AFRICA CHA PLATFORM

REPORT OF THE

8TH BIENNIAL AFRICA CHRISTIAN HEALTH ASSOCIATIONS PLATFORM CONFERENCE

FEBRUARY 27-MARCH 3, 2017, MASERU, LESOTHO

Theme: "Building partnerships for FBO Health Systems Strengthening towards achievement of Sustainable Development Goals"

Prepared by ACHAP SECRETARIAT

P.O. Box 30690-00100, Kenya
Telephone: + 254 20 4444 1920/ 4444 1854
Email: chas@africachap.org
Website: www.africachap.org

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BACKGROUND

The Africa Christian Health Associations Platform (ACHAP) was established in 2007 as an advocacy and networking Platform for improving knowledge sharing and joint learning among CHAs and Church Health Networks in Sub-Saharan Africa. CHA networks have a long history of working within developing countries to provide health care services to populations in need, and they form the integral link between the Ministry of Health and the Faith Based Health Care facilities at the national level. ACHAP provides the framework for a collaborative network with a cohesive voice to advocate for equitable access to quality health care. ACHAP also provides the knowledge and skills for member facilities to deliver better care for their clientele. As at December 2016, ACHAP's membership stood at 41 CHAs in 30 countries in Africa.

Vision

'Health and Healing for all in Africa'

Mission

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.

Guiding principles

Equity and justice
Respect for human dignity
Gender sensitivity
Transparency and accountability
Integrity and good stewardship
Innovation and resourcefulness
Inclusiveness and non-discrimination
Compassion and Solidarity

With the adoption of a new constitution and registration as an international NGO in 2012, ACHAP established formal organization structures to better serve its members.

ACHAP's Key Functions

Advocating & lobbying

This includes influencing relevant organizations without making binding agreements, in support of members or issues of concern to members.

Negotiating & contracting

This includes protecting and promoting interests of members by making externally binding agreements and securing funding.

Supporting members

This includes improving the capacity of members to better do what they do. These activities may be part of the membership benefits or partly paid for services or through direct donor support**.**

Coordination and synergy

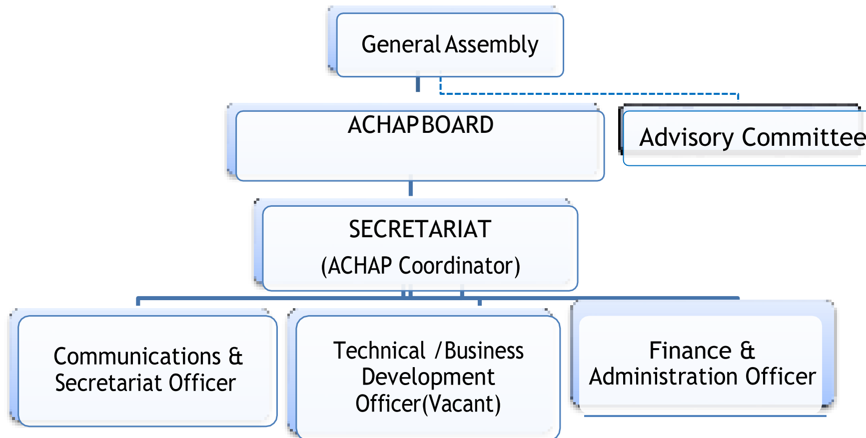
This includes harnessing the collective strength of the network to support members through sharing of experiences and the promotion and application of best principles and practices.

Leadership & value building

This includes sharing and building a common body of thought, values and identity, creating solidarity.

In order for ACHAP to pursue and support these key functions, the ACHAP board approved a new structure that would guide ACHAP's operations and particularly to include an advisory committee that would work closely with the board so as to more effectively position ACHAP.

ACHAP Structure



ELECTED BOARD MEMBERS (FEBRUARY 2017)

1. Peter Yeboah CHAG - Chair
2. Lebo Mothae- CHAL- Vice Chair /Southrn Africa rep
3. Ndilta Djekadoum- AEST- Member –Central Africa Rep
4. Matthew Azoji- CHAN- Member –West Africa rep
5. Pierre Mbeleg- CEPCA – Member francophone Rep
6. Tonny Tumwesigye- UPMB- Member Eastern Africa Rep
7. Samuel Mwenda- CHAK- Member
8. Mwai Makokka –WCC
9. Mirfin Mpundu –Member DSO rep

The World Council of Churches (WCC) and Drug Supply Organizations (DSO's) were co- opted as ex-officio members.

CONFERENCE OBJECTIVES

The ACHAP Conference had the following objectives:

- Understand the role of national faith stakeholders and their role in supporting the realization of SDG's in collaboration with UN agencies, national and local governments, and academia.
- To take stock of the evidence based systems that CHA's have put in place to enhance accountability and decision making as well as advocate for partnerships with others.
- To review the existing partnership initiatives that CHA's have undertaken in the last 2 years to strengthen members capacity for service delivery with emphasis on children and women's health
- To facilitate joint advocacy with and for the Christian Health Associations and Church Health Networks in Africa on matters of health systems strengthening.
- To review sustainable supply chain models that help achieve equity and support supply of essential medicines to the most at risk population groups.
- To enrich the knowledge base of Africa Christian Health Associations and Church Health Networks and participants on global perspectives of health financing facilities and requirements for partnerships from Health Financing partners.
- Provide an opportunity for ACHAP to hold its 8th General Assembly business meeting and review success of its five-year Strategic Plan for the period 2015 - 2019

THEMES AND TOPICS

The theme of the conference was "Building partnerships for FBO Health Systems Strengthening towards achievement of Sustainable Development Goals". The ACHAP Conference drew speakers from government ministries, international donor agencies, private sector, Non-Governmental Organizations and FBO leaders from Christian/Church Health Associations. Topics under consideration included Global Health Partnership opportunities, National Health Sector Partnership models, Partnerships for evidence building and Research, Quality assurance practices and the Influence of faith on service delivery.

CONFERENCE SPONSORS

The ACHAP Secretariat would like to appreciate the following sponsors for supporting our mission and ensuring that the 8th ACHAP Biennial Conference was a success:

- American Leprosy Missions
- Catholic Health Association of the U.S.
- Catholic Medical Missions Board
- Catholic Relief Services

- Christian Connections for International Health (CCIH)
- DIFAEM
- Emory UniversityGradian Health Systems
- G4 Alliance
- IDA Foundation
- IMA World Health
- PEPFAR
- University of Cape Town
- UNAIDS
- World Council of Churches

Conference venue: The Conference was held at the Thaba Bosiu Cultural Centre in Maseru and was attended by over 100 delegates from more 20 countries in both Africa, Asia, the U.S and Europe.

PRE-CONFERENCE 27th FEBRUARY

The ACHAP Biennial Conference has traditionally set aside one day before the Conference for pre-conferences. The pre-conference workshop offer targeted and exclusive content, not generally available in the main conference. The 2017 Biennial Conference was preceded by four pre-Conference workshops focused on the following themes: (a) Health Systems Strengthening through HIV Intervention (b) Ecumenical Health Strategy focusing on current global issues and the role of the World Council of Churches (c) Engaging FBOs to address Sexual and Gender Based Violence and (d) The role of surgery and anesthesia in Health Systems.

PRE-CONFERENCE ON HEALTH SYSTEMS STRENGTHENING

The purpose of the pre-conference was to introduce the health systems strengthening initiative and create an open space for CHAs and their partners to identify related capacities and gaps. It was hosted and convened by two of UNAIDS implementing partners – ACHAP and an academic consortium of Emory University, University of Cape Town, and St. Paul's University in Kenya. CHAs and their partners were offered an opportunity to identify related capacities and gaps through facilitated dialogue sessions.

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Speakers:

- Frank Dimmock (IMA World Health)
- Mimi Kiser (Emory University)
- Maulit Jolly Anne (University of Cape Town)
- Dr. Ronald Kasyaba (UCMB)
- Mwai Makoka (WCC)
- Julienne Munyaneza (UNAIDS)
- Dr. Jill Olivier (University of Cape Town)
- Dr. Samuel Mwenda (CHAK)
- Peter Yeboah (CHAG)

Reflections on health care delivery - Frank Dimmock

Frank Dimmock from IMA World Health, who has served as a missionary in Lesotho for 13 years, gave a background on the formation of the Christian Health Associations. He highlighted the adoption of the idea to form the Africa Christian Health Associations Platform by the Christian Medical Commission (CMC) of the World Council of Churches in Tubingen in 1967. He listed the role of Christian Health Associations as follows: (a) providing linkages between the Church and the Community, providing committed, accessible healthcare services and coordinating technical support from government and resources from external donors.

He listed various challenges faced by CHAs including:

Safeguarding core values in times of engagement with governments and donors.

Potential for change of focus and values that come with conditional grants. Funding levels and funding inconsistencies also pose a challenge to CHAs.

Decentralized systems of health has meant that governments have set up health institutions in places, sometimes in direct competition with CHA institutions.

Handing over of Church-owned health institutions although an option is not one preferred by many CHAs as they feel that the quality of health offered would deteriorate.

He said that ACHAP helped CHAs exchange ideas on issues such as medical equipment maintenance, pharmaceutical supply & distribution, inventory control, as well as other health interventions.

Health Systems Strengthening through HIV Intervention-Mimi Kiser

The first **discussion included the following topics:**

Table 1: Global Priorities – and Integration of HIV into Health Systems

Topic: *Global health and HIV targets, systems integration vs programmatic focus (including vertical vs. horizontal programs/ funding)*

Key themes from dialogue – recognition of particular constraints on CHAs (M & E demands of donors; finances, country demands)

Table 2: Financing of faith-based health services

Topic: *Changes in financial landscape for FBHPs and Universal Health Coverage*

Key themes from dialogue – diversifying funding sources.

Table 3: Community System Strengthening

Topic: ***Focus on community-response and community system strengthening, in particular innovations of faith-community engagement around that***

Key themes from dialogue – need to define what it means; important to balance bottom up accountability with top down.

Table 4: The resilience of faith-based providers

Attendees split into four groups to discuss the topic of resilience. Highlights from their discussions included the following:

Topic: ***Focus on the resilience of FBHPs against different forms of shock and chronic stress.***

Key themes from dialogue **- Partnership, Capacity Building**

-It was said that developing the organizational capacity across CHAs in data dissemination, data collection and data for decision-making was important. Putting together an online learning platform, to learn from each other and share information resources, and linking religious leaders with faith based health systems as well as training them on the impact of HIV was seen as priority.

-South Sudan expressed the need for capacitation and documentation on the best practices being undertaken, namely support for staff and training, holistic approach via partnerships and sub-granting to facilities unable to get funding.

-CRS said that FBO's are partners of preference in home based care, ARTs, building capacity of leadership/management/service provision, supply chain and MnE.

It was said that CHA's need to profile their distinctive leadership leadership capacities in negotiating with government

-CHAG talked of its efforts in advocate on health systems strengthening with government, which involved understanding the language of government with regards to collaboration, understanding the context of negotiations, ability to innovate and integrate the innovation into health package,

-UCT emphasized the need for data collection, and the need to put into writing the contribution of each CHA, – pictures stories, what is going on in each country. An example of Togo where the WCC (EHAIA) brought religious leaders together with key populations to help advanced service accessibility was given. They said that there are a broad range of disciplinary skills, perhaps how to build a team with those skills

-Christian Health Association of India said that holistic health care, needs exist particularly around mental health (projections around depression), CHAI has had good interfaith engagement in this regard. They advocated for creation of unique online sharing platforms to use for sharing of such concerns.

-IMA said that documentation is a challenge to many CHA's, they suggested working with local university, acquiring resources from the AIDS Free website and capacity building using intrahealth history. They also said that religious leaders not informed on policies and related services hence the need for education and advocacy, negotiating where there are tensions, and articulation of alternative leadership models. They also called for strengthening communication between different levels of CHA health provision and and translation of popular declaration slogans into everyday action words, an example being translating of the 90 90, 90 slogan to lower level units.

-CHAMalawi exhorted CHA's to engage more in building research capacity, new business development models as well as applying for more complex grants, scholarships for educating staff and teaching staff how to operationalize policies

-CHALesotho said that donors have been helpful in training member health on finance and MnE so they can function independently in remote places.

