AFRICA CHRISTIAN HEALTH ASSOCIATIONS PLATFORM

Re-Igniting Primary Health Care: The Role of ACHAP

9th Biennial Conference program

AFRICA CHA PLATFORM

February 25 – March 1, 2019

Yaoundé, Cameroon

CAMEROON BAPTIST CONVENTION HEALTH SERVICES 1975

Welcome message

"We now look forward with great optimism, opportunity and excitement to re-igniting Primary Health Care with commitment and compassion, and to strongly deliver our strategic commitment -achieving Universal Health Coverage in sub-Saharan Africa"

Dear esteemed colleagues,

It is my honour and pleasure, on behalf of the Africa Christian Health Associations Platform (ACHAP), to welcome all participants to the 9th ACHAP biennial conference!

Our contributions and focus

ACHAP continues to flourish as a major stakeholder and global actor in health. It is estimated that collectively, the ACHAP network provides health care to over 50% of the population in sub-Saharan Africa. Since its foundation in the early 70s, one of the key activities of our network has been biennial conferences that serve to foster sharing of experiences, promoting strategic shifts in FBO approach to health, forming development partnerships and networking. So, once again, we fulfill our proud tradition of meeting to explore ways and means of improving access to quality affordable healthcare, especially to the deprived and marginalized segments of the society. Historically, Christian faith-based health providers (FBHPs) were co-creators of Primary Health Care (PHC), and Christian Health Associations (CHAs) continue to champion PHC, albeit with systemic challenges.

The sub-Saharan Africa region continues to bear the major burden of global infectious diseases. Evidence show that HIV/AIDS, malaria, tuberculosis (TB) account for the overwhelming majority of deaths in the African Region. Added to these, a range of neglected tropical diseases (NTDs), rise of non-communicable diseases, hepatitis also contribute to avoidable fatalities. The situation is further exacerbated by weak health systems, slow economic growth, rapid urbanization and environmental change, which all amplify the impact of communicable diseases. Worse of all, the spate of wars, conflicts, which lead to large scale displacements, hunger/famine and malnutrition, obstruct the delivery of preventive and curative health services in some settings. This debilitating situation continues to affect most vulnerable and marginalized populations who already face disadvantages – namely women, children, the elderly and the poor.

Thankfully, there is renewed interest and new momentum to promote PHC as the foundation for attaining UHC. Given the limited resources and double burden of disease in most Sub-Saharan Africa countries, there is the urgent need to invest in high impact and cost effective interventions that affect the greatest number of people as well as 90 percent of health conditions that affect people throughout their lives. In fact, FBHPs/CHAs and the Church also have some unique health assets, which must be harnessed and engaged urgently to re-ignite PHC.

Consequently, the conference will deliberate on the theme: "**Re-igniting Primary Health Care: the role of ACHAP**"

Expectations

This conference has brought together health professionals, technical experts, frontline health workers, development partners and church leaders to share experiences, gain new insight, explore fresh ideas and optimize the ACHAP network for sustainable health development. We would discuss, showcase, motivate and formulate innovative approaches to enhancing CHAs contributions in achieving PHC and towards attaining Universal Health Coverage in sub-Saharan Africa.

Tribute

We remain grateful to all partners whose various contributions and support have made the conference organization successful. In particular, we recognize some key partners for their exceptional support: **IMA World Health, American Leprosy Missions, World Vision, USAID's flagship Maternal and Child Survival Program (MCSP), Catholic Relief Services, CCIH, Global Water 2020, the World Council of Churches** and **UNAIDS**.

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

Call to conference participants

Distinguished friends, partners and colleagues, I have been amazed at the strength and potentials of ACHAP, and deeply appreciate your passion and support for this historic conference. As participation in the conference gathers momentum, we now look forward with great optimism, opportunity and excitement to re-igniting Primary Health Care with commitment and compassion, and to strongly deliver our strategic commitment -achieving Universal Health Coverage in sub-Saharan Africa

With our sincere thanks and best wishes,

Peter Yeboah

ABOUT ACHAP

The Africa Christian Health Associations Platform (ACHAP) is an advocacy and networking platform for Christian Health Associations (CHAs) and Church Health Networks from Sub-Saharan Africa. The platform was established through the inspiration and support of World Council of Churches in 2007. On May 4, 2012 ACHAP attained legal Registration as a Regional Non-Governmental Organization (NGO). ACHAP is led by a Board which reports to the General Assembly. The Board drives policy, strategy and advocacy and is assisted by Thematic Technical Working Groups (TWGs) comprising of various member CHAs.

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

The purpose of ACHAP is to promote continued, effective and efficient engagement of Church Health Services in Africa towards achieving equitable access to quality health care among members of the Platform and in Africa at large. The core mandate of ACHAP is to facilitate joint advocacy, networking and communication among Christian Health Associations and other Church Health Networks and partners in support of the Church health work in Africa.

The ACHAP secretariat hopes that the conference will provide you an opportunity to learn, share ideas and network as well as work towards health and healing for all in Africa.

Nkatha Njeru
ACHAP Coordinator & Board Secretary

CONFERENCE BACKGROUND

In 1978, World Health Organization (WHO) collaborated with the World Council of Churches to formulate the *Alma-Ata declaration*, which affirmed Primary Health Care (PHC) as a vehicle to guaranteeing access to healthcare as a fundamental human right. The vision as interpreted intended to keep people healthy and productive within their communities. The assumption too was that a majority of the health needs of communities could be met within a well-functioning primary health care system that would guarantee access to quality affordable health services - promotive, preventive and curative services. Yet, to date, there are still fundamental gaps in providing access to affordable quality health services to vulnerable populations.

Historically, Christian faith-based health providers (FBHPs), including CHAs, financed their health programs and hospitals primarily through foreign aid (donated medical supplies, medicines, missionary/ expatriate medical staff, etc.), and to a limited extent, out-of-pocket payment from patients, albeit heavily subsidized. However, due to recent changes in the global development paradigm, FBHPs/CHAs are facing reduced or discontinued donor support for both capital and recurrent expenditures. This has culminated in a search for sustainable and alternative funding mechanisms to support the Church's mission in health. These include, but are not limited to, new models of health financing being tested by some FBHPs. Given the need for financial sustainability of the Church in health, ACHAP needs to explore/appraise the feasibility of innovative models for PHC.

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

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

Hence, the conference theme: **RE-IGNITING PRIMARY HEALTH CARE: THE ROLE OF ACHAP**

Based on the foregoing, ACHAP needs to review its engagement in Primary Health Care since 1978, identify our successes and failures, codify our collective learning, and develop innovative models that can be scaled up and that are attractive to both donors and governments, in order to make robust recommendations for improved investments for achieving Universal Health Coverage.

Accordingly, the Conference shall explore the following objectives:

OBJECTIVES

1. Promote FBO-government partnerships at country, sub-regional and regional levels.
2. Strengthen faith-based health systems of care that include PHC towards UHC.
3. Explore Financing models for PHC.
4. Increase visibility and advocacy leverages.
5. Consolidate ACHAP/ CHAs innovative approaches in managing HIV/AIDs epidemic and strengthen capacity of ACHAP/CHAs for upcoming grant opportunities/acquisition, program management, financial accountability and transparency.

Format: The conference format will cover the breakout, sessions: plenary, workshop

Target Participants

- ACHAP Members
- World Council of Churches.
- Association of African Churches
- Development Partners including IMA, CCIH, CRS, USAID, PEPFAR, PHARMACCESS, USAID's flagship Maternal and Child Survival Program (MCSP), WORLD VISION
- UN Agencies
- Academic Consortium
- WHO-Country office and Africa Region.
- Ministry of Health Officials from sub Saharan Africa
- Individual participants, well-wishers, students, and friends of ACHAP
- WHO
- Africa Development Bank
- Regional groups like EAC, SADCC, ECOWAS, PTA etc.
- Ministries of Health, Women and Social Affairs
- Other INGOs/FBOs like GHA, CCIH
- Private Sectors (Banks, Communication companies, Corporate organization, etc.)
- Health Care Suppliers (Pharmacies, Laboratory Institutions, Private Health Facilities)
- Health Professional Associations (Physicians, Nurses, Community Health Workers, Laboratory Workers, Pharmacy Association)
- Para-Health and Legal Associations (Lawyers)

Welcome address from host

The Cameroon Baptist Convention Health Services (CBCHS), is glad to welcome you to this important Conference organized by the Africa Christian Health Associations Platform this year in Cameroon. The CBCHS registered and became a member of ACHAP in 2015.

Faith-based health systems have not only spearheaded innovative strategies to offer quality care to those who most need it at the grassroots level, but also used limited resources in an accountable manner. ACHAP recognizes the need for innovative partnerships, responsive and resilient health systems, especially in re-engineering PHC towards achieving Universal Health Coverage/ Sustainable Development Goals. This Conference is an opportunity to evaluate our successes and failures, share best and promising practices, examine existing innovative models of health care, consider the partners we can work with, and act now. We have all it takes to implement universal health coverage. Let's use PHC as a stepping board to scale up health services to all who need them. Our expectation as host is that this conference should come up with robust recommendations for improved and innovative investments in health care to ease access for all in Africa.

We appreciate all the actors that participated directly or indirectly to the organization of this conference. We thank the ACHAP Secretariat team for the day to day support they provided in the course of organizing this conference. We thank the government of Cameroon for facilitating the visa process and

offering protection to all our visiting participants to this conference. We thank the MOH, WHO, and other Key organizations or individuals for accepting to chair this high-level conference and count on their usual support to implement the resolutions that will be adopted. We thank all the authors of abstracts, those who prepared presentations, and those who offered to exhibit their experiences and services during this conference. We thank every participant who traveled from far and near to be a part of this conference. We pray the Almighty God to grant you a happy stay in Yaoundé, a successful conference, and a safe trip back home.

