny, Joanne McGriff

Organization: Global Water

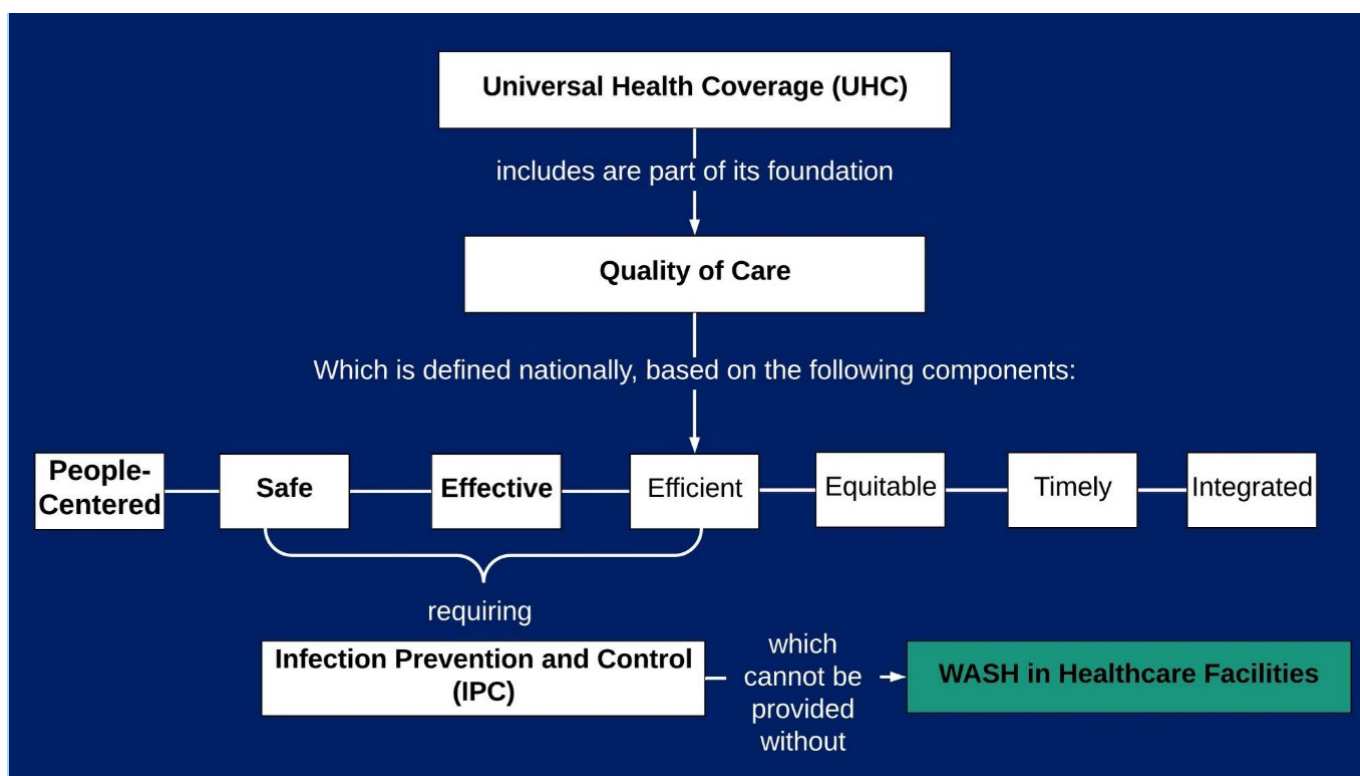
Target organizations: CHAL, UCMB, CHAG, CHAK, ZACH

Module 1

In this module, participants were taken through the basic and expanded definition of WASH, which is covered in SDG 3 and 6.

In a health care setting, hygiene expands personal, menstrual and hand hygiene to include infection prevention and control, environmental cleaning and equipment processing. Sanitation includes sanitation facilities (toilets/latrines), fecal waste management and healthcare waste management (sharps and infectious waste).

The global vision is that every healthcare facility should have the necessary and functional WASH services and practices in order to provide essential, quality health services for everyone, everywhere. A healthcare facility without such WASH services is not a healthcare facility.



The global target is at least 50 per cent of all health care facilities globally and in each SDG region have basic WASH services by 2022, and 80 per cent by 2025, with the ultimate aim of 100 per cent by 2030. Improvements seek to address inequities across geographic (rural and urban) areas and among primary, secondary and tertiary facilities.

All facilities should be aiming for basic WASH service by 2030 as spelt out in the JMP service ladder. This means:

- **Water:** Water is available from an improved source located on premises.
- **Sanitation:** Improved sanitation facilities are usable with at least one toilet dedicated for staff, at least one sex-separated toilet with menstrual hygiene facilities, and at least one toilet adapted for people with limited mobility.
- **Hand hygiene:** Functional hand hygiene facilities (with water and soap and/or alcohol-based hand rub) are available at points of care, and within five meters of toilets.
- **Healthcare waste:** Waste is safely segregated into at least three bins, and sharps and infectious waste are treated and disposed of safely.
- **Environmental cleaning:** Basic protocols for cleaning are available, and staff with cleaning responsibilities have all received training.

Physicians have been calling for improved hygiene as part of the strategy to reduce morbidity and mortality among patients for several centuries, yet WASH provision is inadequate in many healthcare facilities in lower- and middle-income countries, including labor wards.

The consequences of poor WASH affect the health facility, individual and employer and include limited ability to provide quality medical care, greater risk of hospital-acquired infections and emerging threats from outbreaks like Ebola and antimicrobial resistance.

Module 2

Universal health coverage means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

According to Dr. Tedros Adhanom Ghebreyesus, Director-General, WHO, UHC is the top priority of the world health body. Effective WASH in healthcare facilities is the foundation of UHC which has as a key component, quality of care.

When addressing the improvement of WASH in HCF, a health systems approach requires the provision, utilization, quality and efficiency of WASH services throughout the health system, and encourages the adoption of healthy WASH/IPC behaviors and practices.

Key initiatives under health system strengthening include Quality of Care (QOC), Infection Prevention & Control (IPC) and Antimicrobial Resistance (AMR).

The key take-away points from the session were as follows:

- WASH is a fundamental pre-requisite for the delivery of quality healthcare.
- Infection prevention and control cannot be properly implemented without the full set of WASH infrastructure, supplies and behavior.
- Healthcare-associated infections will continue to proliferate as long as there is inadequate attention paid to the WASH related services and behaviors that can reduce transmission of pathogens.
- WASH in health care is essential to address the emerging global threat of antimicrobial resistance.

The second part of the workshop focused on the experiences of five CHAs supported by ACHAP to implement WASH in their respective countries.

Monicah L. Nsubuga from Uganda Catholic Medical Bureau, Mpho Ngwenya from CHAL Lesotho, Alex from CHAG, Ghana, and T. Hungwe from ZACH, Zimbabwe gave reports on what was done, challenges encountered and way forward.

In Ghana, a baseline assessment of WASH conditions in 11 selected CHAG facilities had been conducted. The assessment revealed poor WASH conditions in the facilities. CHAG had procured WASH items for distribution in the health facilities.

CHAG planned to conduct WASH assessment in 20 of its hospitals, print and distribute IEC materials on WASH and present findings of the baseline assessment at the annual conference of all CHAG facilities in June 2019. Additional funding was needed and being sought to conduct the WASH assessment in all CHAG facilities.

ZACH had done WASH assessment in 10 of its hospitals and clinics using the WASHCon assessment tool. WASH commodities had been procured for 10 facilities and the health units sensitized on repair work that needed to be done to improve their WASH conditions. Facilities were sensitized on prioritizing WASH/IPC activities, including providing a budget line for them. The IPC committees were sensitized and the supported facilities encouraged to initiate WASH activities using their own resources.

During the discussion session, participants were encouraged to develop job descriptions for cleaners, intensify supervision and surveillance, work on behavior change, collect data for advocacy, control contaminated water that can prolong treatment of patients, work on patient satisfaction and involve all stakeholders in WASH.

Workshop 3: Responding to Health Crises: How Working Through or with Church Organizations Increases Effectiveness and Builds Reputation with Donors and Government

Facilitators: *Dr. Larry Sthreshley, Dr. Alice Mudekereza*

Organization: *IMA*

Moderator: *Frank Dimmock*

The moderator opened the session by defining the term ‘crisis’, stressing that every country is currently facing a crisis and will face one in the future. It was therefore important to know how to respond to crises.

Dr. Sthreshley shared the strategy IMA had used in responding to three Ebola outbreaks (Kikwit – 1995, Luebo – 2008, and North Kivu – 2018/19) in the Democratic Republic of Congo (DRC). Among the strategies used in the above crises were networking with local churches, rapid response, providing logistics, using community volunteers and training hospitals to fight Ebola. The first responder to the Kikwit Ebola crisis was IMA, who alerted CDC and provided logistical support to set up a laboratory and trace contacts.

The Ebola outbreak of 2018/19 in Eastern Congo is the second largest in history and not yet under control. Local communities have attacked and destroyed health facilities and attacked health workers as well.

To ensure sustainability, post Ebola interventions to stabilize community health facilities were done as well as health sensitization. The FBOs were asked to do Ebola messaging due to greater trust from the community.