-John Blevins said that the Interfaith Health Program (IHP) at Emory University offers mentorship and a training platform for FBOs to help them tailor their applications to funders in a language that funders appreciate, especially of evidence-based funding opportunities.

UNAIDS/FBO PARTNERSHIPS. STRENGTHENING FAITH COMMUNITY PARTNERSHIPS FOR FAST TRACK

Julienne Munyaneza, UNAIDS FBO initiative consultant.

Julienne Munyaneza from UNAIDS gave an overview of the UNAIDS/FBO partnership initiative in which ACHAP is an implementing partner. She gave five areas of focus that the UNAIDS Faith Based initiative is focused on:

- Collection analysis and dissemination of data.
- Addressing stigma and discrimination in communities and health care settings.
- Increase demand for HIV services and retention in care.
- Strengthen FBOs networks both Christian, Islamic and others, to reach the most marginalized and at-risk populations with comprehensive, equitable HIV testing, prevention and treatment services.
- Development and strengthening FBO leadership and advocacy.

She listed the outputs of the initiative that combines 9 other partners, as follows:

- Strengthened FBO leadership and advocacy for Fast Track and ending AIDS by 2030
- Increased FBO capacities for scaled up engagement of FBO providers of HCT, prevention and treatment.

She outlined challenges in data collection, experienced by Christian Health Associations. These include:

- A lot of work done by FBOs is not documented.
- Impact of the changes on HIV work and any other development issue by changing political leadership in the United States.
- Funding from Scandinavian partners being redirected towards the migrant problem.
- Stigma and discrimination towards key populations.

The following were given as useful links for religious leaders working in the field of HIV:
Invest in Advocacy: Community Participation in accountability is Key to Ending the AIDS Epidemic
Stronger Together: From Health and Community Systems to Systems for Health
The World Council of Churches has also invested in this area:
"Getting Involved" on the leadership commitments to HIV, including the WCC Central Committee Pastoral Letter
"What we do" on the clergy testing campaign worldwide and WCC theme for World AIDS Day – 1 December 2016
Passion and Compassion: The Ecumenical Journey with HIV by Manoj Kurian
WCC-EAA: Faith-based groups bring hope for a fast-track HIV response

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CHAs said that the need for capacity building is a cross cutting issue among all of them. They however needed a standardized way of capturing their strengths and weaknesses. They said that the initiative needed to address the capacity to do research as well as training on how to manage bigger grants. The need for collaboration with academia was also championed as they would provide research capacity. It was mentioned that donors at times do not align their priorities with those of the CHA they are proposing to work with, leading to mis- alignment of efforts. It was also mentioned that the ACHAP Secretariat needed to be strengthened to have capacity to research and undertake writing of grants. It was said that academic partners could offer support that did not require large amounts of money. It was said that the concept note on health systems strengthening needed to be circulated among all CHA's as many did not have a complete understanding of what it entailed.

Link: http://africachap.org/en/wp-content/uploads/2015/01/PEPFARUNAIDS-Faith-Initiative-julienne-munyaneza.pdf

PROVING THAT CHRISTIAN HEALTH ASSOCIATIONS AND FAITH BASED HEALTH PARTNERSHIPS ARE IMPORTANT

Dr. Jill Olivier, University of Cape Town.

Key themes: Quality service delivery, efficiency, resilience of Faith Based Health Providers

Dr. Jill Olivier gave an overview of Faith Based Health providers from around the globe. In the era of SDG's, the focus has changed from contracting and secondment and focus is now on quality, efficiency, and resilience. The SDG era has been characterized by massive spending in the establishment of information systems to build evidence, supplementing advocacy efforts by the private sector. FBO's need to show evidence to substantiate their claims to healthcare provision. Empowerment to use health services was gauged on 3 criteria, availability, affordability and acceptability. CHA's were challenged to show how they serve the marginalized, in their mission statement. Data on

provision of Universal Health Coverage among CHA’s was said to be non-existent.

CHA’s were challenged to focus on negotiating at national level. In additional they were asked to acquire routine and longitudinal (over a period of time) data of their contribution to UHC. This, it was said would entail developing evidence gathering capacities within the CHA’s. CHA’s were challenged to engage in technically-informed and substantiated modes of advocacy and operations.

PRE-CONFERENCE ON ECUMEMICAL HEALTH STRATEGY DEVELOPMENT

This pre-conference was hosted by WCC with the Christian Health Associations and religious leaders as part of the consultation towards development of an ecumenical health strategy for WCC.

Speakers:

Rev. Nyambura Njoroge (EHAIA- Switzerland)
Dr. Manoj Kurian- (WCC- Geneva)
Dr. Jill Olivier- (University of Cape Town)
Frank Dimmock (IMA World Health – U.S)

The meeting on the World Council of Churches Ecumenical Strategy looked at the History of WCC health and healing work since the commission was created, it looked at current global health challenges and discussed about the role of the ecumenical movement and WCC on such health issues. There were 5 working groups that looked at advocacy, communication, theological reflection and resilience in emergency and cross cutting issues which actions that will be included in the zero draft of the ecumenical strategy that will be presented in May 2017 at the next consultation in Geneva. This was the first step of a consultative process that will lead to ecumenical health strategy.

Link: http://africachap.org/en/wp-content/uploads/2015/01/Health-Healing-the-theological- imperative-World-Council-of-Churches.pdf

http://africachap.org/en/wp-content/uploads/2015/01/WCC-Concept-paper-on- comprehensive-ecumenical-health-strategy.pdf

PRECONFERENCE ON ENGAGING FBO'S TO ADDRESS SEXUAL AND GENDER BASED VIOLENCE

Speakers:

- The Rev. Amy Gopp (IMA World Health-U.S.)
- Ezra Chitando (EHAIA)
- Pauline Njiru (EHAIA- Kenya)
- Dr. William Clemmer (IMA World Health - U.S.)
- Solange Mukamana (Tearfund S.A)
- Vuyelwa Chitimbire (ZACH – Zimbabwe)

The pre-conference highlighted the roles FBOs and faith communities can play in acknowledging, responding to, and preventing SGBV. It considered the perspectives of survivors, engaged in Contextual Bible Study and theological reflection, as well as explored how CHAs may address this often-overlooked health crisis, and learn from a four-tiered comprehensive approach to responding to sexual violence in the DRC.

It also looked at how masculinity and gender roles play into SGBV. Shame, silence, secrecy and stigma were discussed as the biggest impediments to fighting SGBV. Contextual Bible study teachings were offered as a way to help people interpret sacred texts. Communities are generally male dominated and women don't have a voice.

This pre-conference was intended to educate all those who hope to transform this outrage into human dignity and inspire FBOs to move from silence to action.

Read more: https://imaworldhealth.org/enough-enough-faith-based-organizations-address-sexual-gender-based-violence-africa/

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3. PRE-CONFERENCE ON THE ROLE OF SURGERY AND ANESTHESIA IN HEALTH SYSTEMS

Speakers:

Karen Sichinga (CHAZ)

Professor Pankaj Jani (COSECSA)

Dr. Augustino Hellar (Jhpiego)

Dr. Mwemezi Kaino (KCMC)

Gradian Health Systems, the G4 Alliance and the Churches Health Association of Zambia (CHAZ) co- hosted a workshop on the connections between surgery/anesthesia, faith-based organizations and the SDGs. The session's speakers offered unique insights on the topic from complementary perspectives:

Karen Sichinga outlined the linkages between surgery/anesthesia and other key health issues, sharing CHAZ's experience integrating surgical and anesthesia care into their member facilities.

Professor Pankaj Jani from the College of Surgeons of East, Central and Southern Africa (COSECSA) provided a high-level overview of the momentum behind global surgery and opportunities for FBOs to become involved in advocacy and training networks such as the G4 Alliance and the College of Surgeons of East, Central and Southern Africa (COSECSA).

Dr. Augustino Hellar (Jhpiego) showed how the global surgery movement is making its way down to the country level, sharing an update on Safe Surgery 2020 in Tanzania and their work around national surgical planning. Dr. Mwemezi Kaino from the Kilimanjaro Christian Medical Centre (KCMC) shed light on the practical considerations around surgery/anesthesia at faith-based facilities, speaking

about the challenges he's faced leading the anesthesia and critical care departments at Kilimanjaro Christian Medical Center.

The session concluded with a dynamic discussion among the speakers and CHA representatives from 13 countries. The CHA's agreed on the need to create an online forum for FBOs interested in surgery/anesthesia - a platform for sharing partnership opportunities, training resources, planning and assessment tools, best practices and a variety of other ideas to strengthen surgical and anesthesia care within FBO networks.

CONFERENCE DAY ONE 28TH FEBRUARY 2017: PARTNERSHIPS FOR HEALTH SYSTEMS STRENGTHENING

KEY NOTE ADDRESS: SDG'S AND THE ROLE OF PARTNERSHIPS IN ACHIEVING THE 2030 AGENDA

SPEAKER: Dr. Cornelia Atsyor (WHO Country rep, Lesotho)

Dr. Cornelia said that 193 member states adopted the 2030 agenda for sustainable development. He said that Lesoth0 was the largest participator in Africa. He noted that agenda 2030 had 17 objectives and its realization was the responsibility of all countries. The need for collective approach and cr0ss-country learning of lessons was important. He said that the goals are interdependent and can only be achieved through partnership. With regards to SDG 17 which talks about strengthening the means of implementation, Dr. Atsyor said that CHA's can utilize partnerships as a means of resource mobilization. He asked CHA's to be bold in approaching private as well as public institutions for resource mobilization.

Partnership with government was also highlighted as being a key factor in CHA's realizing their complemetarity strength. Private sector were highlighted as being providers of new technologies, new jobs.

OFFICIAL OPENING

Guest Speaker: Dr. Molosti Monyamane, Minister for Health Lesotho

The official opening was conducted by Dr. Malerato Khoeli the Principal Secretary in the field of health who represented Dr. Monyamane. Dr. Malerato acknowledged ACHAPs initiative to hold Conferences around Africa, from its inception. He pointed to the MoU that CHAL had with the government of Lesotho which was formalized in 2007. He said that the MoU assured health workers in both government and CHAL facilities of standardized salaries, the MoU also committed the government of Lesotho to improving the infrastructure of CHAL units as well as ensure expanded health coverage by supporting infrastructure development in rural areas. He pointed out to the challenges facing the implementation of the MoU including high HIV prevalence, high maternal and infant mortality. He urged CHAs to share knowledge and experiences with CHAL so that Lesotho can achieve SDG's faster. Moreso, he called for abolition of silo programs between government and CHAs saying that SDGs cannot be achieved if each partner worked in silo. Dr. Khoeli officially opened the conference.

PANEL 1: GLOBAL HEALTH PARTNERSHIP OPPORTUNITIES FOR CHAS

This session brought together development partners and government agencies to offer a perspective on effective donor-FBO/CHA partnerships in systems strengthening and show

how to build and foster such partnerships towards making a contribution to the SDGs. They also provided a feel of partnership with CHAs from their organisation's perspective.

Key themes: Donor communities, partnerships

Speakers:

Ellen Starbird: (Director - Office of Population and Reproductive Health, USAID)
Alti Zwandor: (UNAIDS Country Director - Lesotho)
Omer Zang: (Health Economist World Bank - Lesotho)
Maurice Adams: (Executive Director- All We Can)
Jean Duff: (President, Partnership for Faith & Development and the Joint Learning Initiative -JLI)
Moderator: Rick Santos (CEO and President, IMA World Health)

Ellen Starbird: USAID

It was said that the USAID operated on the principles of equity and accessibility for all. USAID gave a background of its history of partnering with an array of local organisations, especially FB organisations who have done a lot to scale up lifesaving innovations, and strengthened community systems, etc. USAID said that Faith Based Organizations bring a trust in the system, and deep roots in the community that enable them to bring about important change. Examples of the collaborations that USAID have had with Faith Based organizations were presented as follows:

Ending preventable child and maternal deaths: In this partnership FBO's were part of call to action with USAID in 2012. The campaign included a pledge of 10promises to children. Faith entities were part of the development of this intervention: including 10 behaviour changes: hand washing, breastfeeding and vaccination.

It was said that USAID held FBOs to the same standards it held other partners to. USAID also added that FBO's needed to document their accomplishments and bring this evidence to bear in their USAID- related applications. The documentation need not be in numbers, stories or evidence based narratives to show who has been impacted and what that impact has meant for them is what was important.