Prof Tih Pius
Director of Cameroon Baptist Convention Health Services

About the host organisation

Created in 1936 by the Baptist missionaries from the United States of America, the Cameroon Baptist Convention (CBC) Health Services, the medical arm of the Cameroon Baptist Convention, fully transitioned in 1975 to an indigenously led Organization offering holistic services to millions of people at both facility and community levels. Its now serves all regions of Cameroon through a network of **7** tertiary Hospitals, **32** Integrated Health Centers and **52** Primary Health Centers. CBCHS has a workforce of over **4500** permanent staff and its facilities consult slightly above **1.2 million** and admit about **60,000** patients annually.

Besides facility based services, Residency and Training Programs for Medical Doctors and other health professionals, the CBCHS runs several robust programs that meet complex community health needs. For instance, through the Life Abundant Primary Healthcare Program, CBCHS has set up over 80 primary health care centers in underserved communities some of which have now become hospitals. Its disability program addresses the socio-economic and health needs of Persons Living with Disabilities and promotes an inclusion. The CBCHS Non-Communicable Disease (NCD) Control and Prevention Program, runs facility and community based activities to reduce the impact of NCDs in communities. The CBCHS drug procurement, and distribution department known as Central Pharmacy (CP) is one of the largest in the country. It is now a certified procurement, manufacturing and distribution plant that produces infusion fluids, high quality mineral water and other sterile and non-sterile products which are used in CBCHS facilities.

The CBCHS is well known for its contributions to the HIV and AIDS response in Cameroon and in the West and Central African sub regions since 1994. CBCHS introduced Prevention of Mother-To-Child Transmission HIV services in Cameroon in February of 2000 and has since then remained a technical partner to MOH in PMTCT. From 2011 till date, CBCHS is implementing a CDC/PEPFAR sponsored named “HIV-Free” now in four regions of the country (Center, Littoral, Northwest and South West). As an experienced provider of HIV and AIDS community and facility based services, CBCHS is strengthening the capacities of communities, local organizations in Cameroon and in other African countries for effective HIV response.

In 2011, the CBC Health Services signed a Memorandum of Understanding (MoU) with the Ministry of Public Health based on which CBC Health Services intensified Health System Strengthening (HSS) efforts to further improve health care delivery in the country.

ORDER OF EVENTS

DATE & TIME	SESSION	FACILITATOR / MODERATOR	VENUE
Arrival Day: Monday 25 February 2019			
9:00 – 17:00	Registration and Hotel Check-in	ACHAP	
18:00 – 19:00	Interdenominational Service **(Open to All Conference Participants)**	Rev. Dr. Nditemeh (CBCHS)	
19:00 – 21:00	Dinner (preparatory meetings for day 1 moderators & presenters)	ALL	
Day 1: Tuesday 26 February 2019 - Pre-conference Workshops			
07:30 – 08:30	Late Registration	ACHAP	
8.30-8.45	Opening Prayer & Devotion	Matthew Hackworth (IMA)	Salon Unité
08:45 – 09:00	Welcome note and introduction of the preconference workshops	MC	
09:00 – 12:45	Workshop 1: **Improving care on the day of birth and beyond: Engaging faith-based organizations to improve maternal & newborn health outcomes along the continuum of care** *(Open to All Conference Participants)*	**MCSP & CCIH** (Jacqueline Wille, Neeta Bhatnagar, Mona Bormet)	Salon Mfoundi
	Workshop 2: **WASH in healthcare setting** *Target Participant*: CHAL, UCMB, CHAG CHAK, and CHAL	**GLOBAL WATER 2020** (Lindsay Denny, Joanne McGriff)	Salon Fébé
	Workshop 3: **Responding to Health Crises: How working through or with Church organizations increases effectiveness and builds reputation with donors and governments: Experiences in Democratic Republic of Congo** *(Open to All Conference Participants)*	**IMA | LWR** (Dr. Larry Sthreshley, Dr. Alice Mudekereza, DR.C- IMA)	Salon Unité
12:45 – 13:45	Lunch Break	ALL	
14: 00 – 15:30	Workshop 4: **Skills building on *Establishing Health Kiosks*** *(Open to All Conference Participants)*	**World Vision** (Gloria Ekpo, Lauren Van Enk, Daphne Mpho)	Salon Unité
	Workshop 2 **WASH in healthcare setting (continuation)**		Salon Fébé
15:30-18:00	**Field Visit (meet at hotel reception at 15:30pm) –coordinating : Dr. Francois CBCHS**		
18:30 -20:30	Dinner (preparatory meetings for day 2 Moderators & presenters)	All Participants	

DAY 2: Wednesday 27 February 2019			
DATE & TIME	**SESSION**	**FACILITATOR / MODERATOR**	**VENUE**
08:30 – 08.50	Opening Prayer and Morning Devotion	Rt. Rev Fonki	Salon Unité
08:50 – 09:00	Short message from Host -CBCHS	Prof. Pius Tih (CBCHS Director)	
09:00 – 09:15	Welcome Address & Official Opening of the Conference	Mr. Peter Yeboah (Chairman, ACHAP Board)	
09:15 – 09:45	Overview of Primary Health Care Services in Cameroon: *The role of FBOs towards achieving Universal Health Coverage*	The Honorable Minister of Health - Cameroon.	
09:45 – 10:10	Keynote Address: **Re-igniting Primary Health Care: The Role of ACHAP**	World Health Organization (WHO) Representative	
10:10 – 10:55	Plenary Session 1: (Panel discussion) **Strengthening FBO's Health Systems for PHC towards UHC**	**Moderator:** Dr. Mwai Makoka (WCC) Panelist: CBCHS (Prof. Tih), Peter Yeboah (ACHAP), Dr. Monique Chireau Wubbenhorst (USAID), MOH Cameroon representative, WHO representative	
10:55 – 11:10	Health Break	ALL PARTICIPANTS	
11:10 – 12:10	Plenary Session 2: **FBO-Government partnerships at country, sub-regional and regional levels for promoting PHC and realizing UHC** **Selected abstracts**	**Moderator:** Dr. Gloria Ekpo (World Vision) Presenters: • Melissa Freeman (USAID) • Dr. Josephine Balati (CSSC) • Mafase Ng'ong'ola Sesani (CHAM) • Dr. Douglas Kinuthia Gaitho (CHAK) • Dr. Bildard Baguma JMS	Salon Unité
12:10 – 12:50	Plenary session 3: **Health Promoting Churches**	**Moderator**: Jim Cox (IMA) Presenter: Dr. Mwai Makoka (WCC) Respondents: Rev. Dr Ncham Goodwill (CBCHS), CCIH (Doug Fountain), AACC (Rev Dr. Simon Dossou)	
12:50 – 13:50	Lunch	ALL	
14:00 – 15:30	Breakout Session 1: **Financing models for PHC for UHC**	**Moderator: Dr. Samuel Mwenda** • Elled Mwenyekonde - CHAM • David Balikitenda – UPMB • Pasteur Didier Ouedraogo - ASAD • Kuni Esther – CBCHS • Martin Thondolo -Nkhoma hospital	Salon Unité
	Breakout Session 2: **Health technologies and information for increasing visibility and advocacy leverages towards improved PHC**	**Moderator:** Dr. Ndilta Djekadoum • Mrs. Sarah Sackey Martei-Olletey – CHAG • Gift Merix Werekhwe – CHAM • Faith Irene Wagaki – CHAK • Doreen Kudwoli – Medic Mobile • Nic Moens – Africa ehealth Foundation	Salon Mfoundi
	Breakout Session 3: **Optimizing Health workforce for PHC**	**Moderator:** Samantha Law (HRH2030, Chemonics) • Godlove Nkuoh-CBCHS	Salon Fébé

		• Dr. Titha Dzowela-CHAM • Peter Kakute-CBCHS • Katy Gorentz- HRH2030, Chemonics	
15:30 – 15:45	Health Break	ALL	
15:45 – 16:45	Plenary Session 4: Feedback and take home messages from Breakout sessions	**Moderator:** Dr. Ndilta Djekadoum	Salon Unité
16:50 - 17:45	Executive Directors' (ED) session with WCC	Dr. Mwai Makoka(WCC)	Salon Fébé
18:30 – 20:30	Special Dinner Session (by invitation only)	World Vision	
	Dinner (preparatory meetings for day 3 Moderators & presenters)	(All Participants)	