Another crisis in the DRC occurred in August 2016 when open conflict between the government and local militia broke out. Over 4,000 people were killed and over a million displaced. The OFDA has provided assistance to 125 health areas in the first phase of its intervention and another 96 will be roped in during the second phase. Over 120 health facilities were looted or burned during the conflict.

The OFDA assistance caters for reimbursement of costs for:

- Health care in 125 health centers in 12 health zones
- Delivery for normal births
- Cesareans for those that need it
- All emergency surgeries
- Care for SGBV
- Family planning services

The DRC has also experienced a famine crisis. Through a local NGO, PRODEK, the project provided seeds and tools for 9,000 families for two growing seasons under its food security component.

Dr. Alice Mudekereza spoke on the fight against Sexual Gender Based Violence in Eastern DRC by networking with local churches and CBOs, using technical partners to train and build capacity of the churches and CBOs to ensure quality and promote “positive” gender norms in respect to cultures and individuals.

She added that working with FBOs had resulted in quick implementation, better reach because of their presence, acceptance because they are a part of the community, interventions that respect communities and individuals as well as hope for sustainability. With increased capacity building, the FBOs provided the best way to reach the remote areas. In the GBV project which will run in 2018-2022 with funding from USAID, 35,000 survivors received comprehensive care.

Food for thought

What is the role and responsibility of ACHAP in helping FBOs better respond to crises?

Group work

Group one

Question

You are working with an infectious disease outbreak at the border of your country. There is frequent migration between countries and the disease is likely to spread across the border. What steps should you take to mitigate/minimize the risk of spreading the disease?

The group highlighted the following steps:

- Disease and causative agent identification
- Notify the health system, MoH, CDC
- Sensitize the community and the health workers not to create panic
- Contact tracing or line listing
- Minimize movement across borders

Group two

Question

What are some of the reasons faith-based health providers should be prepared and respond to health crises?

The members highlighted the following reasons:

1. They are found in almost every community and are trusted.
2. Our spiritual and moral obligation to care for those in need.
3. If we are prepared, we will have the capacity to respond when challenges come.
4. Most crises begin in a local area and local solutions can work.
5. We can often detect or know in advance where a crisis can strike.
6. We are the first responders.
7. Easily get resources.

Group three

Question

Share examples of how CHAs have responded to health crises; the challenges, successes and lessons learned.

The group shared the case of a HIV/AIDS crisis in Malawi.

- All FBOs agreed with government to fight the epidemic.
- Carried out free testing and sensitization.
- Helped train staff in counselling and management of the condition.
- Brought in experts to build capacity in HIV/AIDS management.
- Used schools to pass HIV/AIDS messages

Challenges

- Limited resources.
- Beliefs and culture hindering treatment.
- Wars that resulted in destruction of facilities and hence high defaulter rates.

Workshop 4: Skills Building on Establishing Health Kiosks

Facilitators: Gloria Ekpo, Lauren Van Enk, Dephin Mpofu

Organization: World Vision

The session began with a brief introduction of World Vision and the organization's contribution to the fight against HIV/AIDS. The session also examined assets of FBOs in ending HIV which were identified as follows:

- An estimated 84 per cent of the world has a religious affiliation.
- 75 per cent of Africans trust their religious leaders.
- An estimated 30-70 per cent of health infrastructure in Africa is owned by faith-based organizations.
- Leveraging the power, platforms, people and networks of a well-informed and mobilized faith community is essential in controlling the HIV epidemic.
- Faith platforms can be maximized to improve literacy around HIV prevention services, strengthen referral, support adherence and retention in HIV care for PLHIV.

Around the world, countries are approaching epidemic control by meeting 95-95-95 targets. Data suggests the last 95 on adherence is weak across many countries. There is therefore opportunity for FBOs to address priority populations and the adherence gap.

The USG recently announced a USD100 million kitty for FBOs in the fight against HIV/AIDS. PEPFAR has been meeting with select FBOs at country level towards establishing priority areas to be addressed using the kitty.

What is a health kiosk?

This is a safe space at a faith worship center that provides information on health/HIV and makes referrals for services by trained faith worship center volunteers using locally available HIV and health information and communication materials to increase access to health and HIV services within congregations and communities.

Expectations from the Health Kiosk Program

- Well-informed congregations on HIV and health related matters.
- Increased knowledge of where and how to access services.
- Increased uptake of information on health and HIV related issues.
- Increased referral for services.
- Increased uptake of HIV and health services (e.g. HIV testing, PMTCT, MCH, VMMC.)
- A more caring and supportive community on health and HIV issues.
- Improved collaboration between faith centers and health facilities.
- Improved collaboration among participating pastors

To establish a health kiosk, a worship center needed to be well updated on current issues in HIV/AIDS including:

- Barriers to HIV/AIDS epidemic control such as stigma and discrimination and the HIV infection cycle.
- Who is missing or has been left behind in the fight against the pandemic. In most countries in Africa, men and boys have been identified as largely missing from efforts to address HIV/AIDS. It would therefore be prudent to address the barriers and identify the interventions necessary to overcome these obstacles.

The steps of setting up a health kiosk were presented as follows:

- Assess the place of worship.
- Consider the budget including personnel, supplies and M&E.
- Together with faith leaders, choose activities for the health kiosk.
- Network with nearby health facilities to receive referred clients.
- Develop tools for data collection and monitor results and get feedback.

To establish an effective health kiosk, four main objectives need to be addressed and the requisite activities planned:

Objective 1:	Safe space for dissemination of HIV and health information selected as a Health Kiosk at faith worship centers.
Objective 2:	Faith worship centers provide information on HIV and health issues to their congregations.
Objective 3:	Congregational members are mobilized to access HIV/health information and services.
Objective 4:	Referral and linkages to HIV and Health services from faith worship centers are increased.

Participants were also taken through the program M&E tools as well as a case study of Zimbabwe where health kiosks had been established. To come up with this approach in addressing HIV/AIDS in Zimbabwe, World Vision collaborated closely with government (MoH) and church leaders. Referrals are not done only to church health facilities but to any nearby facility.

Plenary session 1: Panel Discussion

Moderator: Dr. Mwai Makoka (WCC)

Panelists: Prof. Tih Pius, Peter Yeboah, Dr. Monique Chireau Wubbenhorst

Organizations: CBCHS, ACHAP, USAID

Strengthening FBO's Health Systems for PHC towards UHC

Presented by Dr. Monique Chireau Wubbenhorst



Session panelists Prof. Tih Pius, Peter Yeboah and Dr. Monique Chireau Wubbenhorst during the conference.

Dr. Monique began by observing that PHC was at risk of being left behind in the move towards UHC, yet it was foundational to achieving UHC. Also at risk of being forgotten was the focus on prevention and optimal health as well as optimal health systems.

Universal Health Coverage (UHC) is a target of SDG 3 which states: "Ensure healthy lives and promote well-being for all at all ages". The target states: "Achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care and access to safe, effective, quality and affordable essential medicines and vaccines for all".

There are multiple definitions of what it means to achieve UHC. It is not fully resolved whether UHC should be accomplished through government health financing arrangements or a mixed approach, built over time or addressed all at once, or cover the whole healthcare system. Additionally, we need to be clear on whether it should include prevention, curative care and supply and demand side factors.

UHC should be an aspirational goal for countries, which is progressively realized depending on the country context. Top-down, government-centric systems may not be able to provide the features of an optimal health system, for a variety of reasons.

The important role of the private sector and civil society, including faith-based organizations in the implementation and achievement of UHC should be explicitly recognized because achievement of universal access to health care requires attention to the whole health system.

Primary health care

A focus on primary health care and community workforce leads to a better skill mix for the health sector. Community health is foundational to primary health care, emphasizing the critical role of CHWs, midwives and primary care physicians as part of the health workforce.

Focus on prevention and optimal health

The priority for public health campaigns is to prevent disease and health risk behavior. This means preventing disease and disease risk factors, including malaria, TB, vaccine-preventable diseases and malnutrition. It also means avoiding exposure to risks that are associated with poor health and social outcomes, such as infidelity, tobacco, alcohol, drugs, poor eating habits, exploitation and violence.

Creating optimal health systems

Optimal health systems are accessible, accountable, affordable and reliable. In optimal health systems, people get the care they need in ways they trust. When they need care, it is available. People do not have to pay too much or travel too far for health care.

Dr. Monique noted that USAID works with partners to create optimal health systems through:

- Focusing on primary health care
- Supporting patient ecosystems
- Letting countries lead
- Helping build resilience
- Emphasizing sustainability
- Engaging and aligning efforts with a wide variety of partners and stakeholders
- Designing new approaches for scale-up
- Scaling up proven approaches
- Considering markets for new products, especially those targeted to the poor
- Using technology appropriately, considering its social and environmental costs.

Panel discussion

Prof. Tih Pius affirmed the commitment of CBCHS to PHC. He said the organization was providing affordable health care to all, ensuring community participation and socially acceptable services. Sustainability of services remained a key challenge. The CBCHS, he added, believed that 'prevention is better and cheaper than cure'.