Alti Zwandor: UNAIDS Lesotho

Alti Zwandor from UNAIDS Lesotho said that Faith Based organisations were among the 1st to respond to the call to been considered as partners in responding to the HIV pandemic when it broke out in Lesotho. It was noted that UNAIDS had engaged Faith Based leaders in shaping global strategies including FAST TRACK. She noted that the best example of partnership was exemplified by the engagement of FBO's in 2016 in shaping the final version of the global strategy and getting commitment to the political declaration. She noted that FBO's leaders played a key role in high-level advocacy for political commitment to ending

aids by 2030. Noting that the global strategy is well aligned with SDGs 3, 5, 10, 16, and 17 she said that these goals can only be realised with strong partnerships and engagement of PLHIV, and CSOs.

It was said that UNAIDS had started moves towards implementation of the declaration to end the AIDS epidemic by 2030 in collaboration with FBOs and it had come up with a call to action which spoke to moving from commitment to action.

She said that religious leaders had a large presence at community level and strong grass- roots engagement. They also influenced community norms and individual behaviour and practices. Examples of what UNAIDS had achieved in collaboration with religious leaders was listed as follows:

Progress in ending infections among children in Eastern and Southern Africa. Doubling the number of PLHIV enrolled on ARVs. Coverage also went from 24% in 2010 to 34% in 2015.

UNAIDS also managed to put 10.3 million people on ARVs; and likely to achieve goal of ending AIDS much earlier than the target, so the goal has been increased from 14 million to 16 million.

FBOs have great reach and potential to help reach 90-90-90 targets. UNAIDS recognized FBO's comparative advantage in areas such as schools and other development programmes in addition to health institutions that they owned. It was stated that Health Care Workers needed empowerment in order for them to become advocates as they do their community engagement work. UNAIDS said that they recognized the need to build capacity of FBOs to deliver a more sustainable AIDS response. Few high impact interventions were recognized as bringing great results, the high impact interventions needed innovation and prioritisation.

The FAST TRACK strategy on ending the AIDS epidemic by 2030 was mentioned. It was said that despite an initial impressive results in Eastern and Southern Africa, UNAIDS had recognized the need to address young girls who are sexually active and those having sex with people who were not of their own age. It was said that young women and girls contributed around 25% of new infections. It was mentioned that the people with whom the girls were sleeping with were a hard constituency to reach. In addition, key populations were not deemed a target population for FBO's because they were not comfortable in dealing with them. It was mentioned that FAST TRACK targets allowed for devolving resources to local level.

Omer Zang: World Bank, Lesotho

Key themes: World Bank, Private sector, FBO's

It was mentioned that the World Bank had a platform for dealing with private sector , which included FBO's in developing countries. It was also mentioned that there is need to capitalise on the assets of the private sector and FBOs to achieve SDGs. The private sector could receive support from WB group through:

Access to finance

Development of professional standards and self-regulation

Dialogue between public and private sectors.

Connecting investors across countries to pilot innovative initiatives.

It was mentioned that In Lesotho, the World Bank was engaging with CHAL through government, in an output-based aid (OBA) project, and recent assessment comparing CHAL and government-owned facilities, showed that the flexibility of non-state sector allows OBA to be more effective and sustainable in the long-run.

It was mentioned that FBOs in Lesotho demonstrated clear leadership and management skills that helped innovate, implement and scale-up in hard to reach areas.

FBO's in Lesotho were recognized as having a set of investment, infrastructure and networks that allowed donors and government to use in achieving results.

FBO's were lauded for having clear accountability lines.

Maurice Adams: All We Can

Key themes: Sustainable solutions, local organizations, advocacy, education.

All We Can (AWC) helps local organizations to implement effective and sustainable solutions for people living in some of the world's poorest and least served communities, in addition, they engage in advocacy and education, both in Britain and internationally, to tackle some of the systemic causes of poverty.

It was said that AWC works with FBOs and churches who others may not want to work with because they are small or hard to reach. AWC said that they partner with organizations to focus on non-project specific competency building initiatives. Among the capacity building initiatives that AWC offer include strategic planning, capacity development of their staff.

AWC said that they partner with an organization for a period of between 10 and 15 years. AWC is found in 12 countries and works with 25 organisations and 8Church based organisations.

AWC has worked in Uganda to help an organisation develop a strategic plan. They also helped the organisation to plan for capacity development and strategic planning implementation. As a result, the organization has been able to apply and receive funding from EU and DFID.

In Zimbabwe, AWC has worked with the Methodist Church to develop a project design,

AWC said that they have a relational approach to partnerships and they take time to understand an organizations mission and vision. They are guided by an organizations mission as well as connecting the organization to others who can help advance that mission. AWC are also engaged in emergency assistance and disaster management training and advocacy.

Jean Duff: Joint Learning Initiative (JLI)

Key themes: Collaboration, policy making, research, academia

The Joint Learning Initiative on Faith and Local Communities (JLI) is a collaboration between global and national academics, policy-makers and FBOs. The aim is to collect evidence of the work that has been done, so that policy makers can engage the remarkable assets of FBOs. ACHAP Board members have been members of the learning hubs.

Partnerships operate through learning hubs: virtual collaborations that bring academics, policy-makers and practitioners together: what is the role and contribution of the FB-sector to a specific issue: what do we know, what are the research gaps and how do we communicate this better to a skeptical audience?

Most organizations are unaware of the broad capacity of CHAs throughout this continent. We have heard about the important role of local faith communities. JLI has a learning hub on mobilization of local faith communities:

Includes 20 organizations, including Salvation Army, World Vision, CRS, Islamic Relief, Tear fund, and Organization of African Instituted Churches.

Come together to explore and share what they are doing in terms of large- scale mobilisation of local faith networks

Ebola was a huge wakeup call in this regard – and achieved massive mobilization.

The massive scale-up of local religious leaders and faith communities is less known: the scale is immense and includes large-scale mobilization of FB volunteers.

For example, organization of African Instituted Churches demonstrates how links through faith leaders can reach a huge number of people: working with 3000 lead farmers, and reaching 400 000 small holders on nutrition and safe food practices.

There is tremendous opportunity to scale-up mobilization of local faith communities.

We do know that faith communities are incredibly powerful in reinforcing health messaging.

It was noted that the new US government that took office in 2017 had increased spending in defense whilst cutting down in healthcare. This means that funding for PEPFAR and Maternal and Child Health would be affected. It also meant that CHA's needed to think strategically and document as well as provide evidence of their value addition to healthcare provision in their proposals. A few proposals towards packaging their healthcare services in relation to PEPFAR included the following:

-To position themselves as a service provider to the poor and the marginalized with special emphasis to provision of healthcare to the poorest of the poor, fragile states, etc. In addition CHA's need to focus on evidence for the services they already provide to low-income individuals.

-Strengthening partnerships with local universities to improve quality of evidence.

-To position themselves as a local partner in the global context to move funding to the local level. In addition, expand partnerships with congregations and local religious leaders.

-Initiate strategic conversation with existing religious and denominational funders regarding the strategic use of UN No Malaria funds: to build capacity of local FBOs for malaria response.

For ACHAP: ACHAP needs to locate and showcase best practices and collective activity and contributions of the system.

If ACHAP can continue to strengthen, it can take on advocacy role with international bodies.

ACHAP was encouraged to approach the Gates Foundation which displayed a renewed interest in engaging with FBOs.

PANEL 2: EXPERIENCES OF DIFFERENT NATIONAL HEALTH SECTOR PARTNERSHIP MODELS.

***Key themes*: Partnership models, national health insurance.**

CHAs presented their experiences with different kinds of partnership models existing in- country. The presentations focused on partnerships in relation to national health insurance schemes as well as an overview of Private-Public Partnerships in Africa.

Speakers:

- Eleanor Whyle (University of Cape Town- UCT)
- Peter Yeboah (CHAG)
- Andrew Chikopa (CHAG)
- Dr. Josephine Balati (CSSC)

Eleanor Whyle: (University of Cape Town-UCT)

Key themes: Health Sector challenges in Africa

Eleanor Whyle from the University of Cape Town gave a background on health sector challenges in Africa. It was highlighted that from research, FBO's in Africa participate highly in the health sector, providing primary, secondary and tertiary care. Among the advantages that FBO's have include wide geographical coverage, responsiveness and flexibility, trust of the population and influence and leadership. It was stated that partnership models can be

distinguished along several dimensions including, short-term, supply/demand intervention, formal/informal.

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The relationship between a CHA and the State was described as one with shared values and interests, shared history. A long history of healthcare provision has led to formation of trust between FBO's and the government.

Lessons to be learned on the future of Public Partnership Engagements include:

Relationships can be strengthened by more formal detailed and enforceable contracting.

The strength of the Public Private Engagement lies in history, shared values, trust and a fairly even balance of power.

The CHRISTIAN HEALTH ASSOCIATION OF GHANA (CHAG)

CHAG is a network organization of 183 health facilities and health training institutions owned by 21 different Christian Church Denominations. CHAG provides health care to the most

vulnerable and underprivileged population groups in all 10 Regions of Ghana, particularly in the most remote areas.

It was reported that CHAG had an evolving relationship with the government. CHAG had signed an MoU with the government guided by the Health Sector Support Framework in administrative functions. The Mou it was said laid out the rights and responsibilities of each party.

CHAG presented on the CHAG-NHIA (National Health Insurance Authority) partnership model implemented in 2004 which was oriented towards poverty alleviation. 90% of CHAG clients were also NHIA members. The structure of the partnership incorporated service agreement, blanket accreditation as well as tariff review and medical products review. CHAG was the major stakeholder in NHIA. The partnership helped remove user fees amongst all CHAG affiliated facilities. Overtime, NHIA membership from CHAG members has drastically increased.

Challenges included a chronic delay in reimbursements, CHAG also found itself in a position of a collaborator but a critic of the NHIA.

Lessons learnt include: A need for a nuanced approach in policy analysis, lobbying, advocacy and negotiations for matters that affect CHAG member health units, a need to formalize agreements with government. Need to utilize technical skills within CHAG network in building leverages. It was also said that partnerships are characterized by tensions, deficiencies and manipulations and that they require maintenance, adaptation and accommodation.

The Christian Health Association of Malawi (CHAM). The Experience of **Malawis Public- Private Partnership Model**.

CHAM is the second largest healthcare provider in Malawi, providing nearly 37% of healthcare service delivery in Malawi. 90% of facilities in Malawi are found in the rural areas. It was said that CHAM had signed a Memorandum of Understanding with the Government in 2016. The MoU covered government support towards health workers salaries (100%), Financial support through Service Level Agreements and the removing of user fees, student scholarships for Middle level workers. The MoU also stipulates that that CHAM offers an agreed package of health services free of charge and the government reimburses the service cost based on agreed prices per intervention. The Service Level Agreement has resulted in increased utilization of healthcare services in CHAM facilities as well as improved maternal and child health indicators.

Challenges with implementing the Service Level Agreements include:

Congestion due to an increased number of patients accessing free services.

Stretched human resources and equipment.

Inadequate SLA monitoring, evaluation and troubleshooting.

Other insurance schemes in Malawi include private sector which targets the formal employment sectors. Majority of the rural population in Malawi are not covered by any insurance scheme leading to high out of pocket payments. Free services in public facilities reduces the willingness to pay from out of the pocket leading to low premiums contributions.

Lessons learned from Partnership: They leverage and maximize available health sector resources to improve quality of health services

They improve cost effectiveness and efficiency of public health resources and delivery of health services.

Builds capacity in both Ministry of Health as well as in CHAM to effectively delivery quality health services.

The Christian Social Services Commission (CSSC)

The Christian Social Services Commission is a network with 897 church health facilities including 101 hospitals 37 District Hospitals, 59 Voluntary Agency Hospitals, 101 Health Centres and 697 Dispensaries. It also works with 255 church secondary schools. It was mentioned that the government imposed restrictions on private healthcare delivery services in 1977. It re-introduced private health service practices in 1991.

It was said that the rationale behind PPP was demand for health services by an ever- increasing population. New policies promoted increased participation of private sector in provision of health services. PPP was also mooted in order to leverage private sector resources as well as the need to complement government efforts.