DAY 3: Thursday 28 February 2019

DATE & TIME	SESSION	FACILITATOR / MODERATOR	VENUE
08:30 – 08:45	Opening Prayer and Morning Devotion	Rev. Dr. Simon Dossou (AACC)	Salon Unité
08:00 – 09:10	Welcome, Introduction, Expectations	Ms. Patricia Lebohang Mothae-Vice Chair, ACHAP Board	
09:10 – 10:00	*'Market store' :Consolidating innovative approaches in managing HIV/AIDs epidemic: Harnessing* best practices in HIV prevention, care and treatment support services amongst ACHAP/CHAs	**Moderators: Francesca Merico (WCC) & Julienne Munyaneza (UNAIDS)** ZACH, CHAN, CARITAS-DRC, CHA Lesotho , CHA Liberia	
10:00 – 11:00	Panel 5(a) – **Brief Overview of PEPFAR Transition to local prime directive** - USG Panel	**Panelists** 1. Dr. Monique Chireau Wubbenhorst-USAID 2. Dr. Tedd Ellerbrock-CDC 3. Dr. Carl Stecker-CRS	
11:00 – 11:45	Panel 5(b) – **CHA Experiences as Primes or Subs on PEPFAR Awards**	**Moderator:** Carl Stecker (CRS) Panelists: 1. Dr Tonny Tumwesigye- UPMB, 2. Mrs Vuleywa Chitimbire-ZACH, 3. Dr Samuel Mwenda-CHAK	
11:45 – 12:00	Tea Break		
12:00 – 12:40	Panel 5(c) – Workshop: **Assessing Local FBO Partner Preparedness for PEPFAR Transition to Local Primes**	Carl Stecker (CRS)	Salon Unité
12:40 – 12:45	Wrap-up and workshop evaluation		
12:45 – 13:45	Lunch	ALL PARTICIPANTS	
14:25 - 15:40	Panel 6: Addressing Neglected Tropical Diseases(NTDs)	**Moderator:** Jim Oehrig (American Leprosy Missions (ALS) Panelist:	Salon Unité

		1. George Gitau (Africa Director ALM) 2. Julien Ake (Global Director of AIM Initiative) 3. Aubin Yao (Côte d'Ivoire) 4. Josue Tchimou (Ghana) 5. Desiree Imposo (DRC)	
15:45 – :16:25	**Breakout Sessions**		
	Breakout Session 4: MNCH / FP	**Moderator: Dr. Francois CHIMOUN (CBCHS)** Presenters: 1. Osee Djekadoum Ndilta – EAST 2. Eugene Foyeth – CBCHS 3. James Duah – CHAG 4. Christina de Vries – Cordaid	Salon Mfoundi
	Breakout Session 5: Mental Health	**Moderator: Ms. Florence Bull** Presenters: 1. Frank Dimmock - IMA 2. Peter Yeboah - CHAG 3. David Balikitenda -UPMB	Salon Fébé
	Breakout Session 6: Anti-Microbial resistance (AMR)	**Moderator : Mirfin Mpundu** Presenters: **1.** Lindsay Denny – Global Water 2020 **2.** Dr. Cyprian Kamau –CHAK **3.** Dr. Bildard Baguma -JMS	
16:30 – 17:00	Take home messages on PHC and UHC and closure of Conference	Chair, ACHAP Board	Salon Unité
17:00–18:30	General Assembly (by Invitation only)	Chair, ACHAP Board	
19:00 – 21:00	Dinner & Dance	ALL PARTICIPANTS	

Day 1: Tuesday 26 February 2019 - Pre-conference Workshops	
Opening Prayer & Reflection	Matthew Hackworth (IMA)
Workshop 1	**IMPROVING CARE ON THE DAY OF BIRTH AND BEYOND: Engaging faith-based organizations to improve maternal & newborn health outcomes along the continuum of care**
Synopsis	High-quality reproductive, maternal, newborn and child health interventions are critical components of primary care with mutually beneficial outcomes and overlapping contacts within the first year postpartum. Despite this, the services are often provided in silos at health facility and community levels. Faith-based organizations (FBO) are major health care providers in developing countries, providing an average of 40% of services in sub-Sahara Africa. (Bandy & Colleagues-WHO). Maternal and newborn health programs are increasingly addressing and advocating for commitments from faith-based organizations and faith-based service providers. With experience across 32 countries, USAID's flagship Maternal and Child Survival Program (MCSP) has emphasized the importance of providing integrated service for mothers and their newborns across the continuum of care to improve primary health care. This includes supporting maternal and newborn health interventions to improve outcomes for mothers and babies and to ensure that couples are able to achieve their reproductive goals. The program adapts to local cultural beliefs and values and emphasizes voluntary informed choice of reproductive health care. Introducing and implementing high-impact maternal and newborn health interventions such as prevention of postpartum hemorrhage, early initiation of breastfeeding, and counseling on healthy timing and spacing of pregnancy in the first year postpartum have globally improved MNH by maximizing routine contacts with women and families along the continuum of care. In light of this, MCSP and Christian Connections for International Health (CCIH) take the opportunity to engage actively in the preconference session. MCSP and CCIH will share global efforts and high impact interventions for MNH in the first year postpartum and reflect on how continued engagement of FBOs can contribute to improve MNH outcomes along the continuum of care. **Objectives:** Attendees will: • Learn about some of the high impact interventions for operationalization of primary health care across the continuum of care, with a particular focus on the day of birth • Identify opportunities for integration, including touch points for engaging providers and clients across the continuum of care • Engage in a role play activity that can be used and adapted to help identify delays and/or gaps in service provision within their own contexts • Develop action plans to introduce day of birth role plays, walkthroughs, discussions, and improvements within their own contexts Activities will include: • Presentations and discussions about the continuum of care, critical touchpoints with clients, and important interventions • Birth to discharge role-plays to facilitate conversations about service provision, prevention of common delays, quality of care, measurement, etc. • Dissemination of MCSP and CCIH materials, tools, and resources relevant to the interventions along the continuum of care Attendees will leave with a thorough understanding of the current global efforts and high impact interventions for MNH and health timing and spacing of pregnancy across the continuum of care, the challenges, and concrete ideas for potential solutions, particularly on the days of birth and discharge.

Facilitators:	Jacqueline Wille, Neeta Bhatnagar, Mona Bormet	Venue : Salon Mfoundi	Time: 09:00am-12:45pm
Workshop 2	**WASH in Healthcare Setting**		
Synopsis	In June 2018, ten(10) representatives from five Christian Health Associations (CHAs) participated in a three-day training on WASH in HCF. The first objective of the training was to highlight the importance of WASH as it relates to the provision of quality of care. Additionally, participants were trained on the use of Emory University's WASHCon tool, which assesses WASH conditions in health facilities. The training concluded with each CHA drafting an action plan. The representatives returned to their respective countries and conducted assessments in 10 to 15 target HCF. Improvements are being undertaken and documented, ranging from hand hygiene promotion to repairs of infrastructure and water treatment supplies. The ACHAP Biennial Meeting is an opportunity to bring together these CHAs to share their experiences and lessons learned, while also introducing the issue to additional CHAs. Together, the two sets of CHAs will plan for further action to address the needs of WASH in HCF in their countries. Objectives: • Representatives from the five CHAs will share their experiences implementing WASH in HCF improvements. • An additional five to 10 CHAs will be invited to learn about WASH in primary healthcare settings and opportunities within their own countries. • Participants from all the CHAs will brainstorm immediate next steps and discuss options for resource mobilization. Outcomes: • During Day 1 of the ACHAP Meeting (Wednesday), participants will announce the agreed upon next steps. • Photos and videos event, including interviews, will be captured, and a briefing report will document the workshop. • A call will be scheduled to follow up on the activities identified during the workshop, including focal points for WASH in HCF from the new CHAs.		
Facilitators	Lindsay Denny (Global Water 2020) Joanne McGriff (Emory University)	Venue: Salon Fébé	Time: 09:00am-1245pm
Target/Possible Participants	Possible Participants: Group 1: New CHAs (Malawi, Cameroon, Liberia, Tanzania, Sierra Leone, Uganda PMB) Group 2: Existing CHAs (Uganda CMB, Kenya, Zimbabwe, Lesotho, Ghana)		
Workshop 3	**Responding to Health Crises: How working through or with Church organizations increases effectiveness and builds reputation with donors and governments: Experiences in Democratic Republic of Congo**		

Synopsis:	Since 2000, IMA has worked alongside the Congolese government, donors and an array of local and international partners to revitalize the country's health system, fight diseases and improve the health for a population in desperate need. Such long-term investment in the Democratic Republic of Congo has required resilience, creativity, and an incredible network of staff and partners to navigate successive armed conflicts, political instability, impassable roads and other obstacles that continue to threaten the health and well-being of the population. Committed to reducing morbidity and mortality in women and children under age 5 by strengthening the national health system in 52 health zones in the Democratic Republic of Congo, the Access to Primary Health Care Project, known locally as ASSP, had an exceptional year in many ways. Despite recent civil unrest and insecurity in central Congo that affected approximately 3.3 million Congolese—entire communities, health center staff, and partners—the achievements demonstrate a significant resiliency of the health care system that is being reinforced through the ASSP project. IMA and LWR are proud to be a part of the team that is changing the narrative and the trajectory of health care in the DRC. Powered by partnership, new technologies are solving stubborn problems, successes are scaling up into widespread solutions and—most importantly—our vision of health, healing, and well-being for all is becoming more of a reality in the DRC every day.
Presenters	Dr. Larry Sthreshley, Country Director, DRC - IMA | LWR Dr. Alice Mudekereza, Senior Health Advisor, DRC - IMA | LWR
Target/Intended Participants:	Representatives of CHAs and other national/subnational health networks
Venue	Salon Unité
Time	09.00 a.m.-12.45 p.m.
Workshop 4	**Establishing Health Kiosks at Faith Worship Centres to increase HIV literacy and improve access to HIV services – Skills building session for CBOs/FBOs and HIV program implementers**
Synopsis	Faith-based organizations (FBOs) continue to play a critical role in achieving the UNAIDS Fast-Track Targets of ending the HIV epidemic by 2030. An estimated 84% of the world has a religious affiliation, and leveraging a well-informed and mobilized faith community is essential to controlling the HIV epidemic. Faith-based platforms can be maximized to improve literacy around HIV prevention services; strengthen referrals to health services; and support adherence and retention in HIV care. The session shall be facilitated by experienced Public Health Practitioners through presentation and group activity, including 1) an overview of the Health Kiosk program; 2) an interactive, practical group activity to identify platforms, audiences, safe spaces and resources to establish and monitor the impact of the Health Kiosk program; and 3) questions and answers with final evaluation.