Commenting on the observation that FBOs had deviated from PHC, ACHAP Chairman Peter Yeboah said CHAs were from their early days and even in later years heavily funded by missionaries and were not for profit. This funding has now drastically reduced and in some cases completely dried up, yet the CHAs still need to survive. Because user fees could not be charged for preventive services, PHC was affected.

Mr. Yeboah recommended that PHC be assigned to governments with CHAs playing a complementary role. On the downside, however, this option was unattractive to politicians as it would be difficult for governments to use PHC to achieve political ends given its limited funding.

Dr. Makoka summarized the CHAs' dilemma thus: "It seems we are trapped; we know what to do but the economic environment does not give us room to do it since money is in the disease and not in the prevention".

To address this issue, Dr. Monique noted that countries would need to become self-reliant, with governments, FBOs and the private sector financing health and networking to raise finances. Health was important for human dignity but market forces shaded this importance.

Dr. Makoka, with reference to Agenda 2063 for Africa and the Malaria Free Africa Initiative, pointed out that partnerships can be leveraged by:

- Having strategic steps as a way forward
- Leveraging each other's strength
- Revisiting PHC.

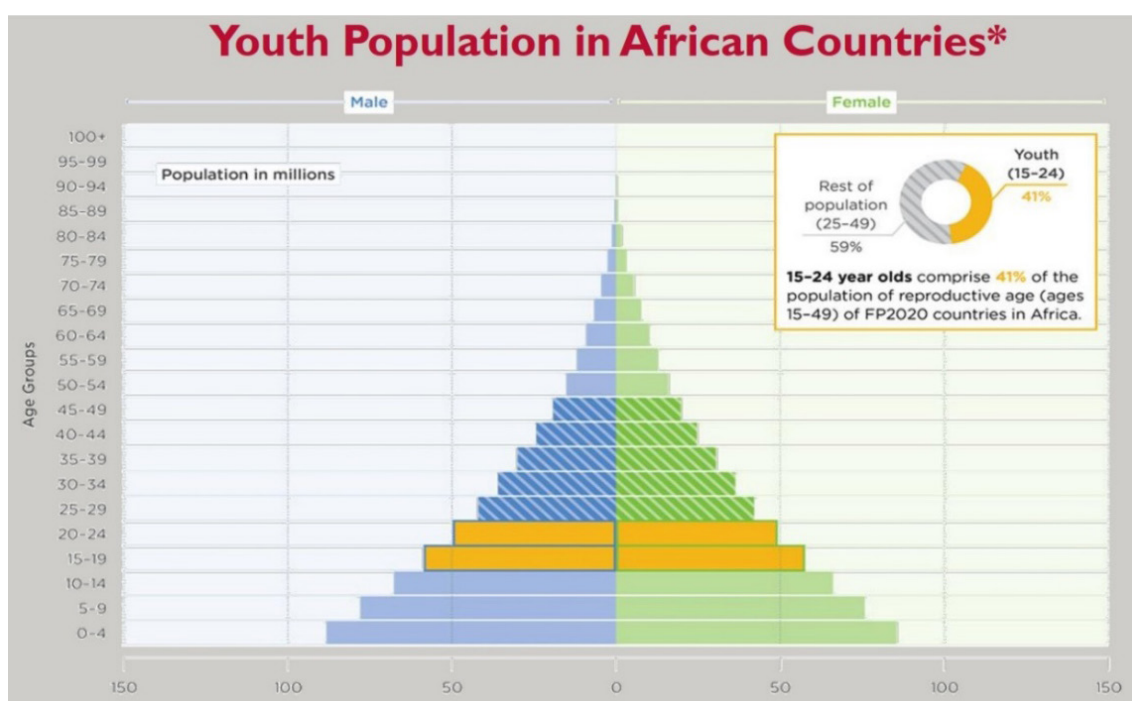
Plenary session 2: FBO-Government Partnerships at Country, Sub-Regional and Regional Levels for Promoting PHC and Realizing UHC

Moderator: *Dr. Gloria Ekpo (World Vision)*

- Presenters:**
- *Melissa Freeman (USAID)*
 - *Dr. Josephine Balati (CSSC)*
 - *Mafase Ng'ong'ola Sesani (CHAM)*
 - *Dr. Douglas Kinuthia Gaitho (CHAK)*
 - *Dr. Bildard Baguma (JMS)*

The moderator opened the session by underscoring the importance of partnerships in achieving set goals.

Melissa Freeman took participants through USAID-FBO partnerships, highlighting key achievements by several partners including World Vision, UPMB and CCIH. She emphasized the need for interventions to reach adolescents and young people.



Dr. Josephine Balati, Director of Health Services, CSSC, spoke on service level agreements in Tanzania. She noted that partnerships between government and FBOs in the health sector in Tanzania have been in existence before and after independence.

Growing demand for health care services has led to contractual arrangements between the government and FBOs for subsidies.

A Service Level Agreement (SLA) template was developed in 2007 to increase availability of quality health services to the general population in accordance to the National Health Policy and its related guidelines. The SLA provides a contractual arrangement for private providers of health services to render health services on behalf of the government. The SLA template was revised and updated in 2017 to address identified challenges.



Session moderator Dr. Gloria Ekpo and panelists.

The service level agreement template is divided into two main parts:

1. A formal agreement template
2. Six schedules that cover the implementation process and include:
 - Services to be provided by the service provider
 - Services outputs and costs
 - Quality standards
 - Management outputs
 - Financing of health services
 - Exemption process and mechanism for reimbursement.

Among the achievements in implementation of the SLA are:

- To date, 84 per cent of FBO hospitals have signed the SLA with the government and receive various subsidies including funds, staff salary, medicines and medical supplies.
- FBOs are more involved in the Comprehensive District/Council Health Planning process.
- Increased opportunity to receive support and funds from development partners to implement health related programs.
- There is increased access and quality of health services.
- Demand and use of health facilities by the community has increased.
- High level of knowledge of PPPs in districts that have received PPP training has been noted as has improved communication and reporting among stakeholders and government.
- The SLA has heralded new opportunities for financing health services and strengthening UHC.

Mafase Ng'ong'ola Sesani's presentation focused on the partnership between Christian Health Association (CHAM) and Malawi Ministry of Health. The partnership is aimed at strengthening provision of Primary Health Care in faith-based facilities.

The Malawi government entered into a partnership with CHAM where provision of primary health care and essential health package (EHP) services are harnessed as key strategies towards the achievement of agenda 2030.

The MoH and CHAM signed an MoU in 2002 which was renewed in 2016. Both parties are committed to providing the EHP services for free, especially to the poor.

In addition to the MoU signed in 2016 at the national level, facilities also sign agreements annually within districts.

The government of Malawi provides the CHAM facilities with the following:

- Salaries of health facility workers and frontline community health workers.
- Pays for essential health services provided by the CHAM facilities based on performance under an SLA.

On the other hand, CHAM and its facilities:

- Provide PHC services in communities. These include health education, health promotion, WASH interventions, child health, nutrition and immunization in the CHAM catchment areas' villages.
- Provide for free an agreed package of essential health care services to the communities.

The package of services offered is scaled up in a phased manner in consideration of the facility's technical capacity, MoH budget capacity and the program management and administration systems.

Numerous gains have been made as a result of the agreement. For example, 24 per cent of Malawi's population is reached with essential health and PHC services. Maternal deliveries in CHAM facilities have increased by 36 per cent while health seeking behavior and facility-community relations have improved greatly. In addition to increased revenue for CHAM facilities, capacity building for health workers has been enhanced to enable them cope with the increased work load.

Dr Douglas Gaitho presented a case study on engagement between Kenya's county and national governments and Christian Health Association of Kenya in HIV service delivery with special focus on the CDC-funded CHAK HIV/AIDS project, CHAP Uzima.

The engagement is necessary for a number of reasons including increasing ownership of HIV services by the MOH, addressing HRH needs and challenges and improving data quality. The introduction of county governments following the 2007 General Elections also led to health becoming a devolved function, hence the need to engage county governments.

During the CHAP Uzima project's October 2017 to September 2018 financial year, a number of partnership initiatives had taken place.



Signing of a partnership MOU between the County Government of Kitui and CHAK's CHAP Uzima project in Kenya.

A partnership framework with National and County Governments was in the pipeline. Led by CHAK, the Kenya Faith Based Health Services Consortium (KFBHSC) had developed and was negotiating a tripartite partnership framework (MoU) between; National Government/MOH-County Government/Council of Governors and FBOs. The MoU covers health systems, health services, financing, M&E and accountability.

Engagement with county governments had also been conducted taking the form of:

- Formal meetings with county health management teams – Seven counties over the last financial year
- Memorandum of Understanding (MoU) - HRH
- Joint capacity building forums – 172 health care workers were trained on new ART treatment guidelines in the past financial year.
- Joint DQAs have been done in 23 health facilities. CHAK is known for its excellent M&E capacity.
- Establishment of regional TWGs: One regional TWG has been established and three others are supported monthly.
- Supply chain and RTK allocation TWGs

Among the challenges encountered is frequent stock out of rapid detection kits and ARVs.

Cost-sharing of HIV services support with county health governments has led to increased ownership by the Ministry of Health with reduced cost of implementation at program level. County engagement is therefore a necessary and sustainable approach for HIV service delivery in faith-based and affiliated health facilities.