Lessons on partnership include:

Achievements for PPPs depend on existence of strong policies, laws, norms and procedures and frameworks.

The frameworks provide guidelines and procedures for governing public, private institutions.

There still exist dissatisfaction within the stakeholders on knowledge gaps in the regulatory framework, coordination, financial support, stakeholders' commitment, human resource capacity and access to essential drugs.

Successes of this initiative include:

Public and private sector stakeholders meeting to jointly make decisions on issues related to health.

Helps in coordinating the activities of member private hospitals including training.

Provides a network to reach both government and private healthcare providers.

Way forward:

-Build capacity of Public Private providers to identity, negotiate and develop PPP's at all levels.

-Monitor and track PPPs in the sector at all levels.

-Reduce donor dependency by settling budget allocation from their own revenues special for supporting public-private partnerships.

Comments from Government of Lesotho on Partnerships with FBO's.

Dr. Molotsi Monyamane (Ministry of Health Lesotho).

The Minister said that as we transition from Millennium Development Goals, it was important to improve on Primary Health Care. He said that the MoU between CHAL and the Government took over 10 years to formalize because owners of Church-based facilities were not willing to be enjoined in it. He appealed for external review of the Government-CHAL MoU from other CHA's who had managed to come up with one.

BREAK OUT SESSIONS

Three breakout sessions were held and delegates were free to choose which session they were interested in attending

BREAK OUT SESSION 1: PARTNERSHIP MODELS FOR EXPANDING MEDICAL EDUCATION

CHAs presented on the opportunities and models they possessed in-country to facilitate and strengthen the capacity of health workers in training as well as research.

Speakers:

Dr. Samuel Mwenda (CHAK - Kenya)

Dr. Bruce Dahlman (INFAMED- Kenya)

Sr. Deena Veejay (CHAIndia)

Rev. Razafimahtratra (FJKM- Madagascar)

Christian Health Association of Kenya

CHAK is a national Faith Based Organization of the Protestant Churches health facilities and programs from all over Kenya registered in 1946. CHAK partners with the Ministry of Health, County Health Ministries, Donors, Consortium Partners, the Catholic Health Bureau, UN Agencies, Private Sector and communities. CHAK has chosen to partner due to an inadequate financial base for medical education, infrastructure expansion and systems development. There also exists competition for training facilities and clinical experiences.

Availability of technology that enables e-learning across institutions and continents has also spurred the need for partnerships. Expatriates willing to offer their expertise for medical education as well as scholarship opportunities are some of the reasons that partnership has proved valuable for CHAK.

Partnership models pursued include: (a) vertically, with institutions of higher learning and downwards with lower level facilities. (b) Horizontally, among peer training institutions and service delivery facilities and (c) In conjunction with research institutions.

Examples of working partnerships that CHAK is currently engaged in include a Doctors internship training in partnership with the Ministry of Health where 70 doctors are trained annually, there is also training of nurses in mental health, intensive care and anesthesia, there is internship for nurses, clinical officers, pharmacists and laboratory technicians, medical students clinical rotations all courtesy of the MoU with the MoH.

Challenges include:

- Lack of policy and guidelines on partnerships to help standardize engagement
- Resource mobilization to support initiatives
- Development of mutually beneficial partnerships
- Infrastructure to accommodate students and expand on learning facilities
- Respect for institutional values. Lessons learned include:
- Training partnerships bring on board additional resources for service delivery
- Training improves quality assurance
- Training embeds a culture of continuous learning
- It enhances documentation and dissemination of best practices
- Also improves potential for development of new areas of services and growth.

Institute of Family Medicine

INFA-MED is Christian-based institution registered in Kenya as a Trust, INFAMEDS emphasis is on subspecialty training and care in primary care. Quality health care is inaccessible for much of the population of Africa. INFA-MED addresses this need through the training of Family Practitioners to provide the needed primary health care for underserved populations specifically targeting rural areas and slums of the cities

It was reported that Family Medicine workforces in hospitals faced many challenges, key among them being attractive NGO jobs which give better pay and access to employment opportunities. Being offered residency in western countries and attractive remuneration packages were factors affecting Family Medicine human resource capacities.

It was said that Family Medicine was a necessity in Africa due to increased cost-efficiency, functional in rural areas, Family Medicine practitioners were also able to manage many problems without referral and were more closely connected to the local community.

It was said that Family Medicine takes 4 years as a specialty degree by the end of which the doctor is competent enough to handle care at level 3 and 4 facilities. A family doctor also coordinates care between health center and hospitals.

Catholic Health Association of India

It was said that the Catholic Health Association of India (CHA) was established in 1943 to coordinate efforts of ensuring quality, accessible and affordable healthcare is available in the rural and hard to reach areas of India. CHAI started a Catholic Medical College that recruited nuns and women doctors and nurses. CHAI also got involved in reforming nursing, pharmacy and education. CHAI currently has a membership of 3,533 health. 90% of these institutions are headed by women and 80% of them operate in rural and medically underserved areas.

CHAI member health institutions treat more than 21 million patients per year.

It was mentioned that CHAI had established technical collaboration with international universities such as University of Melbourne, University of Toronto, Ascension Health US, these collaborations are meant to build capacities of CHAI and its member health Institutions in research and health management to undertake collaborative research projects. CHAI has a common procurement project to network all regions and leverage the bargaining power of the larger numbers of Member Institutions. CHAI also systematically compiles and manages data authentication at grassroots levels for policy influencing and advocacy at national level.

Church of Jesus Christ in Madagascar (FJKM)

In Madagascar the Catholic Church has training institutions that deal with training of nurses, however Doctors are trained by the State (govt) owned university. While the Churches in Madagascar have universities, the government does not allow medical education or training of doctors. The Catholic, Anglican, Lutheran and Protestant Churches have partnered to build a university that will have capacity to train medical personnel and have appealed to the government to accredit it. The government still sees the Church as a competitor in provision of medical services

BREAK OUT SESSION 2: EXPERIENCES FROM CHA'S PARTNERING WITH GLOBAL FUND

Key themes: Partnerships, Global Fund, FBO's, competencies,

CHAZ- Churches Health Association of Zambia

CHAZ provides 50% health coverage in rural Zambia and 30% of the national health service. CHAZ has an MoU with the Ministry of Health which covers staffing, and essential drugs. It was mentioned that CHAZ had been a Principle Recipient of the GF for HIV, Malaria and TB from 2003- 2o16. CHAZ also played the Sub-granting role to FBO's and Civil Society in Zambia.

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Competencies needed to act in Sub-Recipient role include:

- Ability to do assessment and risk mapping
- Ability to negotiate grants, administer and manage compliance with grant agreements
- Compliance in Monitoring and Evaluation financial performance of sub recipients
- Having a supply chain in order to manage procurement, storage and last mile distribution.

Lessons and opportunities as Principle Recipients

- Enhances collaboration with government and with others
- Promotes stakeholder unity of purpose on HIV, TB and Malaria
- Strengthens internal systems and helps to build sustainable capacity of the organization.

Challenges

- Bureaucracy through the country coordinating mechanism
- Unpredictable funding (performance based)
- Always changing nature of the Global Fund.

ZIMBABWE ASSOCIATION OF CHURCH RELATED HOSPITALS- ZACH

The Zimbabwe Association of Church Related Hospitals (ZACH) is a Not-for-Profit Faith Based Organization (FBO) founded in 1974. It is the Medical Arm of all Churches in Zimbabwe. The association is accountable to the Head of Christian Denomination (HOCD) in regard to the running of health institutions/hospitals and Clinics.

ZACH represents the link between the Head of Christian Denominations (HOCD), the Ministry of Health and Child Cares (MOHCC) and other Health providers and other agencies

Membership currently stands at 130 hospitals and clinics.

ZACH gave an overview of the Country Coordinating Mechanism (CCM) in Zimbabwe as being derived from the following sectors.

Government (7 representatives), UN agencies (2 reps), Bilateral partners (2 reps), People living with disease (3 reps), Faith Based (2 reps), Private sector (3 reps), NGOs (3 reps), Academia (1 rep), Women's Organizations (1 rep). The Faith Based Organizations conduct annual constituency feedback meetings which they channel back to the CCM. FBO's also submit national proposals for considerations for funding as well as providing oversight to the implementation of the grant. FBO's also approve and implement mechanisms for the selection of Principle Recipients and Sub Recipients.

Successes in Zimbabwe include:

A successful implementation of the Global Fund grant in 2002 has meant additional resources for Zimbabwe. This has led to a reduction of incidences of HIV, TB and Malaria in the country.

Challenges include:

Selection of Principle recipients is limited, CCMs only recommends Principle recipients while the Global Fund has the final say.

CARITAS CONGO

Caritas Congo is the health department of the Catholic Church. CARITS is found throughout DRC and operates through 47 intra-country offices. CARITAS main focus areas include emergency reliefs in health and sustainable development as well as in Education. Among CARITAS's roles include promotion of effective partnerships, advocacy on behalf of vulnerable populations and building capacity of diocesan organizations.

CARITAS has been a principle recipient from July 2011. They work hand in hand with the government and control a budget of US$ 53,000,000.

Experiences with the Global Fund

Purchase and distribution of drugs and anti-TB equipment's and medical materials as well as non-medical consumables.

Rehabilitation of medical infrastructure, construction of wards to cater for people with resistant strains of TB and laboratories and coordination of provincial level Leprosy and Tuberculosis committees.

Advocacy and counseling of TB patients, rehabilitation of neglected patents, transportation of samples, dietary support to TB patients.

Success stories

Partnership has contributed to the operationalization of strategic plans of CARITAS Congo since 2010

Contributed to the fight against TB, HIV and Malaria

Improvement of healthcare access for the population

Improvement of institutional capacity in managerial functions.

Strengthening the I.T system as well as endowment with motor vehicles and motors for boats.

Support for financial management in the form of application of rigorous procedures.

Difficulties

Different salary regimes between local and international organizations.

Bureaucracy and long supply chain process leading to weakening of local supply organizations

Heavy management procedures by the Global Fund

Not taking into consideration the country context during the time of auditing by Global Fund auditors.

Local Global Fund agents work as inspectors and other times as non-observers

Lack of book-knowledge of the project.

Criminal proceedings instituted during audits

Challenges

Attaining results within the context of a poorly financially supported

Realization of good monitoring with little funds and in geographically difficult-to- reach areas.

Improvement of data quality at operational level within the integration ambit of all program.

Lessons learnt

Financial management of funds and inputs in the health system financial procedures is important

The involvement of the community in operationalization of projects gives rise to faster utilization of services

Regular accompaniment by the Global Fund financial team helps with better implementation of the grant.

Conclusion:

Support by the Global Fund has contributed enormously to the betterment of the health care for the population in DRCongo. However, it is advisable to develop a partnership
that is more flexible and responsive in order to attain the SDG's.

BREAK OUT SESSION 3: PROCUREMENT & SUPPLY CHAIN MANAGEMENT

Drug supply organizations presented their experiences in engaging with the public, private sector, civil society and development partners on procurement and supply chain management.

Key themes: Drug Supply, Supply Chain Management Speakers:

Dr. Jonathan Kiliko (MEDS- Kenya)

Bildard Baguma (JMS-Uganda)

EXPERIENCE OF THE MISSION FOR ESSENTIAL DRUGS AND SUPPLIES (MEDS)- KENYA

MEDS was established in 1986 as a trust between the Christian Health Association of Kenya (CHAK) and the Kenya Catholics Conference of Bishops (KCCB). It was established due to reduced government support to church health facilities in the 1980's. Church health facilities were dealing with many suppliers w-ho had limited stocking/holding ranges, there were many un-assured medicines whose quality was also poor.

MEDS core functions include warehousing and distribution of reliable, quality and affordable essential medicines, pharmaceutical Quality control laboratory services and capacity building and client support services.

In order to ensure quality, MEDS has undertaken the following efficiency, reliability and cost- effective steps:

-Acquired ISO 9001: 2008 certification

-Achieved WHO pre-qualification status in 2009.

-Computerized 100% of its stock holdings and included online purchasing capacities

-Ensured 2-5 working days turnaround time for clients' orders

-Door step delivery networks across the country at no extra costs.

-Built a state of the art Warehouse to ensure good storage and efficient processing of orders.