Facilitators:	World Vision (Dr. Gloria Ekpo, Lauren Van Enk, Dephin Mpofu)	Time:14: 00 – 15:30	Venue : Salon Unité
Target/Intended Participants:	This session is for people who are new to the field of HIV or have been involved in the HIV response for some time but seek to learn about an innovative intervention that can build interfaith bridges to improve HIV prevention, care, and treatment. Participants will 1) identify essential components for successful implementation of the Health Kiosk program; 2) analyse platforms and target groups for engagement and implementation; and 3) discover simple tools to implement, monitor and report on the impact of Health Kiosk programs		
Excursion	**Facility Visit**		
	Coordinator : Dr. Francois	Venue : Meet at the hotel reception	Time: 15.30pm

DAY 2: Wednesday 27 February 2019	
Opening Prayer & Morning Devotion	Rt. Rev. Fonki (CEPCA President)
Message from Host - CBCHS	Prof. Pius Tih (CBCHS Director)
Welcome Address & Official Opening of the Conference	Mr. Peter Yeboah (Chairman, ACHAP Board)
	Overview of Primary Health Care Services in Cameroon: The role of FBOs towards achieving Universal Health Coverage The Honorable Minister of Health - Cameroon.
Keynote Address:	**Re-igniting Primary Health Care: The Role of ACHAP** World Health Organization (WHO) Representative
PLENARY SESSIONS	
Plenary 1	**Strengthening FBO's Health Systems for PHC towards UHC**

Synopsis	Background: FBOs have historically been PHC-oriented. CHAs have contributed in building resilient and responsive health systems for PHC with focus on innovative service delivery models for communicable and non-communicable diseases, RMCH and emergency preparedness, human resources for health, sustainable health financing, and health management Information systems/ICT/evidence, amongst others. Nonetheless, embedding sustainable PHC in FBHPs health systems remain a fundamental challenge. Given the renewed international interest in PHC, the need for re-engineer PHC towards achieving Universal Health Coverage/Sustainable Development Goals (UHC/SDGs) cannot be over-emphasized. **Questions/Issues:** So, why have FBOs deviated away from PHC? And how can they return to PHC? Are there innovative and/or cost-effective models of delivering PHC in FBOs? How can higher-level FBHP facilities be supportive of PHC initiatives in their service area? **Expected outcome:** The session is expected, amongst others, to: • Collate innovations (service delivery, HRH, health financing strategies, and ICT) that promote PHC for UHC in FBOs, private and public health systems. • Highlight systemic challenges affecting scale up of PHC amongst FBHPs • Identify prospects and role of ACHAP/FBHPs in re-igniting PHC towards attaining UHC		
Moderator	Dr. Mwai Makoka	Venue: Salon Unité	Time: 10:10am-10:55am
Panelists	1. Prof Tih-CBHS 2. Dr. Monique Chireau Wubbenhorst-USAID 3. Peter Yeboah-ACHAP 4. MOH Cameroon represetnative 5. WHO representative		
Plenary 2	**FBO-Government partnerships at country, sub-regional and regional levels for promoting PHC and attaining UHC**		
Synopsis	Background: Cooperation and partnership are core values of FBHPs. CHAs recognize that Government and Ministries of Health have the primary responsibility for the health of its citizens. Hence, in fulfilling our mission of promoting Jesus Christ's healing ministry, FBHPs are obliged to complement and collaborate with Governments/MOH in service provision, training, regulatory compliance, etc. This imperative obliges both parties to broker a formal relationship often characterized by tension, competition and uncertainties. Nonetheless, MOH shall always remain the major stakeholder and regulator of a country's health system. Whilst development assistance from partners abroad remain indispensable, a sustainable pathway to re-igniting PHC for UHC require that FBHPs/CHAs build the necessary capacity for negotiations and dialogue with MOH/Governments. Consequently, exploring feasible partnership models with major stakeholders remains a necessity for CHAs. **Questions/Issues:** What strategic partnership models exist amongst CHAs, governments and development partners? How can ACHAP promote interactions and forge constructive relationships with collaborators at the country, continental and global levels to promote PHC? Are there partnership frameworks for triangular learning & collaboration (North-South-South)? **Expected outcome:** • ACHAP develops an inventory of Partnership MOUs/Agreements between CHAs and Government/MOH or other partners in sub-Saharan Africa • CHAs shall gain access to various Partnership Agreements and MOU Templates existing between various CHAs and government/MOH, with clear implementation mechanisms, operational pathways for engagements and lessons for engaging governments and partners.		

Moderator	Dr. Gloria Ekpo (World Vision)	Venue: Salon Unité	Time: 11:10am-12:10am
Presenters	1. Melissa Freeman (USAID) 2. Dr. Josephine Balati 3. Mafase Ng'ong'ola Sesani (CHAM) 4. Dr. Douglas Gaitho (CHAK) 5. Dr. Bildard Baguma (JMS)		
Plenary 3	**Community-based Primary Health Care - Health Promoting Churches**		
Synopsis	**Background:** Promoting Jesus Christ healing ministry is a core mission of the Church. Churches establish and own health facilities aimed at improving health, healing, lives and livelihoods of people, especially the poor, needy, neglected, deprived and marginalized segments of the population. With privileged access to unique social spaces-churches, schools, health facilities, inter-faith platforms, the Church leadership have several leverages that could be harnessed to promote PHC towards attaining UHC. **Objectives/Agenda/Expected output:** Based on the above, the session is intended to, amongst others, 1. Highlight the prospects, potentials and challenges of Churches in promoting PHC 2. Present the model health-promoting churches programme. 3. Discuss how CHAs promote PHC through churches using the HPC programme.		
Moderator	Jim Cox (IMA)		
Anchor/Presenter	Dr. Mwai Makoka		
Respondents	1. Doug Fountain-CCIH 2. Rev. Dr. Simon Dossou -AACC 3. Rev. Dr. Nchama Godwill-CBCHS		
BREAKOUT SESSIONS			
Breakout Session 1	**Exploring feasible financing models for PHC**		
Synopsis	Background: Sustainable financing mechanisms remain a key determinant and major challenge for the uptake and scale up of PHC in sub-Saharan Africa. Generally, the faith-based health systems, spearheaded by CHAs, are noted for innovations, resource mobilization, allocation and management of financial resources for the purpose of providing affordable health care to target beneficiaries. In the past, CHAs were aided mostly by donations from overseas development partners. Recently, however, there have consistent withdrawal of donor support owing to change in development paradigm, causing gaps in funding for uptake or scale of PHC. Whilst some CHAs receive government support, others are not considered despite their complementary role and contributions in national health systems.		

Synopsis continued	Objective/Questions Given the need to secure feasible and reliable funding mechanism for PHC, the following questions resonate: 1. How can FBOs reposition PHC as an effective means for achieving UHC? 2. Can we identify case studies and health financing schemes that provide financing models that promote and embed PHC in our settings?
Moderator	Dr. Samuel Mwenda
Presenters	1. Elled Mwenyekonde - CHAM 2. Pasteur Didier Ouedraogo - ASAD 3. Kuni Esther – CBCHS 4. David Balikitenda – UPMB 5. Martin Thondolo-Nkhoma Hospital, Malawi
Time	14:00 pm-15:30 pm
Venue	Salon Unite
Target audience	Open to all conference participants
Breakout Session 2	**Health technologies and information for increasing visibility and advocacy leverages towards improved PHC**
Synopsis	Background: A robust Health Management information system is needed to fulfill the core mission of CHAs at all levels. In fact, making meaningful decisions in the health sector require robust and relevant data which meets the established criteria of integrity, quality, reliability and timeliness. Intuitively, more and better-quality data are a public good for ACHAP members. Unfortunately, there is dearth of precise data or minimal database on which to explore relationships. Consequently, the prevailing inadequate data management and use for decision making amongst ACHAP/CHAs is affecting our capacity for PHC uptake in terms of planning, managing, monitoring and evaluation of health services. There are also unintended adverse effects on CHAs capacity to demonstrate their contributions/attributions, engage in negotiations, lobbying and advocacy. Objective/Question • Hence, the relevant question for consideration is: • How can ACHAP optimize Health Management Information Systems and ICT to leverage CHAs' available (but undocumented) assets, role, contributions and service output data in order to promote their visibility and impact, through dialogue, negotiations, partnerships and advocacy at country, continental and global stage?
Expected output	Information Charter: CHAs sign up to ACHAP data repository and adopt mechanisms for data submission, evidence gathering and use for decision-making. This would serve as a platform to increase accessibility of information on the work of CHAs, as well as present a platform to exchange views, and advance common interests and perspectives for the growth and development of ACHAP