Dr. Bildard Baguma gave the experience of JMS in supporting the PHC project for Private Not For Profits. Uganda's MoH supports PNFs to ensure accessibility to primary health care services.

Historically, funds for essential medicines and health supplies were sent directly to the health centers. Finances were allocated annually to PNFs, for procurement of essential medicines and health supplies.

However, in 2017, MOH centralized the 50 per cent non-wage PHC grant for PNFs at JMS to create a virtual account for each beneficiary. Health facilities prepare and submit annual and quarterly procurement plans to JMS which forecasts and fulfills facility needs.

The grant was centralized to improve affordability of healthcare supplies, ensure equitable access and improved availability of these supplies.

This approach has led to improved quality of products due to a robust quality analysis system at JMS. There has also been improved availability and access to quality health care supplies at the 532 beneficiary health facilities, improved reporting, accountability and traceability of products.

A key challenge is that last mile distribution has been affected by deterioration of road networks during bad weather.

Questions and discussions summary

Participants sought to know the process of submitting concept notes to USAID. They were told that announcements are made in local media, concept notes submitted and the suitable ones selected.

Discussions also centered on how Malawi overcame challenges to sign the MoU with MoH. The need for a joint task force to set up national prices and carryout joint reviews, quarterly M&E and share feedback was stressed.

On strategies for staff retention in CHAK's engagement with county and national governments, Dr. Gaitho informed the participants that under the MOU, staff were recruited by the government.

Plenary session 3: Health Promotion Churches

Moderator: *Jim Cox (IMA)*

Presenter: *Dr. Mwai Makoka (WCC)*

Panelists:

- *Rev. Nditemeh Charlemagne (CBCHS)*
- *Doug Fountain (CCIH)*
- *Rev Dr. Simon Dossou (AACC)*

Dr. Makoka's presentation titled 'Case studies of opportunities to scale up health promotion, NCD prevention, treatment and support through churches with special focus on Tonga, Jamaica, South Africa and North Carolina, USA,' anchored the session.

In his presentation, Dr. Makoka said congregations should engage in PHC for several reasons including:

- To correct unjust distribution of health resources
- To empower people versus over-medicalisation and commercialisation of health
- To reduce heavy dependence on professional and institutional health services, allowing them to provide expert care for complicated illnesses for which they are trained.

He brought out several cases studies of churches that were engaged in PHC with excellent and verifiable outcomes.

In Tonga, there was church-based screening for NCDs and risk factors while in North Carolina, USA, aerobic sessions at the AME Zion church had yielded significant results in control of blood sugar, blood pressure as well as weight loss among participants.

In South Africa, an NCD support group in the Methodist Church of Southern Africa, Durban, was providing adherence support, treatment monitoring and literacy.

He also presented the 4 x 4 model for NCDs consisting of:

1. **Health education:** The congregation as a place of health education where people learn about health and ill-health from both medical, social, and theological perspectives.
2. **Healing and practical action:** The congregation as a place of healing where people are taking practical action at the personal, family, and community level.
3. **Advocacy:** The congregation as a place for caring where advocacy for peace, justice, and care for creation takes place to influence policy, systems and the environment.
4. **Empowerment:** The congregation as a place of empowerment, taking positive and bold action at the workplace or marketplace within the members' realm of responsibility and influence.

Rev. Nditemeh of CBCHS affirmed the model presented by Dr. Makoka and called on CHAs to avoid denominational barriers and theological rigidity to leverage available opportunities. He gave the example of CBCHS which has used the church for health promotion in a program named "Know your numbers (KYNs)". The idea of churches becoming health promoters was therefore feasible.

Dr. Fountain of CCIH decried the habit of locking churches during weekdays and only opening them on Sundays, which to him was a hindrance to health promotion by churches. He added that churches are natural places to confront behavior and hence good avenues for health promotion.

Rev. Dr. Simon told the gathering that AACC promotes unity and advocates FBOs and churches to promote holistic healthcare.

4 x 4 model for NCDs

	Food and Nutrition	Physical activities	Tobacco	Alcohol
Health education				
Healing & practical action				
Lobby and advocacy on PSE				
Empowerment for public witness				

The congregation as a place of health education: learning about health and ill-health from both medical, social, and theological perspectives. **(Health Education)**

The congregation as a place of healing: taking practical action at the personal, family, and community level. **(Healing & Practical Action)**

The congregation as a place for caring: advocacy for peace, justice, and care for creation. – Policy, Systems, Environment - PSE **(Advocacy)**

The congregation as a place of empowerment: taking positive and bold action at the workplace/marketplace within the members’ realm of responsibility and influence. **(Empowerment)**

Discussions also centered on how the church can manage non-medical interventions such as prayers while allowing patients to still access health facilities.

Rev. Nditemeh stressed the fact that some health issues have spiritual root causes and the health facility would be handling the physical symptoms while the church handles the spiritual aspect. He gave the example of CBCHS where chaplains handled spiritual root causes of disease while medical professionals handled the physical symptoms.

Commenting on the use of traditional medicines, Dr. Mwai said these were not taboo but needed to be handled with care.

Breakout Sessions

Breakout session 1: Financing Models for PHC for UHC

Moderator: *Dr. Samuel Mwenda*

- Presenters:**
- *David Balikitenda – UPMB*
 - *Kuni Esther – CBCHS*
 - *Mafase Ng'ong'ola – CHAM, Malawi*



Panelists during the session.

The moderator began by pointing out that the main drivers of PHC were knowledge, HRH, technology, finances, empowerment of communities and stakeholder support.

Financing was a critical component of PHC for UHC because the available resources were limited. There are other competing priorities for government finances and additionally, there have been changes in donor priorities. This means that funding for FBOs has either reduced or completely dried up. These challenges necessitate that we explore ways of sustainable financing for PHC.

Mafase Ng'ong'ola shared a case study of Kaundu Health Centre in Malawi where the local community had come together and established their own health insurance scheme. Although health services in Malawi are offered free of charge in public facilities, many CHAM facilities do not have SLAs and therefore face financing challenges due to high poverty levels in their catchment communities.

The Kaundu Health Centre Community Health Financing initiative was started with an objective to improve MNH/OPD utilization at the facility. Each beneficiary contributes a small amount of money monthly to the scheme as follows: ANC women – USD 0.42, under 5s – USD 0.21, others USD 0.28. Clients pay a shortfall fee of 20 per cent at the point of health care. The money is banked in an account specifically opened by the health facility for the scheme and managed by the community members.

In 2017/2018, the scheme's membership stood at over 4,000, with 631 deliveries in the health center paid for through the community fund. Under five utilization of the fund stood at 4,891 while OPD utilisation was 8,443. These numbers show a marked improvement in utilisation of health services by the community members at the facility. The initiative will be scaled up to other CHAM facilities to achieve universal coverage.

David Balikitenda shared UPMB's experience in establishing Community Health Insurance initiatives run by its member health facilities. The goal is to improve access to affordable, quality health services by establishing Community Health Insurance in at least 20 per cent of UPMB member facilities.



UPMB Community Health Insurance coverage



150,264 Active CHI members
 2,146 Community Groups
 47 Trained Health Facilities/ Providers
 9 Hospitals 38 Lower Level Units/ Providers
 3,339,258,000 Total Premium collections
 97,671(65%) Accessed medical health care
 1,001,777,400(30%) Total Surplus

Among the key achievements of the CHI schemes are:

- Improved preventive and treatment seeking behavior
- Better financial risk protection
- Significantly higher provider cost recovery
- Improved maternal health indices: For example, Kisiizi Hospital has established a mother's hostel for pregnant mothers. During their stay here as they wait to give birth, the mothers are attended to by healthcare workers and given information on proper nutrition.
- Schools are also included in the CHIs. The hospitals do outreaches to the schools and where necessary refer the children to the health facility. This has led to an improvement in student grades as they access quality and timely health care.

An important outcome is improved relations between the communities and health facilities.

Kuni Esther shared on the Local Capacity Initiative, a CBCHS project that encouraged communities to mobilize resources towards improving ANC/PMTCT uptake in five districts in Cameroon.

The LCI project was titled "Building sustainable community based HIV and AIDS care and prevention programs and increasing the uptake of services in the Northwest and Southwest Regions of Cameroon" and was implemented between April 2014 and March 2018.

The review of ANC/PMTCT uptake in a project funded earlier revealed that the districts of Ako, Bafut Benakuma, Mbengwi and Tubah were at the bottom in performance. The HIV Free SW & NW Project which ran from September 30, 2011 to September 29, 2016, was funded by CDC.

Three challenges were identified as causing the low uptake of ANC/PMTCT services in the five districts. These were:

- Limited health personnel
- Lack of basic equipment
- Dilapidated structures in the health facilities

Using a participatory approach, community stakeholders were trained to address these challenges. Sessions were held on resource mobilization to recruit more service providers (SPs), execute minor renovations at targeted health facilities and provide basic needs for ANC/PMTCT services. Guidance and technical support was given for the identification of resources at the community level. Additionally, Income Generating Micro Projects (IGMP) were identified and set up.

The community provided 75 per cent of the total capital to run the IGMP and improve on standards of care at the facilities involved and CBCHS provided 25 per cent.