MEDS Warehouse which is 10,000m2

Challenges:

- Affordability (price & cost) of Essential Medicines & Medical Supplies especially to poor & marginalized communities
- Human Resources Capacity gaps at County & National Government levels
- Limited Coordination & Consultations at County & National level due to lack of standardization approach
- Free and Liberal market/Market dynamics therefore influx of sub-standard & counterfeit products
- Interpretation & Implementation of the Constitution leading to confusion/inefficiency in the health sector
- Debt Burden – Clients not paying leading to supply gaps

Lessons learnt:

There is Strength in Unity: *"Together we are stronger and we can achieve more"*. There is need for Intra-partnerships for greater impact.

Operational research and evidence-based reporting: Our level of innovativeness is dependent on our involvement in operational research and evidence-based reporting.

Quality, affordability, reliability (order fill rate) and capacity to meet customer needs and requirements are ingredients of a successful procurement and supply chain management in Africa

PROCUREMENT AND SUPPLY CHAIN MANAGEMENT- JOINT MEDICAL STORES- UGANDA

The Joint Medical Stores (JMS) was begun as a joint venture between the Uganda Protestant Medical Bureau and the Uganda Catholic Medical Bureau in 1979 with the aim of providing cost effective, quality and safe pharmaceutical services to the population in Uganda. JMS procures, supplies and installs medical equipment, as well as health related products. In addition, they provide quality assurance for their products and services.

JMS relies on 5 actions to achieve this goal. These include effective communication, sustainable business strategy, distinct customer care and after sale service, effective governance and risk management and quality products and services.

JMS partners with UNICEF, UNHCR, UNAIDS amongst other Bilateral donors.

Link: http://africachap.org/en/wp-content/uploads/2015/01/ENGAGING-WITH-PARTNERS- BILDARD-Baguma-JMS.pdf

CONFERENCE DAY TWO: 1st March 2017: BUILDING EVIDENCE FOR HEALTH SYSTEMS STRENGTHENING

PANEL 1: PARTNERSHIPS FOR EVIDENCE BUILDING, RESEARCH IN PARTNERSHIP

Academic institutions with long-standing relationships with CHA's were given an opportunity to show how academic programs can feed into everyday activities of the CHA's as well as how CHA's can incorporate research as part of their outputs.

Speakers:

Dr. Jill Olivier (University of Cape Town- UCT)
Peter Yeboah (CHAG Ghana)
John Blevins (Emory University)

Partnership through Research. Dr. Jill Olivier

Dr. Jill Olivier gave an overview of what kind of data CHA's need in order to do research. She said that not all research needs to follow an academic layout for it to qualify as being useful. She added that CHAs generate a lot of data that can be useful in doing in-house research.

Her presentation mentioned that local research support is part of the SDG's. She stressed the need to have electronic and other secure means of storing institutional health systems data as most CHA's had poor storage modes which were affected by staff movement, weather, and as a result, institutional memory had weakened.

She challenged CHA's to learn about research that had been done with their institutions, both empirical and embedded.

She also cited different types of research that CHA's can carry out, which are not cost- intensive. Among the challenges for conducting research, she cited the following:

- Imposed and conflicting agendas of funding institutions
- Apportioning resources for the research Resourcing (research doesn't generate funds for the system)
- Lack of transparency: about objectives, capacity, available information
- Politeness': Agreeing to carry out a research in order not to offend the sensitivity of those asking, but in real sense, not having the will-power to follow through
- Timing and trust building: (lack of both)
- Changing contexts: eg Staff turn-over, new priorities
- Researchers that damage the health system, and abuse the relationship. E.g asking for data and never explaining the outcome of the
- Lack of feedback to the system

She listed the components of a good research partnership as involving the following:

Written agreements guiding the research relationship (eg even if no funds involved, guiding relationship, data agreements) • A regular communication strategy • A strategy to take care of staff turn-over (especially in researches that take place over time) • The partnership should build CHA in-house capacity in some way (eg research capacity, available evidence etc). Recognition of in-kind support from both partners.

Participants were concerned about clearance of researchers by an ethics board composed of the management of the CHA. It was suggested that CHA's could partner with academic institutions to handle clearance of researchers. It was also suggested that CHA's partner with academic institutions for CHA staff to learn research courses that were customized to their needs. Retention of data as a result of activities undertaken by outside partners was mentioned as being important.

Salient issues:

CHA's were encouraged to invest in research management courses at universities and invest in different forms of research such as evaluations, longitudinal studies etc. Research need not be labour and cost intensive, it could be as simple as an in house assessments of systems (not necessarily public), external evaluations, comparative studies, large scale Health Policy and Systems Research (HPSR) theses.

Lessons need to be documented about activities that don't work as planned

Health research is all over the SDGs – moment focused on strengthening local capacity

What evidence is being collected and does it match what is needed – make case at national and international level, internal learnings – how is it translated into action and utilization

- Information collected at facility level often not carried forward to national level for use in decision making.
- Data usually reaches back a few years and disappear when staff leave there is little record keeping over time and institutional memories are lost
- There are studies that address each of the health systems building blocks on FBOs but much data is missing.
- WHO sees research as a core function of health system – embedded research that looks at real world problems is appealing to them, CHA's can work in partnership with researchers to develop proposals that speak to each building block.
- Local research and research capacity with participation is key.
- Challenges – imposed and conflicting agendas, resourcing, lack of transparency (politeness), timing and trust building, changing contexts, researchers that damage the health system and abuse the relationship, lack of feedback to the system, lack of CHA capacity to conduct and manage research.
- Components of a good research partnership – work together to frame question, transparency, written agreements, regular communication strategy, strategy for staff change, deliberate activity to share findings, co-creation of outputs, should build CHA in house capacity

EMORY UNIVERSITY- John Blevins

Emory University's Interfaith program was instrumental in the formation of the Africa Religious Health Assets Program in South Africa, later (IRHAP) in collaboration with the University of Capetown, University of WitwatersRand and the University of Kwa Zulu Natal. Emory has also partnered with PEPFAR which works with CHAs and ACHAP to implement a health system strengthening program that entails younger CHA's being mentored by older CHA's. The program involves ACHAP, CHAK, CHAL and will be rolled out to other African countries.

Emory was involved in crafting of key recommendations out of consultations in 2012 and 2015 to influence PEPFAR interactions with FBOs. Emory was also involved in helping to draft a mentorship program between CHAK and CHAL where CHAL identified systems in governance and administration that needed strengthening and went to CHAK in Kenya for a mentorship process whose recommendations were highly appreciated back at CHAL.

Lessons learned – funders have own priorities and need to develop strategies to respond, role in changing priorities, true partnerships find areas of collaboration and building a supportive environment

Link: Applied Research and Programs Between the Interfaith Health Program, CHAs, and ACHAP

Christian Health Association of Ghana- CHAG, Peter Yeboah

It was said that research at CHAG had been most neglected. It was said that evidence is often anecdotal and lacked research and attribution to back it up. The lack of a research policy and capacity to identify research priorities were identified as major impediments. There was a need to be able to identify pro poor services within a rapidly changing country health context and become aware of the effects of urbanization and the unintended assimilation into government policies. It was said that there existed a huge prospect and potential for research for improving CHAGs core mandate of service delivery. This could be made possible by leveraging research partnerships for achieving SDGs.

CHAs' were challenged to build capacities to manage expectations between researchers and donors as well as to partner with academic institutions to help in developing ethics boards and understand different ethical issues.

CHAs' were challenged to come up with a journal to record their research findings, this was in addition to being able to identify research issues that do not need ethical board clearance and that were easy to carry out. Eg data analysis. Plus, learning how to incentivize research.

PANEL 2: BUILDING THE EVIDENCE BASE ON FBO/CHA CONTRIBUTIIONS: RHERORIC TO ACTION

Key themes: Data collection, contracting, performance, Christian Health Association of Malawi (CHAM): Titha Dzowela

CHAM has 174 facilities in Malawi and is found in 28 out of the 29 districts in Malawi. In a year, they produce 80% of health worker requirement for the country. It is considered as the second biggest provider. The outpatient department attendance trends from CHAM hospitals have varied from 11%-12% of the total OPD attendances in Malawi. CHAM has 42% of the bed capacity in the public sector.

A contract between the Government of Malawi, represented by District Councils and CHAM health facilities. The contract provides an agreed package of health services, free of charge to the population. CHAM is still vital but positioning is declining and utilization is declining.

Link: http://africachap.org/en/wp-content/uploads/2015/01/CHAM-from-rhetoric-to-action-Titha- Dzowela.pdf

IMA World Health: Alfredo Fort

Christian Health Associations need to provide evidence that is unique and of qualitative distinction. Their data needs to be relative to the work of the government or in relation to Health Care in general. Donors are scrutinizing performance based strategies in order to determine value for their monies. It is therefore not enough for CHA's to say that they do good.

CHA's were challenged to include "evidence generation" in their multi-year plans, board meeting agendas, declarations and annual Reports. They were also challenged to Invest in M&E capacity building through training, utilization of analytical software and exposure of staff to best practices in M&E through Conferences and meetings. In addition, they should ensure that they carry out studies that compare, define and show their contributions. They need to invest in websites, reports and bulletins and peer reviewed work that showcase their contributions.

Investing in infographic skills, pictures tell better stories than words.

Emory University: Deb McFarland

Deb McFarland a professor at Emory said that the lingo around evidence revolved around Health systems performance, Health systems strengthening, Universal health coverage and resilient health systems.

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CHAs were challenged to familiarize themselves with indicators and how to respond to them they were asked to be part of the indicator creation process. Trust was identified as one of the most important prerequisites of a resilient health system. It was suggested that the Ebola crisis had left populations without trust in political, economic and health systems.

Building trust: "Strengthening health systems for resilience means strengthening social and political systems.This means going beyond surveillance, health infrastructure, training and delivery of medical care to long-term investments for institutions that foster trust." (www.ids.ac.ukIDS Practice Paper in Brief 16 February 2015).

Link: http://africachap.org/en/wp-content/uploads/2015/01/Deborah-Mc-Farland-Emory-From- Rhetoric-to-Action.pdf

Ecumenical Pharmaceutical Network: Mirfin Mpundu

EPN is a worldwide network of 105 members from 37 countries in 5 continents who have an interest in or are involved in the delivery of just and compassionate quality pharmaceutical services. EPNs areas of strategic focus include anti-microbial resistance and infectious diseases, research and information sharing, non-communicable diseases, maternal and child health, capacity development of pharmaceutical services. EPN gave examples of evidence of inadequate and inequitable access to essential medicines and medical supplies in East Africa and their interventions in Pooled procurement mechanism initiated among drug supply organizations in Rwanda (BUFMAR), Uganda (JMS), Kenya (MEDS) and Tanzania (MEMS), as a result of this they achieved 13% cost savings equal to USD 254,346. Other examples of evidence-based interventions include launch of Ecumenical Scholarship Program (ESP) – Diploma in Pharmacy and a certificate in Essentials of Pharmacy Practice (EPP) courses in order to fill a gap of inadequate and unskilled pharmacy staff in Faith Based Institutions in Africa. As a result of these interventions, 40 students have graduated from Zambia, Cameroon, Uganda and Tanzania over the last 3 years as well as 192 others from Chad, Niger, Tanzania, Malawi, South Sudan, Nigeria and Kenya.

These interventions, amongst others, have led to: Increased availability of medicines (e.g. through pooled procurement in Cameroon) - Decreased level of expired medicines in CHIs

Improved dispensing practices - Improved rational use of medicines -Improved storage conditions for medicines - Guaranteed quality of medicines.