Moderator	Paul Pierre Mbeleg	Venue: Salon Mfoundi	Time: 14.00-15.30pm
Presenters:	1. Mrs. Sarah Sackey Martei-Olletey – CHAG 2. Gift Merix Werekhwe – CHAM 3. Faith Irene Wagaki – CHAK 4. Doreen Kudwoli – Medic Mobile 5. Nic Moens – Africa ehealth Foundation		
Breakout Session 3	**Building, Planning, and Optimizing a PHC Workforce Using the Health Worker Life Cycle Approach**		
Synopsis	Human resources for health (HRH) constitute the critical most important tool for the uptake of PHC towards the attainment of UHC in sub-Saharan Africa. Despite the need for adequate number and mix of HRH in country health systems, there is acute/critical shortage of essential health workers per target populations, especially amongst faith based health providers/ CHAs. The lack of coherent HRH Management Information System also makes it difficult to manage to evolve relevant policies to improve the health workforce situation. The situation has been attributed to inadequate investments in the formulation and implementation of HRH strategies to train, recruit, deploy, enhance productivity and retain the right health workforce. The lack of robust HRH policy and practices affects front line primary health in sub-Saharan Africa. Presenters will showcase a health worker-centered approach and resources to build, plan, and optimize the health workforce. Starting with a conceptual approach, then moving to real-life applications, and ending with a skills-building demonstration, this engaging session will provide practical resources and examples from the USAID-funded HRH2030 program and CHAs to contribute to health for all. Questions/Objectives Based on the foregoing, the session shall deliberate on the following questions: How can ACHAP map the current landscape of human resources for health in Africa What are the key HRH issues affecting the update of PHC? How can we address common human resources for health challenges to optimize the primary health care workforce of the future? What are some of the innovative HRH policies and practices that could improve the uptake of PHC in sub-Saharan Africa?		
Moderator	Samantha Law (HRH2030, Chemonics)		
Presenters	1. Godlove Nkuoh-CBCHS 2. Dr. Titha Dzowela-CHAM 3. Peter Kakute-CBCHS 4. Katy Gorentz- HRH2030, Chemonics		
Time	14:00pm-15.30pm		
Venue	Salon Febe		
Target Audience	Open to all conference participants		

DAY 3: Thursday 28 February 2019	
PLENARY SESSIONS	
Plenary 5-7	**Focus on PEPFAR Transition to Indigenous Primes and Opportunities for Local FBOs 7 Steps of Planning**
	Why? Amb. Birx announced in April 2018 at the COP18 meeting in Washington, DC (and on numerous other occasions since then) that PEPFAR is setting a target to transition PEPFAR procurement to local primes: 25% by end of 2018, 40% by the end of 2019, and 70% by the end of 2010. How this will be implemented and evaluated is not well-understood by local faith-based organizations (FBOs). The African Christian Health Associations Platform (ACHAP) and Catholic Relief Services (CRS) are jointly proposing a workshop at ACHAP's Biennial Conference and General Assembly in Yaoundé, Cameroon, on 27 – 28 February. The workshop will offer ACHAP participants an in-depth overview of CDC's and USAID's roadmap for implementation of PEPFAR's directive for 70% of PEPFAR funding to transition to indigenous partners by the end of FY20. This session will review COP19 planning process and timeline and explore key opportunities for FBO-PEPFAR engagement, review what is known about PEPFAR FBO Initiative, review typical USG procurement mechanisms with specific examples of CDC and USAID procurement, discuss how FBOs can make themselves more prime ready, review assessment tools for preparedness to receive and implement direct USG funding, and examine and discuss areas that are likely to present challenges for FBOs and other potential indigenous primes, such as managing multiple subgrantees and meeting donor reporting requirements, etc. **What? The Objectives** This Scope of Work responds specifically to the proposed focused session on Thursday 28 February: "Focus on PEPFAR. Transition to Indigenous Primes and Opportunities for Local FBOs." • CDC and USAID colleagues review the PEPFAR transition to local primes directive (70% by FY20); • CDC and USAID colleagues review and outline steps and timeline in the process of PEPFAR transition to indigenous partners in the COP19 Planning process; • CDC and USAID colleagues review their specific agency perspectives on strengths, opportunities and challenges that Christian Health Associations (CHAs), local FBOs, and local communities of faith will likely encounter during the PEPFAR transition to indigenous primes; • ACHAP members with PEPFAR prime experience present their experiences and lessons learned as USG recipients and as indigenous local primes; • CDC and USAID review procurement mechanisms: • Identify key elements of local partner preparedness critical for successful transition to indigenous local primes in USG opportunities; • Engage in mutual discussion on PEPFAR transition to indigenous partner primes planning and how implementation and evaluation of transition to indigenous primes are relevant for CHAs and local FBOs implementing HIV activities in PEFAR countries; • Identify strengths, challenges and opportunities for CHAs and their local members in PEPFAR transition to indigenous primes;

	• Provide an opportunity for participants to learn about and interact with tools for local partner preparedness assessments.
Expected Outputs or Deliver-ables	**What for?** By the end of the session, the participants will have: Greater knowledge and understanding of the PEPFAR transition to indigenous prime targets, processes, and timelines. Greater knowledge and understanding of the challenges, opportunities and implications of the PEPFAR transition to indigenous primes on CHAs and that of their members. Identified at least three immediate action steps that they can take for greater participation in the PEPFAR transition to local primes.
Moderator/Co-Facilitators	1. Dr. Monique Chireau Wubbenhorst-USAID 2. Dr. Tedd Ellerbrock-CDC 3. Dr. Carl Stecker-CRS
Plenary 8	**Strengthening Partnerships & Creating Synergies: ACHAP Meets the NTD Challenge**
Synopsis	Neglected tropical diseases (NTDs) are present in all ACHAP member countries, with some reporting five or more. Encompassing almost two dozen bacterial, parasitic and viral diseases, NTDs affect tens of millions of people in Africa where they overwhelm health systems, burden developing economies and erode quality of life. NTDs are termed 'neglected' as those most affected are the poorest populations living in rural areas, urban slums and conflict zones.
Expected output	Attain a deeper understanding of the NTD burden Catalyze ACHAP members' vision for NTD work Discover NTD program synergies between ACHAP members and other sectors Gain a more complete understanding of American Leprosy Missions' work in the region
Moderator	Mr. Jim Oehrig (Vice President of Integral Mission, American Leprosy Missions, USA) — Time:14:25pm-15:40 — Venue: Salon Unite
Panelist	1. Mr. George Gitau (Africa Regional Director, American Leprosy Missions, Kenya) 2. Dr. Julien Ake (Global Director of AIM Initiative / Senior Technical Advisor effect: hope Canada / Côte d'Ivoire) 3. Dr. Désiré Hubert Imposo (Surgeon, Evangelical Medical Institute, DRC) 4. Mr. Aubin Yao (Director, MAP International, Côte d'Ivoire) 5. Mr. Josue Tchimou (Executive Director, SMAid, Ghana)
Target Audience	Open to all conference participants
Breakout Session 4	**Innovative Approaches to Reducing Maternal, Neonatal and Child Mortalities: Learning Lessons**
Synopsis	Maternal mortality remains a challenge in sub-Saharan Africa. Several interventions and programs have been developed and implemented over the past decade, yet the MDG targets were not achieved by 2015. Consequently, several FBHPs/CHAs have introduced number of interventions comprising the MDG Accelerated Framework (MAF). **Objectives:** • Explore collaborative learning mechanisms to improve maternal health with facilities iden-tifying their own problems and proposing solutions to contextual problems. • Share lessons on how to leverage technology / WhatsApp to share knowledge and skills particularly in deprived areas. • Use innovative campaigns to drive quality maternal and neonatal care

Moderator	Dr. François Chimoun	Time: 15:45p.m.-16:25	Venue: Salon Mfoundi
Presenters	1. Osee Djekadoum Ndilta – EAST 2. Eugene Foyeth – CBCHS 3. James Duah – CHAG 4. Christina de Vries – Cordaid		
Target Audience	Open to all conference participants		
Breakout Session 5	**Integrating Mental Health into Primary Health Care**		
Synopsis	It is estimated that Mental Health accounts for 14% of the global burden of disease, with 450 million people worldwide affected by mental problems at any given time. Furthermore, statistics indicate that one in five people will experience a psychiatric disorder (excluding dementia) within a given year. Worse of all, in most sub-Saharan African countries, barely 2% of people with mental illness have access to treatment and care, meaning that there is 98% treatment gap for mental illnesses . Yet mental health remains a neglected area, which is exacerbated by institutional neglect, stigma, and discrimination, amongst others. Therefore, given the global burden of mental illness, mental health should be an integral package of PHC. **Objectives:** • Assess the state of mental health uptake amongst CHAs • Explore innovative approaches to managing or improving mental health		
Moderator	Florence Bull	Time : 15.45pm-16:25pm	Venue: Salon Febe
Presenters	1. Frank Dimmock 2. Peter Yeboah - CHAG 3. David Balikitenda		
Target Audience	Open to all conference participants		
Breakout Session 6	**Anti Microbial Resistance (AMR)**		
Synopsis	There was been considerable improvement in global health, however we also recognize that many people still cannot access quality healthcare that include access to effective medication that includes antimicrobials. Many factors drive AMR, however a good consideration for the primary health care system can help to solve some of the problems of AMT that we continue to experience.		
Moderator	Dr. Mirfin Mpundu	Time : 15.45pm-16:25pm	Venue: Salon Unite
Presenters	1. Lindsay Denny - Global Water 2020 2. Dr. Cyprian Kamau - CHAK 3. Dr. Bildard Baguma - JMS		
Target Audience	Open to all conference participants		

Empowered community care — An innovative model for digitized and effective service delivery

Duah J.1, Moens N 2
1. Christian Health Association Ghana Africa 2- eHealth Foundation

The current fragmentation in health care and the sharp rise of Non Communicable diseases (NCD) is a serious threat with a high death toll. Controlling patients with NCD, awareness campaigns and improvement in lifestyle are essential. A challenge for the Faith-based hospitals is their lack of financial means and the proper integration of the health care chain. How to combine these challenges in one approach? Strengthening hospitals, reintegrating with PHCs and empowering communities.