Community members were sensitized through health fairs and encouraged to utilize the health facilities following the efforts put in by stakeholders to improve quality.

A total of 47 IGMP were set up during the project's duration. The extra income allowed the communities to recruit 36 SPs to reinforce human resources in the targeted health facilities. The income also paid stipends to newly recruited SPs and did minor renovations in the health facilities. Health Focal Point persons were appointed to ensure services for pregnant women took priority at council sessions.

As a result of these interventions, uptake of ANC/PMTCT increased from 6,741 pregnant women consulted in 2014 to 7,078 in 2017.

A key lesson learned from the project was that with innovative financing, adequate training and technical support, HIV services can be greatly improved and sustained through community participation in resource limited settings.

The key takeaway from the discussions was that for these health initiatives to be successful, several factors came into play:

- Resources were well managed
- Communities were mobilized
- Resources were mobilized by communities
- Hence sustainability.

Breakout session 2: Health Technologies and Information for Increasing Visibility and Advocacy Leverages Towards Improved PHC

Moderator: *Paul Pierre Mbeleg*

- Presenters:**
- *Sarah Sackey – CHAG*
 - *Gift Merix Werekhwe – CHAM*
 - *Doreen Kudwoli – Medic Mobile*
 - *Nic Moens – Africa ehealth Foundation*
 - *Dr. Douglas Gaitho – CHAK*

A robust health management information system (HMIS) is important for obtaining relevant data for meaningful decision making at all levels of the health sector. There is therefore need for ACHAP to optimize HMIS and ICT to leverage CHAs' contribution and service output data in order to promote their visibility and impact at country, continental and global levels.

Gift Merix Werekhwe from CHAM, Malawi, presented a comparative analysis of physical and mobile phone based tracing in HIV/AIDS clinical trials.

A mixed method evaluation was used to assess the relationship between patients' attitudes towards tracing and the tracing methods used as well as to compare physical tracing mechanisms and mobile phone technology tracing in terms of cost, patients adherence levels and patients response rates.

Majority of the patients (82 per cent) preferred mobile phone tracing because:

- It rules out status disclosure
- It is convenient (i.e. it can be conducted at all times regardless of time and place).

Clients' adherence to clinic appointments and study procedures rose from 65.5 per cent with physical tracing to 86.2 per cent after introduction of the mobile phone. Time taken to trace clients was significantly reduced as was the need and use of human resources and cost of tracing.

The study concluded that combining mobile phone technology with the physical tracing mechanisms in patient follow up should greatly improve treatment compliance, patients' response rates and the overall retention of patients in clinical trials.

Sarah Sackey Martiei-Ollety presented research findings on the impact of e-health management information systems on maternal healthcare in CHAG.

Since the 1990s various interventions have been initiated to reduce the high maternal mortality rate in Ghana. It is thought that quality data on maternal health can influence policy decisions leading to reduction in maternal mortality.

The study found that the health management information made work easier and produced more accurate, complete and timely information than the manual system. There was an 11 per cent decline in maternal mortality rate (from 194 in 2011 to 145 in 2015) while ANC4+ visits increased by 238 per cent. The supervised delivery rate increased by 13.2 per cent.

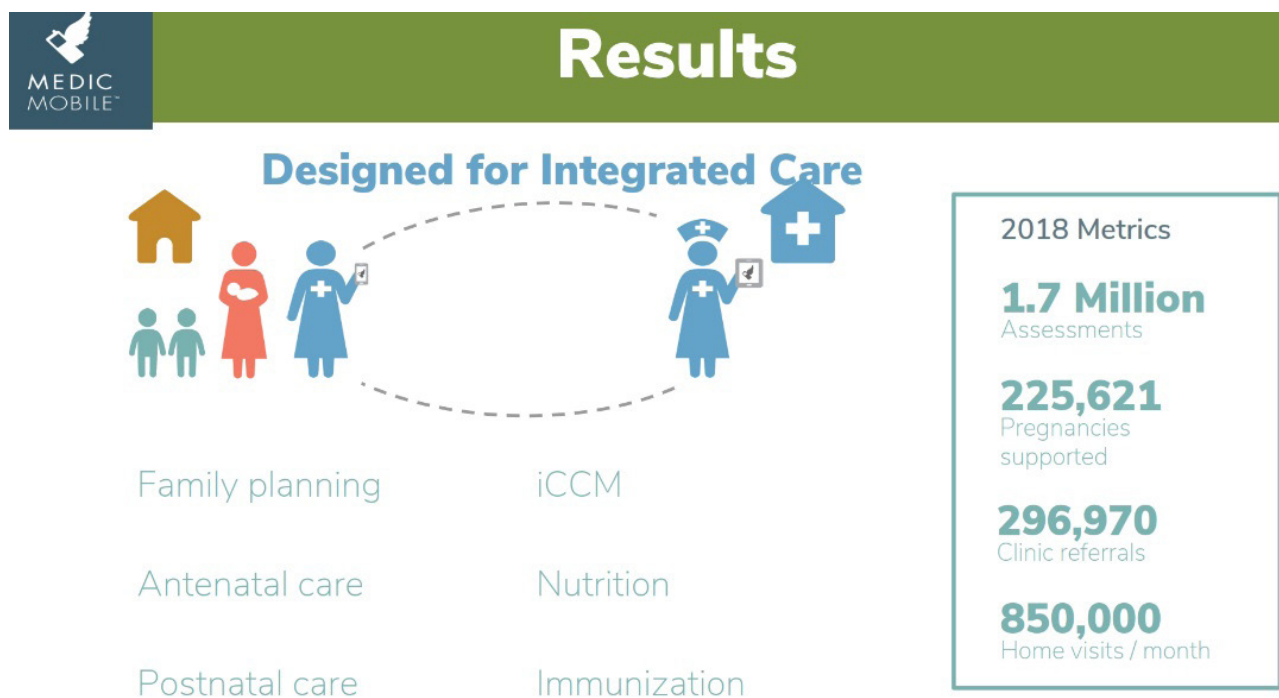
This study serves as a powerful reminder that progress in maternal health efforts is hugely dependent on progress in having adequate and timely data that will be used to influence policy decisions on maternal health leading to reduction in maternal mortality.

Doreen Kudwoli from Medic Mobile, Kenya, gave a presentation on how the organization was bringing digital health tools to last mile clinics.

Medic Mobile has developed a software for health workers providing maternal child health services in the hardest-to-reach communities. The toolkit is free, open-source, and designed with the input of health workers. It is designed for integrated care including family planning, antenatal care, post-natal care, nutrition and immunization.

Using a mobile phone, the health worker is able to view tasks and directions to the client's home. The software contains profiles of every family and individual as well as actions to guide health workers through care. The analytics view gives the health worker an overview of progress towards set targets.

In 2018, the software reported 1.7 million assessments, supported 225,621 pregnancies, made 296,970 clinic referrals and 850,000 home visits each month. Medic Mobile reaches 23 countries, 244,630 health workers and 12 million people.



Dr. Gaitho spoke on CHAK's experience in the implementation of point of care EMR to improve data quality and patient outcomes in HIV treatment.

The CHAK HIV/AIDS project, CHAP Uzima, has successfully utilised the International Quality Care Patients Management and Monitoring System (IQCare) Electronic Medical Records (EMR) to improve efficiency, data completeness and quality.

CHAK has focused on implementation of Point of Care (POC) EMR where the clinician attends to the patient and charts the findings, lab requests and drug prescriptions directly into IQCare. The system is used by clinicians, administrators and pharmacists for patient registration, patient management and managing pharmacy inventory.

The POC approach has benefits to the health care worker, patients receiving care, those responsible for monitoring and evaluation (M&E) and for planning of resource allocation.

The Point of Care EMR system use has contributed to:

- Improvement in data completeness and accuracy, and timeliness in reports generation
- Clinical decision support
- Encoding of clinical protocols and guidelines in the system
- Improvements in efficiency

- Immediate availability of information in the system to the health care worker while managing the patient
- Supporting a team-based approach to patient management
- Clinical calculation – paediatric dosing, BMI, pill count.

Africa eHealth Foundation was established by professionals involved in the health and concerned about the future of the Faith Based Health Providers in view of dwindling international support and the many constraints they faced.

Dr Nic Moens in his presentation, ‘Empowered Community Health Care – A smart approach to local health system strengthening and provision of access to health for disadvantaged groups’ noted that smart, empowered community care is key to taking health care in Africa to the next level.

Africa eHealth Foundation is a network of medical, IT and hospital management specialists who work in Europe and Africa. The organisation develops innovative approaches to health systems and has been leveraging the power of ICT as a game changer since 2004. It is also involved in development of e-health strategies, telemedicine (radiology), result-based financing solutions, community health, hospital information systems (45+ hospitals), hospital improvement programmes, finance, diabetes- hypertension development and management in the Netherlands.

The organisation believes that technology is a game changer and can transform a sector in a very short time.

Questions and discussions centered around sustainability of health technologies, ethics around patient information and infrastructural challenges such as inconsistent power supply prevalent in most countries in Africa.