Link: http://africachap.org/en/wp-content/uploads/2017/03/ACHAP-Conference-Presentation-EPN.pdf

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BREAK OUT SESSIONS: EVIDENCE LEADING TO IMPROVED PRACTICE

BREAKOUT SESSION 1: LESSONS LEARNT FROM HIV & FAMILY PLANNING PROGRAMS

Key themes: Religious leaders, advocacy, collaboration,

Speakers:

- Mona Bormet (CCIH- U.S)
- Jane Kishoyian (CHAK Kenya)
- Yoram Siame (CHAZ Zambia)
- Mirfin Mpundu (EPN Kenya)

Christian Connections for International Health - CCIH, Mona Bormet

CCIH presented on the Christian Advocacy for Family Planning Africa (CAFPA) project. CAFPA is a collaboration between 5 Churches in Nigeria as well as well as the Ecumenical

Pharmaceutical Network (EPN). It was said that in Nigeria, religious leaders were not seen as opposed to family planning initiatives in a survey carried out in 2014. However, FBOs received minimal support from the government in commodity supply, trainings and Family Planning materials. It was said that the biggest barrier to FP service provision was client misinformation. It was mentioned that the Nigerian government Family Planning blueprint had envisaged increasing Contraceptive Prevalence Rate (CPR) BY 36% IN 2018. Religious leaders committed themselves to creating demand for FP products as well as demystifying misconceptions on FP during Bible studies. They also committed to improving supplies and commodities security via advocacy to government. FBO providers lobbied for inclusion in the government supply chain of FP commodities as well as for more budget allocation for training more health workers and religious leaders especially in FP.

Link: http://africachap.org/en/wp-content/uploads/2015/01/CCIH-on-advocacy-and-faith-for- ACHAP-3_1_2017-FINAL.pdf

Christian Health Association of Kenya: Jane Kishoyian

Role of CHAK in reduction of HIV/AIDS through Family Planning.

The role of CHAK in reduction and elimination of HIV/AIDS through FP was elaborated. HIV prevalence rate in Kenya is around 6% which accounts for 1.6 million people living with HIV infection. Kenya is one of the six "high burden countries in Africa.". Family planning services can prevent Mother to Child Transmission, contraceptive methods such as male and female condoms protect against sexual transmission of the virus plus helps women avoid unwanted pregnancy.

Healthcare workers are trained on basic emergency obstetric care and long acting Family Planning methods.

Religious leaders are sensitized on evidence-based benefits of Reproductive Health, Family Planning and HIVintegration. CHAK has opened dialogue with religious leaders on reproductive health and family planning. Religious leaders help improve demand for family planning services through advocacy.

So far 250 community health workers, and 150 community health volunteers have been trained on the importance of referrals and usefulness of various FP commodities.

Religious leaders discussing the importance of Family planning and community sensitization

Achievements:

- 8,635 clients referred to health facilities for FP methods by religious leaders
- 38,611 new FP acceptors in 10 facilities
- Improved FP uptake and improved method mix. Challenges:
- Staff turn-over in member health units leading to loss of institutional memory
- Cultural and religious biases against contraception
- Occasional erratic supply of commodities
- Inadequately skilled personnel on Lactational Amenorrhea Method

Way forward:

CHAK will continue with capacity building through mentorship
Continue support in commodity management to ensure no stock-outs
Strengthen data collection and reporting system.
Continue advocacy with county government stakeholders and donors for resources.

Churches Health Association of Zambia: Yoram Siame

Key Reflections on the Churches Work in HIV and FP

The Church needs to focus on competency building for people living with HIV/AIDS.

In addition, the church needs to engage indigenous self-propagating institutions to ensure locally driven changes in socialization behaviors. There is need to support church leaders and clergy who take the risk of being front runners. Engagement of the church is not just about the top leadership, but engagement of clergy and congregation.

Church need to guard against use of labels such as progressives and non-progressives for people who agree or don't agree with their point of view.

BREAK OUT SESSION 2: TACKLING Neglected Tropical Diseases (NTDs), FOCUSING ON PROGRESS AND LESSONS LEARNT IN CONTROLLING NTDs.

Key themes: Community participation, advocacy Speakers:

Josephine Balati: Christian Social Services Commission (CSSC)- Tanzania

Jim Oehrig: American Leprosy Missions (ALM) – US

CSSC coordinates and works with a network of over 900 church health facilities including 102 hospitals, 102 health centers and 696 dispensaries. These facilities contribute about 42% of the health services provided in the country. CSSC also works with a network of 58 health training institutions. More than 10 NTDs affect rural poor communities and contribute to increasing poverty in the affected communities. The most common NTDs include filariasis, onchocerciasis, trachoma, soil transmitted helminthiasis and schistosomiasis. These NTDs are associated with serious chronic and social economic consequences. FBOs are involved in the implementation of the NTD national program through advocacy of prevention activities. More than 172 church based primary schools are involved in health promotion activities to enhance behavior change. The school program for NTDs usually targets children between 5-15 years old. The network of church based hospitals administers drugs for the treatment of lymphatic Filariasis, Onchocerciasis, trachoma, soil transmitted helminthiasis and schistosomiasis.

Church based facilities are also engaged in monitoring and supervising the community drug distributors.

Lessons learnt:

Community participation and ownership is key to success of prevention, control and elimination of these diseases.

Religious leaders should be involved in dissemination of information and sensitization of their congregants to seek treatment.

For morbidity alleviation, specialized treatment is required eg. For surgery on hydrocele and trachomatoustrichiasis and lymphedema management.

Jim Oehrig (American Leprosy Missions): Accelerating Integrated Management (AIM) INITIATIVE

AIM grew out of an innovative disease-mapping breakthrough that was supported by American Leprosy Missions in partnership with the London School of Hygiene and Tropical Medicine as well as the Ministry of Health in Ghana. Using routine surveillance data of existing cases and morbidity, AIM now partners with Ministries of Health, NGOs and others to map cases of neglected tropical diseases (NTDs), enabling more accurately targeted delivery of health services in various countries.

Jim highlighted AIM's objective of increasing early diagnosis and access to appropriate treatment for people affected by and at-risk for Neglected Tropical Diseases.

Approach:

Mapping disease burdens: AIM collects (NTDs) countries' routine surveillance data of existing NTD cases and morbidity. With this information, AIM produces digital maps that reflect the geographic overlays of multiple diseases with village-level accuracy.

Evidence Based Strategic Planning: AIM works with Ministries of Health and other NGOs to develop countrywide, evidence-based Strategic Plans for Integrated Case Management of NTDs. The plans enable countries to efficiently allocate limited health resources and help end the practice of deploying healthcare services one NTD at-a- time.

Implementation of integrated interventions: With accurate maps and integrated strategic plans in hand, Ministries of Health will have the visual data to identify NTD- impacted communities and efficiently deploy integrated interventions. This improves healthcare delivery efficiency by limiting the need to send more than one health worker to treat individual NTD cases.

Link: http://africachap.org/en/wp-content/uploads/2015/01/Accelerated-Integrated-Management- Healthcare-Delivery-Access-and-Efficiency-.pdf

BREAKOUT SESSION 3: STRENGTHENING FBO HEALTH SYSTEMS LEADERSHIP THROUGH TRAINING AND CURRICULUM DEVELOPMENT

Introduction*:* Members of the CHA networks explained the relevance and importance of training oriented towards faith-based and non-profit leadership. CHA membership with experience relating to training in health systems, from academic partners were asked to describe the importance of the training.

Key themes: FBO leadership, collaboration, systems thinking, accountability

Speakers:

Sam Nugblega (CHAG Ghana)

Michael Mugweru (ACHAP Secretariat)

Mwai Makoka (World Council of Churches- Switzerland) CHRISTIAN HEALTH ASSOCIATION OF GHANA: Sam Nugblega

Health System challenges in Ghana include:

Changing disease burden

Shifting demographic compositions

Growing completion for roles and resources

Strong leadership capacity is required to address the above challenges. Leadership competencies are required are, technical, managerial and personality. Leadership becomes a barrier when levels of leadership are not clearly defined and leaders lack the requisite competencies and appropriate authority. No effective systems exist to harness the work of academia and practitioners for systems strengthening and the work of academia and practitioners do not significantly impact each other for the desired outcomes to occur. It was said that there was limited collaboration between Faith Based Academic institutions and Service Delivery institutions in order to build leadership capacity and strengthen the health system. Lack of evaluation of training regimes leads to ineffective curricula.

Areas of consideration

-Strengthening collaboration between academia and practitioners for effective systems research and improved heath outcome including curricula improvement, utilization of research findings and funding arrangements.

-Strengthen the capacity of service institutions in systems and policy research

-Develop a research culture and agenda within the CHA's.

-Opportunities exist within the network of CHA's to improve health system and leadership development.

Michael Mugweru ACHAP Secretariat

CHAs have a unique and broad reach in African countries, they provide primary, secondary, and tertiary healthcare services, in addition, they own schools for the education of health professionals; community health programs;

outreach initiatives to vulnerable communities; and national networks that support health, development, and social services.

CHAs maintain an established, long-term presence that is interconnected and comprehensive. By transversing national networks to grassroots programs, CHAs offer one of the quickest response systems to a country's health needs.

Health Systems training is important to CHA leadership because it concerns itself with contextual factors that affect health worker effectiveness as well as health seeker behavior. In particular, case study approaches to dealing with health systems problems place the leadership of CHAs at advantageous positions where they are able to have a system-specific eye view that enables them to:

-Define their role and scope of influence as a leader/manager within the context of the health system.

-Appreciate the systems requirement for the hardware of system management namely the human resource, finance, technology, organizational structure, service infrastructure and information systems as well as the software issues of ideas, interests, relationships, norms and values necessary to achieve health outcomes.

-Understand the behavior and relationship among actors and agencies and how those relationships affect outcomes in one's country.

-Support and analyze policy development and see how it contributes to health outcomes in their areas of jurisdiction.

World Council of Churches: Mwai Makoka

Leadership within CHA's should be based on accountability, recruitment should not be casual. CHA's were challenged on whether they were objective in recruitment of leaders in their institutions or whether they were skewed towards picking favourites.

BREAK OUT SESSIONS: EVIDENCE LEADING TO IMPROVED PRACTICE

BREAK OUT SESSION 1: QUALITY ASSURANCE PRACTICES IN RELATION TO PROVISION OF MEDICINE AND ESSENTIAL SUPPLIES

Joint of Medical Stores (JMS). UGANDA- Bildard Baguma

Joint Medical Stores Quality Assurance System.

JMS plays a gatekeeping role in provision of medicines and essential supplies. This is achieved through prequalifying product manufacturers and products themselves, physical inspection to detect sub-standard products, auditing suppliers for Good Distribution Practices (GDP), auditing manufacturers for Good Manufacturing Practices (GMP) and audited Laboratories for Good Laboratory Practices (GLP).

Environmental Quality Control includes: Construction design of warehouse, Temperature and humidity control, use of Cold chain management protocols, contingency plans in place as well as alarm systems.

In transportation JMS prequalifies transportation company. • Regularly validates environmental conditions during transportation to provide confidence that transportation does not affect product quality • Train transporters on Good Distribution Practices for medicines.

Challenges

Porous borders leading to importation of counterfeits

Poor regulation/limitations

High cost of skills development/maintenance

Link: http://africachap.org/en/wp-content/uploads/2015/01/Quality-assurance-in-provisionof- essential-supplies-JMS-Uganda.pdf

BREAK OUT SESSION 2: IMPROVING DATA AND INFORMATION GATHERING IN RURAL AND HARD TO REACH SETTINGS

Association of Medical Missions of Botswana (AMMB) - Martha Mothibe

The Association of Medical Mission in Botswana is a secretariat that brings together Faith Based Organizations for mutual advocacy, learning from each other and benchmarking best practices. Members subscribe to the association and each member functions independently. AMMB has two hospitals and several community clinics as well as boarding schools and a rehabilitation center.

In Botswana, community consultation and information gathering in the hard to reach areas is driven by the office of the President of the country.

One of the school of nursing has collaborated with local NGO's community members, traditional doctors in order to develop a basic manual for maternal services to be used to collect information in the farmlands. Although the manual was not used, information from the exercise was use to craft a questionnaire to identify maternal healthcare seeking behaviours in one of the districts. The questionnaire was administered to 195 women. A conclusion of that study was that most women prefer home deliveries, barriers to hospital delivery included lack of transportation, fear of hospital procedures and cultural difference in child birth practices.

Lessons:

(a) Mission facilities offer basic services to communities found in far to reach areas, in various forms and without documentation

(b) Mission hospitals are known countrywide for their specialized services.

(c) Data accumulates in mission hospitals but without a system of processing it for the benefit of that hospital, it remains useless.

(d) Language barriers pose a challenge to communities who do not have common languages with service providers.

(e) Distances are the largest barriers to rural people receiving services

Conseil des Eglises Protestantes du Cameroun (CEPCA) - Pierre Mbeleg

CEPCA was formed in 1969 and is a network of 11 churches. At present, it has 30 hospitals and 250 centres throughout Cameroon. CEPCA is the most important health network after the state in terms of national coverage.