How to get back to an efficient referral chain if money is lacking and distances substantial? Traditional approaches are costly and do not bring always the desired results. Smart digital solutions together with change management are needed to integrate new best practices in the daily work flows. An App is used by the patient, the community health workers and this relates to a call centre situated at the hospital. All data is recorded – like blood pressure, glucose level, and appointments - and entered in the electronic health record of the patient and integrated in the hospital information system. In this way, the nurse and the doctors have full control on the patient. During the visits to the PHC and the hospital all findings of the consult can be added to the electronic health record. Reminders and educational material can be pushed to the patients. In Ghana, this project has started at two hospitals with the surrounding PHC's, and community groups in their catchment area. It is based on a successful experiment with a diabetes call centre in Accra.

Hospital performance improvement.

An important part of the programme is to strengthen the efficiency and the revenue collected at the hospital. The availability of digital data gives management full insight in the data and allows for a gradual improvement of the performance of the hospital. Also, the DHIS2 reports are generated automatically.

The results of the programme are monitored using a penta-aim research methodology that includes; patient convenience, clinical outcome, cost efficiency, performance health professionals and business results for the health facility.

Community participation in financing HIV services delivery in the Northwest Region of Cameroon: The Local Capacity Initiative (LCI) Program

Kuni E., Abuseh J., Nshom E., Mboh E., Lum O., Keng V., Monju J., Chimoun F., Tih P
Cameroon Baptist Convention Health Services

The Local Capacity Initiative (LCI) program was implemented to sustain HIV services through community generated resources with focus on the Prevention of Mother to Child Transmission (PMTCT) of HIV. The program ran from April 2014 to March 2018.

Using a participatory approach, community stakeholders were trained, mentored and guided to identify challenges that prevented uptake of Ante Natal Care (ANC)/PMTCT services in their communities. They were guided and supported technically to identify resources locally; hence Income Generating Micro Projects (IGMPs) were set up to provide needs of health facilities while improving the standards.
Key challenges were poor standard of care due to limited financial resources and limited number of Service Providers (SPs) to render quality services to the Pregnant Women (PW).

The initiative recruited 36 SPs locally to reinforce human resources. Uptake of ANC/PMTCT increased from, 6741 PW in 2014 to 7078 in 2017. A total of 47 IGMPs were set up in 29 health areas whose income met basic needs at facilities. Health Focal Points were appointed in councils to ensure smooth health care in facilities prioritizing PW.
With innovative financing and technical support, HIV services can be improved and sustained through community participation in resource limited settings

Increasing access to health care through community health insurance at kaundu health centre, malawi.

1.E. Mwenyekonde 2. M. Makoka 3. N. Kaira
1.Christian Heath Association of Malawi (CHAM), 2. World Council of Churches (WCC), 3. Kaundu Health Centre, Malawi.

OBJECTIVES: To increase access to health care through community health insurance (CHI) at Kaundu health centre, Malawi.

INTRODUCTION: Users in CHAM facilities' catchment areas face challenges when accessing paying health services especially in the

facilities without Service Level Agreement (SLAs). CHAM implemented a CHI at Kaundu health centre with a goal of increasing utilization of health services.

STUDY METHODS: The activities included: mapping of villages, setting up of a task force team and coordination desk, community sensitization meetings, orientation of District Executive Committee, orientation of community structures, and improvements in drug supplies of the facility.

RESULTS: 1,048 members were enrolled in the first year. Since 2016, utilization of services has grown and membership is more than 4,000. From 2015 to 2017, OPD services increased from 4,325 to 8,443, U-five patients increased from 2,884 to 4,891, ANC and deliveries increased from 106 to 1,016. Total funds increased from 375 USD to 1,090.

CONCLUSION/RECOMMENDATIONS: CHI resulted into improved utilization of health care at Kaundu by the general public. The facility also demonstrated improved quality health care due to public demand for better services. CHI will be scaled up in CHAM facilities.

Continuous Capacity Building: Essential for human Resource development for public health improvement.

Godlove Nkuoh1, Eveline Mboh1, Paul Ngang 1, Pius Tih1, Janefrank Nalubega2
1Cameroon Baptist Convention Health Services, 2Mildmay Institute of Health Sciences, Uganda

INTRODUCTION: Continuous Capacity building is a public health approach to improving and enhancing knowledge, developing skills, and enabling health systems toimprove on the management of health systems, health programs and health conditions. The WHO developed a 2009 -2013 Strategic plan for capacity building which emphasizes that capacity building needs should include those related to human resources, institutional and infrastructural capacity networks and partnerships.

BACKGROUND: The CBCHS started a Regional Training Centre(RTC) f in 2004, as a special institution for human resource development in the health sector. The center aims to enhance knowledge, develop skills and improve human resources, institutional and infrastructural capacity and bring about improvement in health services and implementation research.

METHOD: In partnership with Mildmay Institute of Health sciences which is a specialist Health Care Training centre in Uganda, the CBCHS RTC in Mutengene Health Services Complex (HSC) runs work-based modular Diploma and degree courses in Health. The training program is unique in that it provides a problem-learning approach where candidates receive oneweek face-to-face lecture and allowed to do self-studies at their work place in consultation with their assigned academic supervisors online. This keeps learners on the job as they study and develop new skills while working and using their salaries to care for their families.
The RTC advertised and recruited students in the following academic courses:

1. BSc (Hons) Health and Social Systems Management
2. A Diploma in Public Health (modular)
3. Diploma in Medical Records (modular).
4. Diploma in Human Nutrition and Clinical Dietetics (modular).
5. Diploma in Paediatric Palliative Care (modular).
6. Diploma in Community HIV and AIDS Care and Management (Modular)..

RESULTS: In 2016, 17 students enrolled into a Diploma in Health and Social systems Management. 8 in a Higher Diploma in Pediatric Palliative Care, in a Diploma in Community HIV & AIDS Care and Management and 12 in a Diploma in Human Nutrition and Clinical Dietetics. Of these 45 students enrolled, 31 graduated in December 2018 while 28 students are continuing in two different programs.

CONCLUSION: Capacity building is one approach towards increasing human resource development for health so as to increase the number of qualified and skilled personnel to offer preventive and curative health care services while also effectivelymanaging human and financial resources as well as infrastructural development. This training program is contributing to fill this gap which exists in Cameroon and other developing countries. There is need to evaluate the performance of the trainees in the work place to determine the impact of the trainingon the population.

Building Health Systems on PHC: Nkhoma Hospital ASSET Project Approach Towards Revitalization of Primary Health Care

Martin Boyd Thondolo
ASSET Project, Malawi

The ASSET concept promotes mobilization of local communities to use their own assets and increases local ownership and local contributions to improve health outcomes. The ASSET Project strives at strengthening the district health system in a strictly bottom up approach. The project builds on or revitalizes the existing government PHC system in Malawi which includes District Environmental Health Officers (DEHO), community health workers (HSAs), Health Center Advisory Committees, and Village Health Committees. The ASSET Project employs the SALT participatory methodology to stimulate local responses towards identified health concerns which are established by local communities themselves. The project is based on the voluntary engagement of local people to improve the health of their communities. In the implementation of Nkhoma Hospital ASSET Project in the catchment areas of church health institutions in the districts of Ntchisi and Lilongwe in Malawi, local communities have been introduced to home visitations, SALT conversation and asset mapping methodology. The following health concerns have been addressed by using local assets: Hygiene and sanitation, nutrition and access to health services at local level through construction of village clinics. Instead of using health outcome indicators the project is mainly monitored by documenting process indicators.

Contracting between Government and FBOs - Experience of Service Level Agreements (SLAs) in Tanzania

Peter Maduki, Josephine Balati, Godwin Ndamugoba
Christian Social Services Commission, Tanzania

Both the public and private sectors provide health care services in Tanzania. The public health sector is responsible for 60% of service delivery and the remaining 40% is contributed by the private sector which include FBOs, Private-for-Profit providers and CSOs. In Tanzania, Public Private Partnerships such as FBO-government partnerships has been in existence for a long time since independence.

Due to inadequate resources in the public sector such as infrastructures, skilled staff, funds, medicines and supplies, medical equipment, the Government formally negotiated the Hospital Agreements in 1992 with FBOs. At the end of 2007, the Ministry of Health, Prime Minister's Office, Regional Administrative and local Government (PMORALG), FBOs (CSSC and NMC) and Association of private health facilities (APHFTA) developed a Service Level Agreement (SLA) template that provided a contractual arrangement for private providers of health services to render health services on behalf of the government. The SLA template was designed purposely to increase the availability of quality health services to the general population in accordance to the National Health Policy and its related Guidelines. Due to various implementation challenges and changes in health service delivery, the SLA template was revised and updated in 2017.

Contracting with the FBOs has many benefits for both parties involved. Benefits for the public sector among others include: strengthening the partnership between the public and private sector; enhance monitoring and regulations of the FBO/private sector; delegation of responsibility of delivering services, pooling resources and cost saving. Benefits for the FBOs/NGOs include: increasing ability and opportunity to fulfill their mission of reaching and saving the poor in remote and rural areas; allocation and access of resources; recognition and involvement in policy formulation, Contracts have challenges include: competition between contractors and public providers for resources; Inadequate adherence on contract terms etc.