Breakout session 3: Building, Planning, and Optimizing a PHC Workforce Using the Health Worker Life Cycle Approach

Moderator: *Samantha Law*

- Presenters:**
- *Godlove Nkuoh – CBCHS*
 - *Dr. Titha Dzewela – CHAM*
 - *Peter Kakute – CBCHS*
 - *Katy Gorentz – HRH2030, Chemonics*

Ways of ensuring sustainability include continuous capacity building, recycling and replacement of all personnel involved. Additionally, health administrators need to value health information technology staff by ensuring a favorable work environment. Quality data can be used to inform policy decisions, leading to a reversal of negative health trends such as high maternal mortality.

The HRH2030 health worker life cycle approach consists of three actions:

- (a) Building the future health work force where future health workers are trained and graduate from the training institutions.
- (b) Health workforce planning, support, monitoring and policy making which leads to retention of the health professionals employed after graduation.
- (c) Optimizing the existing health work force which ensures an available, accessible, acceptable, high quality health work force that is needed to improve health outcomes.

The HRH2030 health worker life cycle approach is supported by various resources that are available online as follows:

- (a) Building the future health work force
 - Gender competency framework
 - Rapid task analysis
- (b) Health workforce planning, support, monitoring and policy making
 - eLearning course – HRH Principles and Practices
 - Human Resource Information System (HRIS) Assessment Framework
- (c) Optimizing the existing health work force
 - Optimizing health worker performance and productivity

Health worker optimization matters for a number of reasons:

- (a) Human resources for health are one of the largest health system cost drivers. The World Bank estimates that as much as 40 per cent of government health budgets in sub-Saharan Africa go to wages¹.
- (b) WHO has projected a gap in health workers of 18 million by 2030 globally².
- (c) Optimizing health the health workforce in the context of ART service provision can address staff shortages and free up health worker availability for primary health care service delivery.
- (d) For high HIV burden countries, optimizing ART service provision is key, as the number of PLHIV on ART is expected to dramatically increase as countries strive to achieve the 90-90-90 targets by 2020 and 95-95-95 targets by 2030.

Participants were taken through an overview and demonstration of the HRH optimization tool for ART service delivery (“HOT4ART”).

User inputs

- Number of ART clients (stable/unstable, by sub-population group) to be served over the next 12 months
- Number of service providers (skilled and lay) by cadre
- Estimated time spent by staff on ART service delivery vis-à-vis other tasks
- Types of differentiated service delivery (DSD) models being implemented or planned

Tool outputs

- Human resource needs/gaps for differentiated service delivery (DSD) models currently implemented
- Task-shifting/sharing options to decrease gaps and optimize personnel
- Visualization of service provider needs by DSD model
- FTE staffing gaps or excesses for different scenarios

The tool is available online at www.HRH2030program.org. In addition to the tool, the site also has:

- a webinar introducing the tool
- a case study using real data from Uganda (in French and English)
- a detailed user guide (in French and English)
- 11 step-by-step video tutorials.

¹World Bank, *Working in Health: Financing and Managing the Public Sector Health Workforce*

²WHO, *Global Strategy on Human Resources for Health: Workforce 2030*

Contact information is available on the site in case of questions, feedback or technical assistance in use of the tool.

More HRH resources, including all the ones mentioned in the presentation are available online at www.hrh2030program.org/resources.

Various CHAs presented their experiences with the HRH2030 health worker life cycle approach as follows:

Building the future health workforce

- a) Dr. Titha Dzowela from CHAM (Malawi) gave an overview of the medical training colleges under its umbrella
- b) Cameroon Baptist Convention Health Services (CBCHC) gave an overview of the courses offered in its training centre. In partnership with Mildmay Institute of Health sciences (MIHS), a specialist Health Care Training centre in Uganda, the CBCHS training centre offers work-based modular courses where candidates receive one week face-to-face lectures and are allowed to do self-studies at their work place in consultation with their assigned academic supervisors online while still working to sustain their families.

Planning, support, monitoring and policymaking

Godlove Nkuoh of Cameroon Baptist Convention Health Services (CBCHS) spoke on the creation of Primary Health Centres (PHCs) in communities.

Optimizing the existing health workforce in strengthening healthcare systems

Peter Kakute Nwefu presented on LAP, a program of CBCHS created in 1980 with 54 existing PHCs and 16 that were upgraded. The program was created to enable remote communities initiate, administer and sustain a program of better health for all in their environment and culture.

The program involves setting up a village primary health center where the population can access health services, trainings of village health workers done and technical support and supervision for the health workers done.

Plenary session 1: Market Store: Consolidating Innovative Approaches in Managing HIV/AIDS Epidemic: Harnessing Best Practices in HIV Prevention, Care and Treatment Support Services among ACHAP/CHAs

Moderators: Francesca Merico – WCC, Julienne Munyaneza – UNAIDS

Organizations: ZACH, CHAN, CARITAS-DRC, CHA Lesotho, CHA Liberia

During the session, ZACH presented on targeted HIV testing while CARITAS from DRC spoke on how church leaders and members had been trained to fight against stigma and discrimination in the community.

CHAL (Liberia) had united churches to look at their challenges, formed a social panel that organized a workshop and came up with a roadmap towards addressing the challenges identified. Bishops were united, churches brought together and the CHAL Board able to meet the government on issues concerning the nation such as cleanliness of the cities. This shows that churches have the power to engage with political leaders.

CHAN involved church leaders to develop a training curriculum to address stigma and discrimination. The curriculum was being used nationally.

CHAL (Lesotho) worked together with the government to take care of HIV and STI clients and developed guidelines to address GBV. Capacity building was done for professionals and church leaders sensitized and mobilized on HIV/AIDS issues.

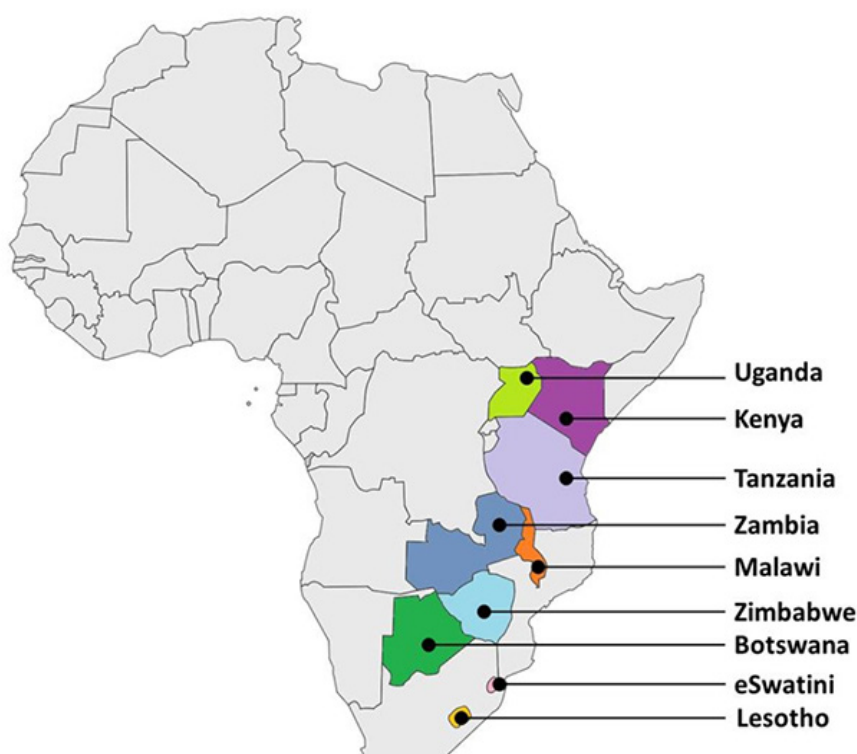
PEPFAR has announced an additional USD 100 million for FBOs. The additional funding was announced in advance of World AIDS day 2018 by US Vice President Michael Pence.

Panel 5: Brief overview of PEPFAR Transition to Local Prime Directive

- Panelists:**
- *Dr. Monique Chireau Wubbenhorst (USAID)*
 - *Dr. Ted Ellerbrock (CDC)*
 - *Dr. Carl Stecker (CRS)*

The USD 100 million will be invested in addressing key gaps toward achieving HIV epidemic control and ensuring justice for children, including through leveraging the unique capacities and compassion of faith-based organizations and communities.

The 9 African Countries Selected to Participate in the PEPFAR FBO, Faith, and Community Central Initiative



PEPFAR has also announced a gradual funding *transition to indigenous partners* (25 per cent by 2018, 40 per cent by 2019 and 70 per cent by 2020)

The USD 100 million PEPFAR faith-based initiative has three priorities:

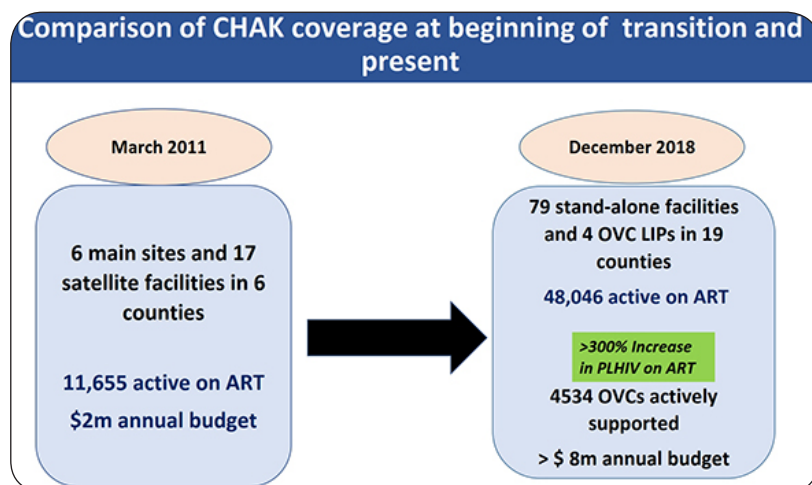
- Priority 1: Be made whole: restore FBO funding to pre-COP18 levels (4 countries). This money is available to spend immediately.
- Priority 2: Messages of hope to reach men.
- Priority 3: Address adolescents and violence.