CEPCA utilizes data forms in hard copy which are administered by the CEPCA secretariat administrators, they are then sent to all member health units depending on the nature of data to be collected (pathology HR, financing etc). A special training session on data collection at member unit departmental level. Data collected is channeled back through the department back to the secretariat for collation.

Challenges:

Poor level of salaries for staff involved in data collection leading to low morale

Non-trained staff used for data collection leading to poor data quality

Lack of basic material like paper

Lack of concern about data collection issues.

Long distances between member health facilities and sites where data is supposed to be collated.

Lessons learnt:

Advocacy for use of data is important

Building capacities of staff to collect data is important

A good information system that feeds decision making system in governance is a pre- requisite to any advocacy effort and achievement of SDGs

Catholic Medical Mission Board (CMMB) - South Sudan Rose Ejuru

Rural health facilities play a key role in providing accessibility to quality care to the majority of their populations. Reliable and comparable data from rural health facilities is critical for impact assessment, effective decision and planning.

Challenges in data collection:

Poor roads, insecurity

Poor internet and phone connectivity

Lack of skilled personnel

Lack of effective reporting tools (health information systems) resulting to irregular or incomplete records

Improving data and information gathering involves:

-empower health professionals to critically evaluate gathered data and information at the facility level

-strengthen understanding of importance of data quality and improve data cleaning

-increase sense of ownership of the data by staff

-Provide standardized tools for recording data and information at facility level

-Simplify and improve data collection

-Advocating through government (MOH) and NGOs to have better budget that can cover new innovations and alternatives of collecting data.

-System strengthening remains key health care settings, efforts should be focused on ensuring that human and financial resources, political will and commitment and collaboration remain dedicated to the task of improving ways of collecting data

Lessons learnt

-Advocating through government (MOH) and NGOs to have better budget that can cover innovations and alternatives of collecting data.

-System strengthening remains key health care settings, efforts should be focused on ensuring that human and financial resources, political will and commitment and collaboration remain dedicated to the task of improving ways of collecting data

-Poor-quality data hinders monitoring and evaluation of health facility performance and intervention in rural setting

- For better intervention in rural and hard to reach setting requires the right information on which to base programs.

-Having the data is not enough; we need to understand the underlying factors affecting data and information gathering

-Each data collected can provide indications on practical ways of addressing problem in these hard to reach setting.

BREAK OUT SESSION 3: INVESTING IN HUMAN RESOURCES WITH A FOCUS ON EMERGENCY PREPAREDNESS, RESPONSES AND RESILIENCE

Key themes: Conflict, service delivery, fundraising

Speakers:

The Rev. Samuel Peni, Bishop of the Episcopal Church of South Sudan South Sudan Context

South Sudan is already a context of war, conflicts, violence and un certainties. The Church network can be said to be the only stable form of infrastructure. The Church has tried to provide Health and Education services to the people of South Sudan during this time of turmoil.

During the decades of civil wars in South Sudan churches have tried to maintain health and school services. With little to no training, the church has persisted in having the two programs moving.

Challenges include raising funds for training, building the capacity of health workers and keeping the personnel in the midst of competition from international humanitarian NGO's. have not been easy. The Catholic Church has incorporated some strategies to help keep its dwindling human resources.

The Strategies we tried to use are as follows:

- Sign an MOU before granting Scholarships with potential health workers to stay and work for at least a few years before moving on.
- In the agreement their certificates, diplomas are retained until the contract is finished
- Church offers offer more trainings adding value to their specialization
- Provides housing for them
- Include benefits such as scholarships for their children
- Incorporate a referee who will act as point of recourse incase the contract is breached.

Link:http://africachap.org/en/wp-content/uploads/2015/01/Investing-in-Human-Resources-with-a-focus-on-Emergency-Preparedness-Response-and-Resilience.pdf

PANEL 3: INFLUENCE OF FAITH ON SERVICE DELIVERY

Key themes: Influence of faith leaders, harmful societal practices.

Speakers:

Mona Bormet, (CCIH U.S)
Rev. Nyambura Njoroge, (EHAIA- Geneva)
Solange Mukamana (Tear Fund S.A)
Rev. Phumzile Mabizela Mona Bormet (CCIH)

CCIH said that the Church was uniquely positioned to deliver family planning messages and services. They gave video examples from Nigeria of congregants giving their beliefs concerning FP before and after listening to religious leaders talking on the same. The importance of spacing and the health of the mother were highlighted as advantages of Family Planning. Religious leaders from Kenya spoke on the need to disseminate the message of family planning to their congregations.

Solange Mukamana (TearFund South Africa)

Indicators of the healing process: Tear Fund said that it was important for survivors of sexual violence to access counselling and be part of a support group. Support groups confer positive attitudes towards life and hope for the future. Support groups were also mentioned as improving the quality of life of individuals. Faith Based actors were recognized for their importance in preventing Sexual and Gender Based Violence. Faith based health providers were applauded for journeying and providing safe spaces for survivors of SGBV, they were also applauded for investing in understanding the priorities of SGBV survivors. Faith Based health providers were advised to work with governments to influence SGBV policies. Most importantly they were exhorted to preach against harmful social norms including harmful masculine theologies. Partners were urged to invest in ensuring confidentiality of survivors which is a pre-requisite for healing, gender injustice in schools needed to be addressed via curricula training.

Link: http://africachap.org/en/wp-content/uploads/2015/01/Solange-Mukamana-SGBV-by- survivors.pdf

Rev. Phumzile Mabizela: INERELA

History of INERELA+

INERELA+ core business includes Stigma and discrimination, Resilience building and promoting disclosure. It was said that INERELA promotes reclaiming of positive cultural practices and getting the whole family involved. It was pointed out that ancestor worshiping ancestors had been labelled as a negative trait at the intersection of religion and healing.

It was said that the role of Religious Leaders in promoting faith healing and the different elements e.g., water, oil, faith cloths were important as well as a recognition of ARVs as a gift from God.

It was said that globally, in 2015 there were an estimated 17.8 million women living with HIV (15 and older), constituting 51 per cent of all adults living with HIV. Young women and adolescent girls aged 15-24 were particularly affected. It was said that globally, in 2015 there were an estimated 2.3 million adolescent girls and young women living with HIV, that constitute 60 per cent of all young people living with HIV (15-24).

In promoting disclosure, it was said that INERELA+ promoted the practice of men getting tested early which afforded them an opportunity to live long and full lives.

In reclaiming positive cultural practices INERELA+ challenges gender inequality, by challenge the role of women as caretakers, making it difficult to negotiate for safer sex as well as addressing marital rape.

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CONFERENCE CLOSURE

The Conference was closed by the ACHAP Board Chair Karen Sichinga who highlighted the value that CHA's add to national health systems by providing affordable compassionate healthcare. She also called upon donor partners to negotiate more closely with FBO facilities because the values that drive FBO service provision differ from those that drive other service providers.

KEYNOTE GUESTS

The ACHAP Conference was attended by the Minister for Health for Lesotho, Dr. Molotsi Monyamane, the WHO Country rep for Lesotho, Dr. Cornelia Atsyor.

KEY MESSAGES ON FBO CONTRIBUTION TO SDGs

Preamble

Nearly 120 faith leaders and global health experts met for 3 days and deliberated on building partnerships for faith-based health systems strengthening toward achieving the Sustainable Development Goals during the 8th Biennial Africa Christian Health Associations Platform Conference held on February 26 - March 3, 2017, in Thaba Bosiu Cultural Village, Maseru, Lesotho.

Recognizing that:

CHA's provide a significant amount of health service and they recognize the need for

evidencing this contribution, CHA's acknowledged the need for capacity building for both qualitative and quantitative evidence that can verify their contribution to healthcare.

Committed to:

CHAs' are committed to work with partners towards achieving the SDGs and look forward to continued collaboration with international, national and within our national health systems.

We commit to good steward of resource even in resource-poor settings acknowledging that we provide a significant percentage of health service provision across the African continent and do have qualitative outcomes of the work being done in the communities.

Bearing in mind that:

There exist CHA's that find themselves in fragile states, as a community of CHAs, we commit to supporting fragile states through sharing capacity and exchanging best practices among CHA networks. CHA's also commit to be transparent and show a good account of resources bestowed to them even in resource constrained settings.

Noting that:

CHA's have traditionally had a pro-poor approach to health provision and that we commit to align ourselves to UHC values of equitable access to healthcare.

Hereby:

Call upon : The United Nations, Africa Union, SADC and other developmental partners to collaborate more closely with Faith Based Organizations.

Stresses: The need for data-driven service provision statistics by CHA's and the need for continual engagement with the government in times of financial uncertainty.

Call for : Collaborative partnership in order to strengthen international, regional initiatives towards the achievement of Sustainable Development Goals.

Ends

ANNEX 1

CONFERENCE SPEAKERS AND MODERATORS

- **Speaker: S**
- **Moderator: M**

	Name
S	Ms. Lebo Mothae
S/M	Dr. Manoj Kurian
S/M	Dr. Jill Olivier
S/M	Dr. John Blevins
S	Rev. Nyambura Njoroge
S/M	Frank Dimmock
S	Ezra Chitando
S	Rev. Pauline Njiru
S	William Clemmer
S	Solange Mukamana
S/M	Ms Karen Sichinga
S	Ellen Starbird
S	Alti Zwandor
S	Maurice Adams
S	Jean Duff
S/M	Dr. Samuel Mwenda
S	Mimi Kiser
S/M	Mwai Makoka
S/M	Rev. Amy Gopp
S	Eleanor Whyle
S/M	Peter Yeboah
S/M	Dr. Bruce Dahlman
S	Andrew Chikopa
S	William Razafimahatratra
S	Sr. Deena
S	Ms. Vuyelwa Chitimbire
S	Dr. Daniel Gobgab
S	Dr. Tshitende Marie
S/M	Dr. Jonathan Kiliko
S/M	Nkatha Njeru
S	Dr. Deb McFarland
S	Dr. Titha Dzowela
S	Michael Mugweru
S	Rose Ejuru
S	Mirfin Mpundu
S/M	Mona Bormet
S/M	Jane Kishoyian
S/M	Yoram Siame
S/M	Veronica Mkusa
S	Sam Nugblega
S	Josephine Balati
S	Matthew Azoji
S	Dr. Bildard Baguma
S	Peter Mbeleg
S	Joseph Tamba
S	Rev. Phumzile Mabizela

CONFERENCE PROGRAM

*** The program underwent changes before and during the conference and therefore some sections in the program below have changed**

Date/Time	Activity/Session	Facilitator/Organization
	Sunday, Feb. 26	
9:00 am-5:00pm	Arrival and registration of delegates – Thaba Bosiu Cultural Village	Ms.Lebo Mothae- CHALe
6:00-7:00 pm	Optional interdenominational service	Dr. Manoj Kurian
7:00-9:00pm	Dinner	
Monday, Feb 27	**Pre-conferences**	
7:30am – 8:30am	**Late Registration**	**ACHAP Secretariat**
8:30am – 9:00am	**Introduction of Pre-conferences & Announcements**	**Master of ceremony : Yoram Siame/ Jonathan Kiliko/CHALe rep**
9:00am-4:30pm	**Pre-Conference Workshops 1 – 4** **1. HSS through HIV intervention** This workshop will be an interactive session that will include some input and group work. Discussion will focus on the following areas: Mapping global HIV and HSS prioritization (90-90-90); How HIV has affected CHAs and their health systems; Integration of HIV services; Community connections to health systems: Costing & financing; Stigma & access with key population; Sustainability of CHAs in the face of the demands of SDGs (UHC); and CHA innovative practices for sustainability. **2. Ecumenical Health Strategy** This workshop will focus on the Consultation for development of a comprehensive Ecumenical Health Strategy. It will focus on current global health issues and the role of the ecumenical movement and WCC on such health issues. This is a closed session. PS: The above two pre-conferences will be held in the same room and will run from 0900-0100. After lunch the sessions will be held in different venues.	 **UNAIDS/PEPFAR Faith Initiative** *Moderator: Jill Oliver* Speakers: CHAs Academia: Emory University (IHP), the University of Cape Town (IRHAP) UNAIDS **World Council of Churches (WCC)** **Moderator: Dr. Mwai Makoka** Speakers: Rev Nyambura Njoroge (EHAIA) Dr. Manoj Kurian (EAA) Dr. Jill Oliver (UCT) Frank Dimmock (IMA)