Implementation of Point of Care Electronic Medical Records (EMR) System to improve completeness of data for patients receiving HIV treatment in Faith Based Health facilities in Christian Health Association of Kenya (CHAK) Program

Faith Irene Wagaki
Cristian Health Association Kenya

BACKGROUND INFORMATION: Since the rapid scale-up of antiretroviral therapy (ART) programs in sub-Saharan Africa, Electronic Medical Records systems ((EMR) have been deployed to respond to the growing demand for program monitoring, evaluation and reporting to governments and donors. To ensure accurate reporting and good quality for research, the reliability and completeness of data systems need to be assessed and reported. CHAK provides HIV care to over 47000 patients who are on ART. This is a huge number that needs complete and accurate information for decision making. CHAK uses International Quality Care Patients Management and Monitoring System (IQCare) Electronic Medical Records (EMR) supported by The Palladium Group Kenya. Health facilities use the EMR differently, there are facilities using retrospective data entry into the EMR and also those using point of care EMR.

METHODS: CHAK started Implementation of Point of care EMR in December 2013 and over 40 health facilities have a Point of Care (PoC) EMR whereby health care providers attend to patients using the EMR. Six of them were selected for the study. The statistical analysis methods used was descriptive. Univariate and bivariate analyses was used to quantify associations between variables. Multiple regression and logistic regression was used to assess the relative influence of the predictor variables on the dependent variables.

RESULTS: The health facilities had overally initiated more patients on Antiretroviral Therapy after the implementation of Point of Care (PoC) than before the implementation of Point of Care, 1674 and 204 respectively Baseline WHO reduced from 0.05% to 0.01%, Baseline CD4 reduced from 14.7% to 13.9% and Opportunistic infections reduced from 57.4% to 50.8%. Both methods had complete regimen completeness levels. The location of the health facility, i.e. urban and rural based as association on completeness of the data; rural based facilities were more likely to have incomplete documentation of baseline WHO, baseline CD4 in a retrospective model of data capture, while urban based facilities were more like to have incomplete documentation for opportunistic infections both for PoC Electronic Medical Records implementation and also paper based.

Conclusions: Point of Care Electronic Medical Records implementation has high level of data completeness justifying this model not only for HIV care setting but also for the entire health sector. As EMR is widely used to support HIV treatment programs, researchers should formally evaluate and report levels of data completeness to ensure high quality of data is being used both for research and reporting.

Bringing digital health tools to last mile clinics: a delivery model innovation with Medic Mobile's Standard Package

Doreen Kudwoli, Beatrice Wasunna, Leah Ng'aari, Regina Mutuku
Medic Mobile, Kenya

Several years ago, Medic Mobile designed and built a pre-configured version of their toolkit. The intention was to make the digital health tools that are now in widespread use among large, well-funded organizations more accessible to small, last mile clinics. In order to make this configuration applicable to a diverse set of partners, we referenced global best practices and built "standard" workflows for antenatal care, postnatal care, and immunizations.

The tools allow CHWs to register pregnant women, postnatal mothers, and young children for immunizations, to receive scheduled reminders, and to confirm visits using simple SMS forms. Health facility and program staff can coordinate care with the CHWs using our webapp, and oversee care and impact with dashboards.

Today, the package supports approximately 1500 health workers and has seen 3,344 pregnant women registered with a 65% facility-based delivery rate. We've developed and conducted remote trainings, created videos with local production teams, and have developed a feedback system to respond to requests for workflow changes, features, and other improvements.

Partners, who otherwise might be left behind in the digital health revolution, comprise a great opportunity to achieve scale as well as equitable access to innovations that have the power to save lives.

Accelerating Progress Towards HIV/ AIDS Epidemic Control in Sub-Saharan Africa: The Christian Health Association Lesotho (CHAL) experience and innovative approaches

Patricia Lebohang Mothae
Christian Health Association of Lesotho

It has taken Lesotho over a decade of extensive fight against HIV and AIDS. While the country continues to be tormented by a high prevalence rate of about 25% and an annual incidence rate of 1.5% among adults aged 15- 59 years, a significant progress and positive outcomes of this fight are starting to show. numerous interventions that were employed to arrest the epidemic and they include Voluntary Medical Male Circumcision (VMMC), Prevention of Mother To Child Transmission (PMTCT), test and treat, HIV education and information as well as Anti-retroviral Therapy (ART). Therefore, in 2017 Lesotho experienced commendable results towards 90:90:90 global targets. 77.2% of the people living with HIV know their status, while 90.2% of those are on Anti-retroviral treatment (ART) and 88.3% is virally suppressed. CHAL, with 40% coverage, has been instrumental towards this remarkable national performance.

Notwithstanding such a notable performance, the finishing line seems far as reports indicate low uptake of HTS and ART services by particular groups of the society namely men and adolescents. Only 71% of males living with HIV, in comparison with 81% of females, know their status. On the same note, prevalence in young people (aged 20-24) is 16.7% of young women and 4% young men. This suggests a need to focus more on men and adolescents and as such prioritize interventions that will effectively ensure increased access and uptake of HIV services by these mentioned groups. It is against this background that CHAL through health facilities across the country and with support of the Government of Lesotho and the development partners implemented the following strategies;

1. Men's friendly services – there are dedicated corners and rooms where only men are served by male nurses at the hours that are convenient to them.
2. Adolescent corners with various youth support groups are established to afford a safe space for adolescents to access and use HIV services and sexual and reproductive health services. Young nurses are then employed to serve this group.
3. Sports tournaments are initiated and supported by CHAL as a way to reach out to men and create awareness on HIV, GBV and Sexual and Reproductive Health.
4. Health facilities and local authorities established working relationships that enable provision of HIV services to initiates during their initiation schooling.
5. Outreach services are provided to hard-to-reach communities but mainly herd boys at cattle posts and successfully linked to facilities for continuous care.
6. CHAL collaborates with churches using church structures to provide a stepping stone curriculum in a fight against GBV and for understanding towards norms change.

These interventions, among others, have yielded positive results in relation to access to and uptake of comprehensive HIV services and it is apparent that at this rate, Lesotho, with the contribution of CHAL will reach 90:90:90 targets by 2020. There are priority areas that require more attention to accelerate progress towards control of HIV and AIDS pandemic in Lesotho and these include improved collaboration with the communities and community leaders, acceleration of VVMV at health facilities as the nurses are now licensed to perform VMMC, intensify prevention strategies such as index testing, partner notification and self-testing.

This abstract suggests that for accelerated progress towards 95:95:95 targets by 2013, active community involvement is vital and FBOs become central to igniting the partnership between health providers and the communities and as such empowering communities to take charge and control of the epidemic. CHAL is in this case no exception and wishes to share and demonstrate the lessons learnt from interventions that involved communities, led by and in collaboration with the churches and consequently yielded high results with specific focus on men and adolescents. On the same note, CHAL will share the approaches that have been used, and based on experience such which will be newly introduced and intensified for accelerated progress towards the control and eventually elimination of HIV and AIDS.

Primary Health Care: Moving towards Universal Health Coverage through Basic Access to Health Care. The case of the Life Abundant Health Care (LAP) Programme of the Cameroun Baptist Covention Health Services (CBCHS)

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Cameroon Baptist Health Services

Substantial disparities exist in health outcomes between rural and urban areas, as well as across socio-economic groups.

BACKGROUND: LAP was initiated in 1980 as a pilot phase in four villages as an outreached department for the CBCHS and has now expanded to 54 communities. The purpose of LAP is to enable communities initiate, administer and sustain a programme of better health for all in their environment and culture.

METHODS: The LAP PHC system consists of three interdependent components:
1- The community health facility is built, maintained and managed by a local Village Health Committee (VHC) which approves the services and activities. LAP administrative and clinical team provides technical support, supervision, continuous education for the daily functioning of the PHC to the Village Health Committee and Village Health Workers (VHWs).
2- The PHC is staffed by health promoters and Community Mother Child Health Aides (CoMCHAs). Village Health Workers are selected by the community and reside in the community. Since the community initiates the setting of PHCs by LAP, the level of community involvement is very high, thereby guaranteeing ownership and sustainability.
3- LAP provides initial, continued training, supervision and technical support to the Village Health Committees and PHC staff through Nurse.

RESULTS: From inception, 92 community health facilities have been initiated in 5 out of 10 regions of Cameroon with 16 upgraded to integrated health centres (IHCs) and one is now a major hospital.
448 Village Health Worker been trained and engaged in their communities. Over 116 Village Health Workers trained on Basic Life Support in Obstetric (BLSO) to response to obstetrical emergencies. In addition, various health programmes such Non-Communicable diseases screening and management and HIV prevention of mother to child transmission have been expanded in these rural communities.

CONCLUSION: Most rural communities still face limited access to essential and affordable health care. CBCHS-LAP Program helps communities to fill the health service's needs. By putting in place affordable, community owned and sustainable health structures tailored to the needs of the people. This model which started in four communities of the NWR in 1980 is today a best practice as it has facilitated access

to critical health services for close to a hundred communities in Cameroon. It is important the primary healthcare model be reignited.

Engagement between County governments and Christian Health Association of Kenya in HIV service delivery -Successes and challenges

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BACKGROUND: The Christian Health Association of Kenya (CHAK) HIV AIDS Program (CHAP) Uzima is a five-year PEPFAR-CDC funded project mandated to oversee HIV care and treatment, and orphans and vulnerable children (OVC) services in 79 faith-based and affiliated health facilities (FBAHFs) and 4 local implementing partners respectively spread over 19 counties in Kenya. The program currently has approximately 49,000 patients on treatment and supporting 5,100 OVC. We review county engagement initiatives within the project's last financial year (October 2017 to September 2018) and highlight successes and lessons learnt.