ACHAP members were urged to be pro-active in seeking opportunities to access these funding opportunities in order to make a difference in the communities they serve as FBOs.

Dr. Samuel Mwenda gave an overview of the transition of PEPFAR grant to CHAK as a local implementing partner and the prime. The grant transitioned from AIDSRelief to CHAP in a process that began in March 2011 in line with PEPFAR’s move to local partners. Two projects, CHAP and KARP were awarded in Kenya in a transition done in three phases.

In phase one, assessment of technical capacity and governance systems of local partners was done, recommendations made and implemented. The grant was then awarded, providing for phased transition with a period of six months overlap.

The demonstrated capacity led to scope expansion beyond what was covered in AIDSR relief by the third year of implementation.



According to Dr. Mwenda, CHAK’s strategy for success includes hiring competent staff, sound and well-established systems, effective consortium, peer learning, good communication with CDC, among others.

CHAK was in 2017 awarded CHAP Uzima, a follow-on to CHAP. The project scope has been expanded to include gender based violence, orphans and vulnerable children and more health facilities.

Dr. Tony Tumwesigye spoke on UPMB’s experience with USG grants which began with a non-competitive transition from Catholic Relief Services (CRS)/AidsRelief Project in 2010-2011. The CDC grant was to be administered by two arms, Uganda Protestant Medical Bureau (UPMB)-NESH Project and Uganda Catholic Medical Bureau (UCMB)-ACT Project.

The UPMB received and managed six health facilities with a total of about 9,000 clients on ART in NESH1. The project was to provide comprehensive HIV/AIDS care, treatment and prevention services in UPMB health facilities under the President’s Emergency Plan for AIDS Relief (PEPFAR)

However, PEPFAR cancelled the entire transition implementation in 2011-2012, creating three grants that were re-opened for competition. Following this development, UPMB remained with two high volume sites with 4,417 clients on ART in NESH2.

In 2016, the USG grant was transitioned to regional mechanisms under the national PEPFAR regionalization for health service delivery and supply chain. The country was divided among USG entities – CDC, USAID and DOD – under what was called one partner one facility. This did not put into consideration the faith-based PNFs facilities that were all over the country. The JMS would supply USAID/DOD regions while another supply Chain was created for the CDC region.

According to Dr. Tony, faith-based entities have vast networks of service delivery health facilities in all corners of the country running down to rural villages. With adequate resources, they have the potential to bring the HIV epidemic under control.

Vuyelwa T. Sidile-Chitimbi pointed out that ZACH was a prime for HIV Care and Treatment and VMMC in 2002. In 2017, following a call for formation of a consortium, ZACH joined I-TECH (prime) and other sub awardees to develop the grant proposal. However, on award announcement, ZACH was dropped.

In her presentation, Dr. Monique Chireau W. from USAID brought out the tremendous progress made against AIDS over the past 15 years. This progress had inspired a global commitment to end the epidemic by 2030.

Accordingly, PEPFAR had set out to move funding to local partners as follows:

- 25 per cent by end of FY18
- 40 per cent by end of FY19
- 70 per cent by end of FY20

This funding must go to local partners as direct recipients of USAID funding not sub-recipients. The above goals are overall across 23 PEPFAR countries, not necessarily in each individual country.

To sustain epidemic control, it is critical that the whole range of HIV prevention and treatment services are owned and operated by local institutions, governments and organizations.

As faith-based organizations are essential for USAID's sustainability approach and the journey to self-reliance, Dr. Monique advised the CHAs at the conference to begin programming themselves to be independent and be sustainable as well as form consortia, including other faiths such as Islam. She further urged them to explore the new possibilities for protecting young men, youth and children offered by social media.



"You used to work with pastors and now you lost them –

When we began, we taught what HIV is and how it is detected –

But we left them when we started talking about viral load and about treating early."

- Church Forum Council Member, ADRA

PEPFAR expects to work with local FBOs in the following areas:

- Preventing violence and HIV risk among the youth.
- Reaching men and youth and linking and retaining them in treatment.
- Addressing stigma and discrimination.
- Advancing and sustaining education on HIV.
- Incorporating approaches to prevention within Sunday school and religious education for girls and boys, men and women.
- Working with religious leaders to understand how they see faith healing vs. HIV treatment, and how to engage them.
- Engaging religious influencers with messages of hope.

To effectively participate in local partner transition, FBOs need to comply with US government regulations including NUPAS (Non-US Organization Pre-Award Survey) (ADS 303sam), SAM registration (System for Award Management), have a DUNS number and do audit reviews. The conference participants were taken through NUPAS.

The PEPFAR reporting requirements are as follows:

- Quarterly HIV performance data review – Monitoring, evaluation and reporting targets (MER)
- Annual expenditure reporting
- Annual work plans
- Periodic quality reviews (Site Improvement through Monitoring System - SIMS).

A key group in the local partner transition are the religious leaders who along with their well-established networks of volunteers and community groups, play pivotal roles in promoting and sustaining positive changes in the social norms, attitudes, and behaviors of their communities.

The CHAs were given the following pointers to enable them enter into collaboration with CDC in PEPFAR-supported programs:

1. Respond to the PEPFAR Indigenous Partner Directive by envisioning the role FBOs could play in implementing PEPFAR-supported programs throughout Africa and developing a strategic plan and organizational matrix to achieve your vision
2. Using the Africa Christian Health Association Platform (ACHAP), establish a network of ACHAP members to provide communication, coordination, mentoring, and other support for applying for and implementing PEPFAR-funded programs.
3. Use Virtual Communities of Practice for communicating and mentoring in the ACHAP PEPFAR Network and the PEPFAR programs in each country. These virtual communities, such as Project ECHO, enable collaborative learning that transcends geography.
4. Seek advice and mentoring from FBOs and others, who have been successful in applying for and implementing PEPFAR programs, to learn how your FBO can be successful.
5. Essential tips for applying for CDC Cooperative Agreements were also given during the session.

Panel 6: Addressing Neglected Tropical Diseases (NTDs)

Moderator: *Jim Oehrig – American Leprosy Mission (ALS)*

- Panelists:**
- *George Gitau (Africa Director ALM)*
 - *Julien Ake (Global Director – AIM Initiative)*
 - *Aubin Yao Cote D' Ivoire*
 - *Josue Tchimou (Ghana)*
 - *Desiree Imposo (DRC)*

NTDs are a group of diseases that are endemic in 149 countries in a tropical environment and are estimated to affect more than one billion people, including many children. The diseases affect impoverished people who live in rural and hard-to-reach areas where access to safe water, sanitation, and essential medicines is lacking.

Participants heard that people affected by leprosy should not be stigmatized. A vaccine for leprosy had been developed and would soon be put on trial.

The WHO prioritises 18 NTDs and another two will soon be added to this list. The most predominant case management NTDs in Africa are Buruli ulcer with 3,443 cases, human African trypanosomiasis with 7,197 cases and leprosy with 25,231 cases according to the WHO.

The solution to NTDs lies in an integrated response to case management. This would include hospital based responses, community based interventions and research. Community based responses would include:

- Training
- Equipment
- Education
- Livelihoods and Self care
- Advocacy for WASH
- Operational research
- Strengthening the capacity of health workers
- Increasing awareness among community members
- Total Health Villages- WASH, Livelihoods.
- Provision of essential medicines/supplies

Breakout session 4: Innovative Approaches to Reducing Maternal, Neonatal and Child Mortalities: Learning Lessons

Moderator: *Dr Francois Chimoun – CBCHS*

Presenters:

- *Osee Djekadoum Ndilta (AEST),*
- *Eugene Foyeth (CBCHS)*
- *Christina de Vries (Cordaid)*

Despite several interventions and programs developed and implemented over the decades to reduce maternal and child mortality, the MDG targets were not achieved by 2015. Consequently, several FBHPs/CHAs have introduced number of interventions comprising the MDG Accelerated Framework (MAF).

Osee Djekadoum Ndilta, in a presentation titled ‘Maternal and child health care brought closer to the community: The experience of two health districts in Chad’, showed how a community intervention by health facility staff had helped turn around the health of mothers and children.

Due to low assisted delivery rate (42 per cent), low family planning practice (<10 per cent), low antenatal consultation rate and high maternal mortality (>34 per 1000 life birth) in Chad in 2014, an intervention was carried out in the two health districts from 2016-2018 in order to increase reproductive health service utilization and decrease maternal and child mortality in the area.