	3. Engaging FBOs to address Sexual & Gender Based Violence This interactive pre-conference will highlight the roles FBOs and faith communities can play in acknowledging, responding to, and preventing SGBV, a risk to 1 in 3 women globally. Join us to become better informed and equipped to address SGBV holistically. We will consider the perspectives of survivors, engage in theological reflection, explore how CHAs may address SGBV and learn from a four-tiered comprehensive approach to responding to sexual violence in the DRC. This pre-conference intends to educate all those who hope to transform this outrage into human dignity and inspire FBOs to move from silence to action. **4. The Role of Surgery & Anesthesia in Health Systems** The workshop will focus on understanding the connections between surgery/anesthesia and key global health issues, including SDGs 3.1. The workshop will also explore how FBOs can inform national surgical/anesthesia planning, participate in implementation and help hold governments accountable for including surgery/ anesthesia in their universal health coverage strategies.	**IMA World Health (IMA)** **Moderator: Rev. Amy Gopp** Speakers: Ezra Chitando (WCC) Pauline Njiru (WCC) William Clemmer (IMA) Solange Mukamana (Tearfund) Wayelwa Chitimbire (ZACH) **Gradian Health Systems** **Moderator: Lina Sayed** Speakers: Dr Mpoki Ulisubisya PS, (MOH Tanzania) CHAZ Brendan Allen, (G4 Alliance) Adam Lewis, (Health Systems)
5:30 – 7:00pm	**GALA DINNER** Welcome Reception and 10 year celebration	Dr Samuel Mwenda (CHAK)
Tuesday, Feb 28	**Day 1 – Partnership Experiences and Lessons**	
9:00–9:30am	Opening Prayer and Devotion	CHALs
9:30–10:00am	Welcome and Opening Remarks, Introductions and Conference Objectives	ACHAP Board Chair Ms. Karen Sichinga
10:00 – 10:30am	Key Note Address on Conference Theme: SDGs and the Role of Partnerships in achieving the 2030 Agenda	WHO Country rep. Lesotho Dr. Cornelia Atsyor
10:30 – 11:00am	**Official Opening:** Country overview on Lesotho Health Services and Partnership with FBOs towards achievement of SDGs)	Ministry of Health, Lesotho Dr. Molotsi Monyamane, Minister for Health
11:00 – 11:30am	Health Break	MOH – Lesotho, Dr. Monyamane, Minister for Health
11:30 – 12:40pm	**Plenary Panel 1: Global Health Partnership Opportunities for CHA's** Speakers will offer a well-rounded perspective on the role of effective donor – FBO/CHA partnerships in strengthening health systems, and how effective partnerships can be built and fostered to work toward achieving the SDGs.	**Moderator: Rick Santos- IMA** Speakers: Ellen H. Starbird (USAID) Alti Zwandor (UNAIDS Lesotho) World Bank, Lesotho Bruce Compton (CHA-USA) Maurice Adams (All We Can) Jean Duff (JLI)

12:40 – 1:00pm	Feedback from the Pre-Conference Workshops #1 – UNAIDS/HSS through HIV intervention #2 – WCC/Ecumenical Health Strategy #3 – IMA/Engaging FBOs to address Sexual & Gender Based Violence #4 – Christian Health System/The Role of Surgery and Anesthesia in Health System	Speakers: Mimi Kiser/Jill Oliver Mwai Makoka Rev. Amy Gopp Lina Sayed
1:00–2:00pm	**Lunch Break**	
2:00–3:00pm	**Panel 2: Experiences of different national health** sector partnership models **CHAs will present on the experiences of different kinds of partnership models existing in-country with** focus on partnerships in relation to national health **insurance schemes as well as study on forms of PPPs in Africa.**	**Moderator: Dr. Ronald Kasyaba (UCMB)** Speakers: Eleanor Whyte (UCT) Peter Yeboah (CHAG) Andrew Chikopa (CHAM) Dr. Tilahun Dafurso (EECMY-DASC) Fantory Sekule (CSSC)
3:00-3:20pm	Comments from governments on partnerships with FBO Dr. Mpoki Ulisubisya (PS, MOH Tanzania) Dr. Molotsi Monyamane. (Minister, MOH Lesotho)	
3:20-3:40pm	**Tea Break**	
3:40- 5:00pm	Break-out Sessions: **Room 1: Partnership models for Expanding Medical** Education CHAs will present on opportunities and models they have had to facilitate gaining further experience/training/knowledge that enables strengthening of health professional education as well as research efforts. **Room 2: Experiences from CHA's partnering with Global Fund** CHA's will present on challenges encountered in partnering with the Global Fund as well as experiences learned for the Principle Recipients and the Sub Recipients. Building technical assistance of CHA's and resource mobilization successes and lessons learned will be highlighted.	Session lead: **CHALe Rep** Speakers: Dr. Mwenda(CHAK), Bruce Dalman (INFAMED) Sr. Deena(Catholic Health Ass. of India) Dr./Rev. William Razafindratara(FJKM) Session lead: **Dr. Cyprian Kamau** Speakers: Mrs. Sichinga (CHAZ) Voyelwa Chitimbire (ZACH) Dr. Gobgab (CHAN) Dr. Tshibende Marie (Caritas Congo)

	Room 3: Procurement and supply chain management Speakers will present on experiences on engaging with the public and private sectors, civil society and development partners on procurement and supply chain management.	**Session lead: Nick Shaiyen (CHAN-MEDIPHARM)** Speakers: Patricia Kamara (CHAI) Dr. Jonathan Kiliko (MEDS) Bildard Baguma (JMS)
5:00-5:40pm	Plenary presentation of highlights from break-out sessions. Key messages to carry in relation to partnerships	Session leaders
5:40 – 6:00pm	Close of Day 2 and Announcements	Master of Ceremony
7:00-9:00pm	Dinner	
Wednesday, March 1	**Day 2: Building Evidence for Health Systems Strengthening**	
8:00 – 8:15 am	Opening Prayer and devotion	Dr. Ndilla Djokotoum-Tchad
8:15 – 8:30am	Recap of Day 1. Day 2 overview & Announcements	Master of Ceremony
8:30 – 9:30am	**Partnerships for evidence building** **Research in Practice** In this session, academics with existing and long-term relationships that involve research with CHAs and some of their CHA partners describe best practice and opportunities for research partnership.	**Moderator: Maurice Adams (All We Can)** Speakers: Jill Oliver (UCT) Peter Yeboah (CHAG) John Blevins (Emory University)
9:30-10:00am	Moderated Q&A and audience participation	Nkatha Njeru (ACHAP)

10:00-10:30am	Tea Break	
10:30– 12:00 noon	**Panel 2: Building the evidence base on FBO/CHA contributions: Rhetoric to Action!** In this session speakers will highlight key quantitative and qualitative measurements of FBO/CHA contributions to health service delivery and current research efforts to determine FBO/CHA contributions. Results of the Christian Health Associations and Faith-based Health Networks Survey conducted by IMA World Health will be presented.	**Moderator: Frank Dimmock (IMA)** Speakers: Dr. Deb McFarland (Emory University) Dr. Titha Dzowela (CHAM) Alfredo Fort (IMA) Rose Ejuru (CMMB Sudan) Mirfin Mpundu (EPN)
12:00 – 1:00pm	**Breakout Sessions: Evidence leading to improved practice** **Room 1: Lessons learnt from HIV and Family Planning programs** This session will focus on interventions taken in response to nation-level objectives with regards to reduction/elimination of HIV AIDS and Family Planning including support of innovative programs, focus on adolescents, the role of partnership and advocacy as well as supply chain methods. **Room 2: Tackling NTDs* focusing on progress and lessons learnt in controlling NTDs** This session will focus on strides made in controlling Tropical Diseases with limited resources, disease monitoring and sanitation practices, supply chain management and the role of advocacy with government **Room 3: Strengthened (faith-based) health system leadership through training and curriculum development** In this session, academic and training partners will discuss opportunities and efforts for training in health systems research and leadership – with a particular emphasis on training oriented towards faith-based non-profit leadership. CHA partners that have experienced training or courses relating to health systems will be asked to give feedback on these experiences.	 **Session lead: Dr. Kanyata Sunkutu (UNFPA)** Speakers: Mona Bormet (CCIH) Mirfin Mpundu (EPN) Jane Kishoyian (CHAK) Yorame Siame (CHAZ) **Session lead: Peter Yeboah (CHAG)** Speakers: Veronica Mkusa, IMA World Health Pastory Sekule (CSSC) AIM Initiative **Session Lead: Dr. Tonny Tumwesigye (UPMB)** Speakers: Sam Nubiega (CHAG) Mike Mugweru (ACHAP Sec) Mwai Makoka (WCC)

1:00 – 2:00pm	**Lunch Break**	
2:00 – 3:00pm	**Breakout Sessions: Evidence leading to improved practice**	
	Room 1: Quality assurance practices in relation to provision of medicine and essential supplies Participants will have an opportunity to share best practices in regard to medicines and supplies. They will also discuss systems strengthening necessary in this regard towards the SDGs	**Session lead: Dr. Mirfin Mpundu (EPN)** Speakers: Josephine Balati(MEMS) Matthew Azoji (CHAN-MEDIPHARM) Bildard Baguma (JMS) Lina Sayed (Gradian Health Systems)
	Room 2: Improving data and information gathering in rural and Hard to reach settings Speakers in this session will discuss their experiences and innovations in working in rural and hard to reach areas and share innovative ways in which they ensure documentation of evidence	**Session lead: Dick Day (CMMB)** Speakers: Andrew Chikopa (CHAM) AMMB/Botswana Rose Ejuru(CMMB-Sudan) Peter Mbelleg (CEPCA)
	Room 3: Investing in human resources with a focus on emergency preparedness, response and resilience In this session speakers will share strategies through which they have invested in their human resource towards disaster preparedness	**Session lead: Dr. Beate Jakobs** Speakers: Jeremie Sagara (APSMali) Patricia Kamara (CHALiberia) Bishop Samuel Enosa Peni (Catholic Health Secretariat Sudan) Joseph Tamba (RECOSAG)
3:00 – 4:20pm	**Panel 3: Influence of faith on service delivery** In this session, speakers will highlight experiences on the influence of faith on various health service delivery initiatives including in family planning interventions, HIV/AIDS. Discussions will also explore how religion and theology gets mixed with healing practices.	**Session lead: Rev. Amy Gopp (IMA)** Speakers: Mona Bormet (CCIH) Dr. Rev. Nyambura Njoroge (WCC/EHAIA) Solange Mukamana (Tearfund S.A) Rev. Phumzile Mabizela (Inerela +)
4:20 – 4:50pm	**Tea Break**	

4:50 – 5:30pm	Plenary presentations on highlights from both break-out sessions	Session Leaders
5:40 – 6:00pm	Key messages on FBO contributions to SDG in Africa. Key messages to carry in relation to Health systems strengthening CONFERENCE CLOSURE	Master of Ceremony
7:00 – 9:00pm	Dinner	
8:00 – 9:00pm	Technical Discussion: Building the evidence base on FBO/CHA contributions: Rhetoric to Action!	Frank Dimmock (IMA)
Thursday, March 2	Day 3 : ACHAP General Assembly Business Meeting	
8:00 – 8:30am	ACHAP members General Assembly (Closed Session: ACHAP members Only) •Opening Prayer and Devotional •Welcome Remarks and Acknowledgement of members •Review of last biennial conference report •Discussion on matters arising from last conference	Moderator: ACHAP Board Chair
10:15 – 10:45am	Tea Break	Secretariat
10:45 – 11:45am	ACHAP Secretariat report 2015/2016	Board Chair
12:15 – 12:45pm	2015 – 2017 ACHAP board elections	ACHAP out-going Board Chair
12:45 – 1:15pm	Introduction of New Board and Remarks by Incoming Board	ACHAP Board Chair
1:15 – 1:30pm	Vote of thanks and closure	
1:30 – 2:00pm	Lunch	
2:30-5:00pm	Excursion	
Friday, March 3	Departure from morning	

End