METHODS: As a strategy towards health systems strengthening, the project held county engagement forums which served as formal entry meetings to introduce project activities to the county health management teams (CHMTs) in 9 counties, with 4 of them being the first time the project was working in these counties. The forums provided a platform to discuss performance indicators in HIV prevention, testing, and treatment services and served as an opportunity to plan for joint support supervisions, data quality assessment (DQAs) and capacity building of healthcare workers.

SUCCESSES AND CHALLENGES: Through these engagements we have had several notable achievements. Following the release of the 2018 HIV treatment guidelines, jointly with the county team, we were able to train 127 healthcare workers on the current guidelines. This capacity building initiative will ensure improved and quality care is provided to people living with HIV. In addition, we saw an improvement in staff retention among county recruited staff placed in the FBAHFs when compared to those staff recruited directly through the facility administrations. Out of the 44 staff recruited through the County at the beginning of the project, 86% (38) were still in the project at the end of the financial year. Joint DQAs were conducted in 23 health facilities that saw corrective action plans developed for gaps identified. Through these engagements CHAK has gained visibility within the County government healthcare spectrum as a key player in HIV service delivery. This is evidenced by invitation by Meru County to their health strategic planning meeting and attendance & participation in monthly technical working group meetings in three regions where we implement HIV care services. Kiambu county sought our expertise in care for adolescents living with HIV and had a delegation from the county together with the first lady of Zimbabwe visit our facilities to learn our best practices.
Resource availability remains a challenge. Cost-sharing of HIV services support with the county health governments has led to increased ownership by the ministry of health with reduced cost of HIV services implementation at program level.

CONCLUSION: County engagement is a necessary and sustainable approach for HIV service delivery in faith based and affiliated health facilities.

The role of Faith based Organizations in Advocating for family planing budget line in Ugandan Districts.

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Uganda Protestant Medical Bureau

Christian Health Association Zambia (CHAZ) organized an advocacy building capacity with a theme of Advancing family planning Advocacy in African Christian Health Association Partnership member country to which Uganda Protestant medical Bureau (UPMB) Subscribes. During the training, a project goal was set and objectives developed that could achieve the policy and funding wins aligned with country governments' FP2020 commitments. This attracted advocacy funding for developing 2018/2019 FP budget line in two district that is Gulu and Rukiga with high Pregnancy in Uganda. Methodology: UPMB introduced its self and the Objective of Supporting the District to develop a District FP budget line for the financial year 2018/2019 to the District leadership team through the Chief executive Officer. UPMB continued its introduction to all the four Sub-counties chief, two town council chief, LC5 and RDC. UPMB carried out an FP situation Analysis at selected facilities with in the Rukiga District, Results were shared at different decision making meetings like the DPC, and TPC where different decision makers were met. UPMB collaborated with other Non-Health and District and Regional Health implementing partners to collect support for the need to have an FP budget line. Results -Each of the Leaders in the district was convinced that they needed an FP Budget line - Results of The situation analysis indicated a high level of teenage pregnancy -Recommendation from the Health Education and Community based services committee included a budget line of shs. 3m under the health department Budget financial year 2018/2019 be allowed for FP services. -A family planning advocacy team was selected and lead by the Assistant DHO Maternal health -Finally during the council meeting the budget line was passed on. Lessons -Advocating for FP requires both commitment from health and non-Health Players - There is need for the community to have the right information on FP and how it influences a district or country's investment. - Having an M&E committed to FP

enabled us to have results and Reports on time and also share results tailored for Rukiga District against the whole country FP indicators. Challenges Policy doesn't support access to FP information and use to the Youth and Adolescents yet 50% of the mothers reporting for ANC in the District for the first time are below the age of 18.

Maternity waiting homes: a proven strategy to increase antenatal care uptake in remote communities.

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Cameroon Baptist Convention Health Services

INTRODUCTION: Due to poor road infrastructures and the scarcity of healthcare facilities, accessing the closest health facility is generally difficult in remote areas. This traumatic experience is worst for pregnant women who risk giving birth along the road with little or no help if there is nobody to assist them in the process. Because of this and added to other cultural factors, most pregnant women have often resorted to Home Deliveries despite all the risks associated as high exposure to HIV transmission from a positive mother to child, infant/maternal mortality and other infectious diseases. Through a sub-component of the HIV Project (the Local Capacity Initiative) implemented in SW and NW between 2015 and 2017, health areas with remote and hard to reach zones where strengthened and supported to create maternity waiting homes where pregnant women stay few days or weeks before delivery to reduce risks.

METHODOLOGY: Initial assessment of ANC data of health areas with low ANC uptake: This helped to identify 10 districts in NW (Ako, Bafut, Benakuma, Mbengwi, Tubah) and SW (Bangem, Ekondo Titi, Konye, Eyomojock, wabane). These districts assessed in 2015 had very low ANC outcomes with poorly functioning facility and dormant health committees. Community strengthening, and advocacy interventions were delivered in these sites in collaboration with the Regional Delegations of Public health and Regional Funds for Health Promotion.
Capacity Building of health facilities and revitalization of health committees: Staff of all 81 health areas where strengthened on health care management, hygiene and sanitation, disease prevention, health promotion, health care supervision and auditing, creation of income generating activities. Elections where organized and 81 health area health committees and 10 health district committees revitalized.
Marketing of the concept of maternity waiting homes (MWH): The LCI team analyzed the bottleneck to ANC of some remote areas and advised on the creation of maternity waiting homes. Facilities and health committees empowered appropriated the idea and created maternal waiting homes in their facility. A MWH is a facility within a health unit where Pregnant Women living in distant and hard to reach areas can visit some few days prior to the anticipated date of delivery.
Supervision of the creation of MWHs: LCI guided the facility teams to select appropriate sites where rooms were renovated or constructed. From this 31 sites maternity home were constructed.

RESULTS: A total of 31 out of 81 health areas established MWHs in their health facilities. Of the 31 created homes, from January to September 2017, a total of 215 women have spent at least one night in the Maternity Waiting Homes (MWH) in the implementing health areas. Thereby leading to an increase number of deliveries by trained personnel/clinical staff in the health facilities; that is about 50% an increase in health center deliveries. "…What we have done is to transform one of our wards into a MWH. We only just fitted in the necessary things that befits a waiting home. As at now, 35 pregnant women have benefited from the waiting home…" says the Chief of Center for Akwaja IHC, Mr. Eugene Taah Berinyuy,
The creation of MWHs by the LCI stamped out home deliveries in various communities and increased the number of deliveries by medically/clinically qualified personnel and to ensure proper. This has also contributed to the reduction of neonatal death and the early testing of about 40% of pregnant women in these communities.

CONCLUSION: Through Maternity Waiting Homes constructed in health facilities, high ANC uptake is possible in remote areas. MWHs help eliminate or mitigate home deliveries with associated risks (death, infections, etc). Hence it is worth to recommend this as key health system strategy to address maternal and neonatal deaths in remote communities.

Impact of health management information system on maternal healthcare in CHAG

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Research shows that women who live healthy during and after pregnancy and child birth are more likely to stay healthier later in life. According to WHO, "Maternal Health refers to the health of women during pregnancy, childbirth and the postpartum period". Ghana faced prevalence of maternal mortality in the 1990's. Many interventions had been carried out to improve mother and child health to reduce the high maternal mortality rate. One key area that needs improvement is quality data on maternal health to influence maternal health policy decisions leading to reduction in maternal mortality. Optimization of information technology is considered a plus with health facilities which are fully electronized. In underdeveloped and developing countries linkages between integrated software packages are recommended to optimize efficiency of interventions in healthcare. This study's objective was to assess health management information systems' impact on Maternal Healthcare performance in ANC attendance, supervised delivery and maternal mortality in the Christian Health Association of

Ghana (CHAG). The study design used was a Cross-sectional descriptive type based on both retrospective descriptive and primary data that describe the quality (accuracy, completeness and timeliness) of maternal and child health data capture in CHAG. The study targeted key employees of CHAG Health Management Information Systems (HMIS) which include heads of HMIS, Mother and Child Health (MCH) departments. The sampling technique used to select the study participants was Purposive Sampling. The study used both primary and secondary data. Primary data was obtained from existing Registers for the record keeping of Maternal and Child Health data as well District Health Information System II (DHIMS-2). Observation of the electronic system in place was also done to ascertain the efficiency and effectiveness of the system leading to adequate data capture to make evidence-based decision on maternal and child health issues. Analysis conducted indicates that the health management information systems such as Hospital management information systems (HAMS) in place at CHAG facilities generate accurate complete and timely data on maternal morbidity and mortality at the facility level. DHIMS-2 which is used in the collection and analysis of data from the health provider or facility level enables performance monitoring and feedback giving on maternal morbidity and mortality by the district/regional/national health management units/teams to the management of the health facilities. Furthermore, HAMS's reporting model needs an upgrade. The study found that ANC4+ visits, supervised delivery rate, maternal death audit done increased by 238%, 13.2%, 15% respectively while stillbirth rate and maternal mortality rate reduced by 50%, 2.5% respectively from June 2012 to June 2016 in CHAG (relatively in Ghana) due to quality data output from HMIS to inform maternal health decisions. Health service initiative evaluation confirmed increased use of health facilities in Ghana for delivery by pregnant women. Therefore, CHAG must team up with all state and non-state health actors to develop and use a national integrated HMIS in the medium to long term.

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