The concept involved health center staff moving to the community to get and train animators who would in turn go from home to home, examining and referring pregnant mothers to the hospital for care and delivery. The results showed a general improvement in the maternal and child health indicators from 2016 to 2018. The major challenges were geographic inaccessibility of the communities, limited trained personnel and a strike that occurred in 2017 resulting in a decrease in service utilization and an increase in maternal and neonatal mortality during this period.

Eugene Foyeth delivered an informative presentation on how maternity waiting homes were helping improve ANC uptake in rural communities in Cameroon.

The presentation titled ‘Maternity waiting homes: A proven strategy to increase antenatal care (ANC) uptake in rural communities’ showed how the facilities led to an increase in health facility deliveries in the communities in which they were placed.

Poor road infrastructure and distance between facilities has led to an increased risk of pregnant mothers giving birth before they can access help from a qualified health worker. Other mothers resort to home deliveries for socio-cultural reasons.

Maternity waiting homes (MWHs) were constructed in 10 health districts assessed to have low ANC uptake in the North West and South West regions of Cameroon. The pregnant women stay a few days or weeks in the home before delivery and are attended to by trained staff.



Four-bed capacity maternity waiting home, Abongshie Integrated Health Center in the Northwest Region of Cameroon.

From January to September 2017, a total of 215 women spent at least one night in a MWH leading to an increase in the number of deliveries by trained clinical staff in the health facilities and about 50 per cent increase in health center deliveries.

Through MWHs constructed in health facilities, high ANC uptake is possible in remote areas with decreased home deliveries and a consequent decrease in maternal and neonatal mortality.

Christina de Vries focused on reinforcing the capacity of religious leaders to reflect on ways of discussing reproductive health issues with the youth.

Most youths are exposed to early engagement in sexual activity, early marriages (underage) and early deliveries, all of which contribute to maternal mortality.

Youths were brought together to share experiences and challenges with their sexuality and educated on reproductive health. A systemic intervention approach was developed to train religious leaders and youth ambassadors of both sexes from the North and East regions of Cameroon.

Religious leaders were trained to educate youths, combat early marriages, reintegrate young mothers and use available tools to train other religious leaders and parents to be able to dialogue about sexuality issues with their children and youths.

Youth ambassadors were trained to advocate for the rights of young people and sensitize their peers to discuss sexuality freely with their parents and religious leaders. They were also sensitized on the dangers of early marriage, early pregnancy and non-skilled deliveries.

The session was spiced by testimonies and success stories from two religious leaders and two youth ambassadors from the intervention sites.

During the discussion session, the participants heard that CBCHS had intentions to expand the maternity waiting homes to other areas. The intention was to show the state what had been achieved and seek the government's assistance in the expansion.

Breakout session 5: Mental Health

Moderator: Ms. Florence Bull

Presenters:

- Mr. David Balikitenda – Uganda Protestant Medical Bureau
- Mr. Peter Yeboah – CHAG

Mental health is less prioritized than other health issues in many countries in Africa. Yet health is defined as “a state of physical, mental and social well-being, not merely the absence of disease or infirmity” (WHO, 1948).

Mental health accounts for 14 per cent of global burden of disease with 450 million people worldwide affected by mental health problems. Barely two per cent of people with mental illness have access to treatment, indicating a gap in addressing mental illness in most sub-Saharan African countries.

There is a lack of investment in community-based mental health facilities (WHO’s Mental Health Atlas 2017). Worse still, mental health workers in low-income countries, can be as low as two per 100,000 population, compared with more than 70 in high-income countries. It is against this backdrop that two CHAs from Ghana and Uganda presented their experiences in tackling mental health issues in their respective countries.

Christian Health Association of Ghana (CHAG) is implementing a mental health program whose aim is to improve the lives of persons living with mental illness. The program’s objectives are to create access to care, reduce stigma, discrimination and abuse for PLMI, and re-integrate treated persons back into their communities.

The programme has created higher demand for mental health care, trained health care workers, increased public discussion on mental health and sensitized religious leaders and traditional healers on mental health issues. Great improvement has been seen in patients under the program.

Uganda Protestant Medical Bureau presented a case study of Bwindi Hospital in the south western part of the country which has taken a community program approach (CPA) to address mental health in its catchment population. The hospital has integrated mental health in the general medical services. Those in need of acute care are admitted in the general medical wards.

The Community Mental Health Approach program covers the three sub-counties of Kayonza, Mpungu, Kanayantorogo and Butogota Town Council. The program has helped address the cost of care for mentally ill patients who make up 150 per cent of bed occupancy in the hospital. It is motivated by the thinking that early intervention and home support can prevent emotional distress from escalating into a psychiatric emergency.

It focuses on people who would otherwise be in and out of hospital on ‘a revolving door’ basis, helping them to live in the community and enjoy the best possible quality of life. The program, which was initiated with support from Jamie’s fund (UK), has 1,473 males and 1,106 females aged 25-56 years in its care.



Providing basic personal hygiene for people living with mental illness - CHAG

Among the activities in the community program are:

- a) Community support group session
- b) Socio-economic discussions
- c) Medication adherence counseling
- d) Community mental health.

There is need for policy and legal frameworks, well-trained and equipped human resources for health, community sensitization, including in schools and youth groups, and funding partnerships to adequately address mental health in Africa.

Following the presentations, discussions centered on how to distinguish between mental illness and demon possession. This was important especially for local communities. Communities also needed to know that this is an illness like any other and chaining the patient does not lead to healing. It was important for communities to learn to seek medical treatment for mental health issues.

Mental health issues can be prevented through early detection and counseling. There was also need for e-mental health to provide support for health workers. It would also be critical to equip traditional and church leaders with knowledge on mental health for them to know when to refer patients to a medical facility.

People in conflict situations, prisons, early pregnancy, terminal diseases etc., also need counseling. The session concluded that in fact, everybody is at risk of developing mental health issues due to modern living.

Breakout session 6: Anti-Microbial Resistance

Moderator: *Mirfin Mpundu*

Presenters:

- *Joanne A. McGriff (Emory University)*
- *Dr. Cyprian Kamau (CHAK)*

About 25 African countries have a national action plan on AMR. These action plans are based on awareness on AMR, surveillance, infection prevention and control, rational use of antimicrobials and research. During the session, the importance of waste management and functional WASH systems to reduce infections was stressed.

AMR involves infection transmission, and hospitals are fertile disease zones. Microbes create resistance by mutating and human activities contribute to their mutation. As such, there is need to develop best practices, SOPs, policies, protocols, guidelines and train health workers to fight AMR.

Poor prescription, failing to complete the recommended dosage and counterfeit drugs are the leading causes of AMR. Many health facilities did not have AMR guidelines. This, coupled with frequent stock outs and inadequate laboratory capacities for culture and sensitivity testing, had also led to an increase in AMR.

For health facilities, the most prudent way to stop AMR is through WASH, as this prevents diseases and infections, meaning one does not have to take antimicrobial drugs.

There is need for quality health systems to ensure that correct drugs are given and infections prevented. Training, supervision and continuous education are also steps that can be taken to stop AMR. AMR can also be integrated into existing programs. Developing easy to do, practical processes, proper stewardship and ensuring efficient mechanisms for follow-up can also address the AMR challenge. On-going dialogue is useful in sensitizing communities about AMR.

Conference Resolutions

The Yaoundé Declaration of February 28, 2019

We, the members of ACHAP, in conjunction with our development partners, meeting in Yaoundé from February 25-28, 2019, deliberated, discussed and resolved on the theme 'Re-igniting Primary Health Care: The role of ACHAP'.

Having had intensive discussions, we affirm the principles, ideals and values contained in the Alma-Ata Declaration of 1978 and re-confirmed in Astana in 2018. In the event thereof, we declare the following:

- That we, faith-based organizations, re-affirm PHC as the pathway to promoting Jesus Christ's healing ministry. In particular, we accept our role as the pacesetters, actors, advocates and staunch supporters of primary health care and resolve to ensure that all will have access to quality, acceptable, affordable and comprehensive primary health care services and will be treated with the dignity of our Lord Jesus Christ.
- In particular, we also recognize the roles and responsibilities assigned to our partners. We affirm that our partners have distinctive roles in promoting the ideals and values of UHC. We resolve to collaborate with our partners to ensure that we mobilize resources and ensure equitable allocation of the resources mobilized.
- We as ACHAP will also come together in unity in the PEPFAR-ACHAP network.
- To all our actors and players, we also emphasize the need to ensure that PHC becomes the centerpiece of country health systems.

We therefore call on governments to ensure active, practical partnership with FBOs to ensure that we are respected, recognized and accepted as integral actors and stakeholders of the country primary health care system.

We resolve therefore to strengthen the partnership between FBOs and government, recognizing that governments have the primary responsibility and role of ensuring the provision of equitable health services for their citizens.

We, FBOs, promise and pledge our support and collaboration to ensure that we supplement and complement government health services.

- We recognize that the universality in PHC as contained in UHC means that it is a business for all. We therefore pledge to explore all avenues, processes, opportunities and enablers to ensure that all the resolutions we have made will be actualized in the name of our Lord Jesus Christ. So help us God.

Additionally, ACHAP signed MoUs with Christian Connections for International Health, American Leprosy Missions and World Vision.